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An object relations perspective on accounts of traumatisation among a group of Black South African National Defence Force soldiers

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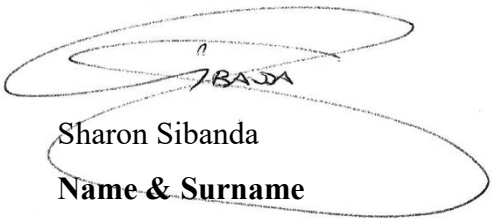
DECLARATION

I, Sharon Sibanda declare that the thesis which I hereby submit to the University of Pretoria, for the degree of Doctor of Philosophy in Psychology is my own work and has not been previously submitted by me for a degree at another university. Moreover, the material referenced herein is duly proclaimed.



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DEDICATION

This thesis is dedicated to my royal daughter and son. You beautiful souls are the anchors of my ship. My angels, my heart's treasures, how thankful and proud I am to be your mama.

ABSTRACT

This study explored the lived experience of traumatisation manifesting as enduring undiagnosed post-traumatic stress disorder (PTSD) on the overall psychological functioning of members currently serving in the South African National Defence Force (SANDF) from an object-relations perspective. A qualitative approach with a phenomenological study design using semi-structured interviews and self-report questionnaires to gather data was employed. Prominent themes formed the content for interpretative phenomenological analysis (IPA) from an object-relations perspective on pathology in relation to untreated trauma of the psyche. The findings indicated that servicemen and women in the SANDF lived in a chronic state of psychic, occupational and relational disintegration. Recurrence of reactivated past unresolved traumas experienced in dreams, troubled sleep and internal conflict were characterised by annihilation anxiety, psychic numbing and repression. Further, there was a chronic sense of loss of the self through loss of good internal and external self-objects as well as in meaning of life and work as a soldier. The findings further revealed overall functional paralysis as evidenced in these SANDF members'continued psychological deterioration, which manifested in irreversible damage to character and cognitive deficits linked to chronic trauma in the form of undiagnosed PTSD.

Keywords: undiagnosed PTSD, psychic and relational disintegration, chronic combat trauma, object relations theory (ORT), phenomenology, interpretative phenomenological analysis (IPA).

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CHAPTER 1: OVERVIEW OF THE STUDY

1.1 Introduction

In many countries, military forces have been integral to defence operations for at least the last two centuries. Military forces, identified by camouflage uniforms specific to each country, do not only protect their citizens by defending their countries, but also support international peacekeeping missions across the globe (Bulletin World Health Organ, 2007). At present, military forces from developing countries, including South Africa, are deployed to participate in many multinational operations. Post-traumatic stress disorder (PTSD) as well as associated mental health problems subsequent to deployment missions presents a major challenge in military mental health treatment in the South African military as well as the military throughout the world. There is substantial psychological fragmentation associated with this deployment related clinical trauma syndrome when undiagnosed, including impaired functioning in an occupational, emotional and relational capacity, as evidenced in the South African National Defence Force (SANDF) (Deah, Klein & Alexander, 2011). PTSD has been shown to be fairly prevalent across the globe, with lifetime estimates in nationally representative samples reaching 6.8% in the US (Kessler & Üstün, 2008). In the veteran population, however, this percentage is notably even higher at 12.0% (Tsai et al., 2014). While gains have been made over the past few decades in understanding and treating symptoms of PTSD, there has been fierce disagreement on the prevalence of PTSD following deployment among different militaries around the world, making it difficult to fully comprehend the relationship between combat exposure and the development of mental health symptoms after deployment (Yehuda, Vermetten, McFarlane & Lehmer, 2014).

Historically, the South African military has had expansive combat experience and has participated in a number of conventional wars including the First and Second World Wars. During apartheid, armed South African Defence Force (SADF) troops were employed to eradicate opposition by non-statutory armed forces to minority rule, often directly supporting the South African Police (Stiff, 2001). Holomisa (1994) reports that on the eve of South Africa's first democratic general election in 1994, the SANDF replaced the then South African Defence Force (SADF). The SANDF integrated military encompasses the former TBVC homelands (Transkei, Bophuthatswana, Venda and Ciskei), MK (Umkhonto we Sizwe), APLA (Azanian People's Liberation Army), KZSPF (KwaZulu-Natal Self Protection Force) and SADF. Integrated members refer to those soldiers that remained in the SANDF through the integration of the seven disparate armed forces to form a national force and did not demobilise to be reintegrated into civilian life (Holomisa, 1994). Interviews conducted with former MK combatants during the latter half of the 1990s placed considerable emphasis on the need for rehabilitation programmes to address both their difficulties of adjusting to everyday life as well as the trauma suffered

as a result of war experiences (Mashike, 1999). It appears that PTSD has persisted undiagnosed in the SANDF long after the cessation of actual combative contact because of a failure to recover from stress spontaneously in a normal manner (APA, 2013). This also highlights the need to understand how characteristics of different combat exposures may contribute to new and unique clinical presentations of PTSD (Yehuda et al., 2014).

It was reportedly expected by former non-statutory armed force members that the integrated armed force would benefit from rehabilitation programmes to assist them to work through their trauma from previous military experiences. Traumatic combat exposure was a result of a militarised and accordingly, violent response to suppressing black resistance as an acceptable solution to Apartheid South Africa's difficult situation (Cock, 1990). The military's confidentiality and security regulations do not permit the release of information related to medical data including statistics on psychiatric cases. During the researcher's years of experience in the SANDF as a clinical psychologist, observations of manifesting maladaptive psychological, cognitive and behavioural presentations at social work and psychological service points suggested that these members may suffer underlying symptoms of undiagnosed PTSD. It is hypothisised that these symptoms may not only originate from current deployment operations, but also from previous operations under the armed forces and remained undiagnosed throughout the process of integration. More than two decades later, some SANDF members from these former armed forces seem to be plagued by mood, behavioural and psychosomatic symptoms that are suggestive of a possible trauma induced psychic organisational structure from combat exposure, which impairs their self-object relational capacity. This is supported by Hoge (2010) in that though a diagnosis of PTSD entails some functional impairment, for some individuals the impairment may be limited to non-occupational situations such as intimate relationships, as observed among some SANDF members. This evidences the latent structure of PTSD, or the manner in which the symptoms are organised across the different factors, which has been a topic extensively debated for over two decades (Armour et al., 2016).

For purposes of this study, PTSD is operationalised as *undiagnosed* and not *complex* to enable an exploration experientially embedded in the meaning or psychic function of traumatic combat experience and its aftermath in PTSD symptoms. That is, what might the symptoms be attempting to accomplish in the psyche (Brooke, 2017). Despite the observed clinical syndrome of undiagnosed PTSD, since the integration of the armed forces, the South African military has been and continues to be involved in a number of external operations. To date, the SANDF has been cautiously engaged in peace-keeping missions in the Democratic Republic of the Congo (DRC) and previously was involved in Burundi and Sudan (Stott, 2002). A study was conducted by Seedat et al. (2003), on the extent of trauma exposure and PTSD symptoms in soldiers who recently returned from a peace-keeping mission. They reported a probability that a high prevalence of PTSD in their sample may have been contributed to by high levels

of premilitary stress exposure, as well as pre-integration combat exposure. Furthermore, 29% of their study group meeting criteria for PTSD also reported marked depressive symptom, with 50% reporting excessive alcohol use consistent with the high rates of comorbid psychiatric disorders often observed in persons with PTSD. It is important to point out that this study was conducted for diagnositic purposes, and that these members remained untreated for fear of stigmitisation but largely due to lack of PTSD treatment programmes within the SANDF (Seedat et al., 2003).

The various non-statutory forces that previously belonged to internal anti-apartheid political movements were intended to work in conjunction with the previous statutory force in a newly formed SANDF. However, the integration of the seven former armed forces would have also necessitated psychologically integrative interventions. This would have aided in processing and containing the psychological wounds of these groups from different military forces with varying cultural backgrounds and combative histories in an effort to forge a new military culture and values to create a new cohesive system (Mashike, 2005). In this chapter, the political and combative South African military background, which led to an integrated national force, is outlined. In addition, the resultant psychic trauma that remains undiagnosed amongst Black members of the SANDF is explained, thus leading to the problem statement.

1.2 Background of the study

In the military context, the term *integration* usually refers to a process in which armed forces and military traditions are merged into one defence force after a war ends. However, the short to long-term process of replacing the SADF with a true national defence force, namely, the SANDF, encompassing the so-called statutory and non-statutory forces that had been at warring ends for 37 years, proved more psychologically convoluted (Mashike, 2005). The premise of this study is that this warring resulted in combat exposure that had enduring psychologically traumatic consequences with clinically observed manifest mood, coginitive, behavioural, relational and psycho-somatic symptoms of undiagnosed PTSD in some military bases. Similarly to the more recent construct of Complex PTSD (CPTSD) which includes not only disturbances in the domains of affect, identity and relational capacities, collectively termed disturbances in self-organization or DSO but also classic PTSD symptoms of re-experiencing, avoidance and sense of threat (Cloitre et al., 2020).

Summerfield (2001) proposed that a complexity of PTSD and related psychiatric conceptualisations is that they represent the medicalisation and pathologising of what may better be understood as human suffering or tragedy. This lends justification for the construct of undiagnosed PTSD in this study given the pathologising element and political complexities of South Africa's unique military history, as well as members' maladaptive attempts at continued repression of their PTSD syndrome. Moreover, military

combat may also represent the exploitation of populations to serve nationalistic and very often political interests. When working with traumatised military personnel one becomes attuned to the ways in which they differ from traumatised civilians. The question of whether biological and other aspects of PTSD resulting from deployment are equivalent to civilian PTSD becomes particularly important in designing specialised treatments for service personnel (Yehuda et al., 2014). There are evident links between this criticism of PTSD diagnostic criteria as rendering problematic repressive and oppressive apolitical relations and the idea of collective and historical traumatisation observed in the SANDF (Eagle, 2014). A further stream of thought about the socio-political location of traumatic stress coined the construct of Continuous Traumatic Stress (CTS). This, first aptly introduced by those offering psychological services to activists during the repressive apartheid years in South Africa (Straker, 2013), refers to the condition of or response to being compelled to live in a context characterised by current and future danger in which traumatic stress is, therefore, not past or post (Eagle & Kaminer, 2013; Stevens, Eagle, Kaminer & Higson-Smith, 2013).

In some instances, where psychic survival was no longer feasible with continuous untreated PTSD, a number of soldiers reportedly commited suicide. The correlation between PTSD and suicide has been a subject of debate, with some studies indicating that PTSD alone is associated with suicidal ideation and behavior (Castro & Kintzle, 2014). Between the start of 1994 and March 2000, almost 300 members of the SANDF committed suicide. Statistics provided by the military revealed that in 1999, an average of four soldiers committed suicide every month (Stott, 2000). It is believed that a significant number of the cases were members of the former liberation armies. Stott further noted that there were 2,040 suicides and attempted suicides in the army between 1990 and 2001. In addition, between April 2000 and March 2001, a further 48 SANDF soldiers committed or attempted to commit suicide (South Africa, Department of Defence, Annual Report, 2000 - 2001). Bartone (1998) wrote on stressors in peacekeeping operations and how these military activities contribute to high levels of stress in troops. Bruwer (2003) conducted research on members of the SANDF and the stressors they experienced in peacekeeping operations.The results highlighted that long working hours, boredom, traumatic events and women who had died caused high levels of stress in members of the SANDF. In the absence of effective psychological management, these risky situations would make members of the SANDF vulnerable to suicidal behaviour.

Globally suicidal behaviour is a psychological presentation that has become a challenge for military forces to prevent and manage. During the 22-year period from 1984 to 2005, 638 suicides reportedly occurred among the United Kingdom (UK) regular armed forces: 624 among males and 14 among females (Koopman & van Dyk, 2012). This can be explicated as follows from an object relations perspective, the theoretical framework grounding this study. Klein (1935, 1946) who adopted an object

relations perspective, which is a branch of the psychoanalytic paradigm, proposed that suicide results when trauma evokes annhilatory anxiety in the fear of disintegration of the self and loss of the sense of self as well as fear of loss of the good object due to the perceived destructiveness of the bad object. Some psychodynamic theorists suggest individuals attempt to regain the traumatically lost object by identifying with it. If the object has been lost through death, the ultimate act of identification is one's own death, and thus it may be that attempts to identify with the lost person result in suicide (Koopman & Van Dyk, 2012).

Winnicott (1974) asserted that the fear of breakdown is the fear of a breakdown that has already happened in infancy but has never been experienced. With this cue, Brooke (2017) suggests that all combat experience is lived at least twice: the first time being with total commitment to mission and survival, where the cost is depersonalisation; the second time being in order to experience for the first time the full human pain of what could not be experienced originally. When there is subsequent failure in the development of this capacity to experience, emotions are experienced as dangerous, threatening and overwhelming, and activate defenses that are needed to protect one against a sense of disintegration. In such instances, the occurrence of later life stressors or traumatic events may increase the likelihood of military personnel developing PTSD in response to a prior traumatic event (Andrews, Brewin, Stewart, Philpott, & Hejdenberg, 2009; Frueh, Grubaugh, Yeager, & Magruder, 2009). Repeated exposure to traumatic experiences in current operations may lead to surviving SANDF members experiencing a delayed onset of underlying PTSD symptoms or enduring characterological and functional deterioration as manifested in impairment in their self-object capacity.

The broad aim of this study was to explore traumatisation and subsequent long-term undiagnosed PTSD in the presenting behaviour and overall psychological functioning of Black members in the SANDF from an object-relations perspective. A secondary aim was to shed light on how members of the SANDF experience conscious and unconscious maladaptive psychological defenses against psychic disintegration from current and previous traumatic military experiences. According to literature a particular event that activates other, long-forgotten memories of previous traumas may complicate and interfere with healing. An individual who has not been plagued previously by intrusive and distressing memories may after being exposed to another traumatic event re-engage such memories of earlier experiences (Van der Kolk, McFarlane& Weisaeth, 1996). In an epidemiological study, Breslau et al. (2009), revealed evidence that substantiated the impact of a new trauma on pre-existing PTSD and further demonstrated that individuals who had already developed PTSD exhibited a remarkably higher increase in symptoms after a new subsequent trauma. According to Breslau et al. (2009) the presence of PTSD after an earlier trauma has a more substantial impact on PTSD symptoms following exposure to a subsequent trauma in comparison to the characteristics of this subsequent trauma. Initially, PTSD was

understood to be the result of a onetime severe traumatic incident. However, PSTD has since been shown to be triggered by chronic multiple traumas as well (Van der Kolk, 2000), with functionally impairing consequences in the long-term when it remains undiagnosed and thus untreated as observed among SANDF members. Thus, a commissioning of a Postraumatic Growth Model in the SANDF would only be effective for newly diagnosed cases in response to immediate combat trauma (Mashatola & Bester, 2020), thereby excluding members with unresolved trauma from pre-integration combat exposure.

1.3 Problem statement

According to Chuter (2000), South Africa was able to execute an integration process with different armies administratively, each with their own traditions, culture and military histories pledging common allegiance to the country's new constitution. Naidoo (2007) asserted that most of the former combatants from the different non-statutory forces had not defined their identities beyond the militarised masculine identity, which defined their activities during the conflict in the 1990s, specifically in the region known as the East Rand in South Africa. Military activities in this region resulted in a multitude of negative social and psychological consequences for those members. Fears during the negotiations to end apartheid rule and the violent armed conflict in retaliation against it suggested that this would undermine national reconciliation efforts and indirectly, economic reconstruction (World Bank, 1996). The integration process was partially embarked upon to counteract this; however, without the foresight of the psychological ramifications of the trauma these combatants had endured and the impact thereof in the long-term. In highlighting the flaws in the demobilisation and integration processes, Naidoo (2007) and Gear (2002) argued that psychological interventions, one of the most pertinent interventions, were excluded in these processes. The psychic wounds of traumatisation manifest as undiagnosed PTSD of the person of the soon to be statutory soldier were lost in the political and economic intricacies and dynamics that drove the integration process. This study was born out of this oversight as well as the dire psychological consequences of traumatisation, which seem to have become a burden on the soldiers and the SANDF as an organisation.

The influx of members to sickbays may have a link to comorbid untreated psychiatric syndrome associated with trauma as observed by military healthcare practictioners in the increased rates of presentations with somatic complaints, substance- and mood-related disorders and sexual misconduct. The inability to access patient (members) information within the SANDF on the underlying factors of these presentations makes treatment and restorative measures a challenge. This has resulted in functional impairment amongst members in the SANDF. In this study, functional impairment refers to the phenomena of cognitive, occupational and psychological impairments as well as emotional detachment possibly linked to traumatisation as deduced from serving members' patterns of relating to their internal and external world. Van der Kolk (2000) explained that symptoms of depression, increased aggression

against self and others, depersonalisation, dissociation, somatisation, distrust, shame, self-hatred, compulsive behavioural repetition of traumatic scenarios and a decline in family and occupational functioning may occur even when patients only meet sub-clinical criteria for PTSD. Therefore, focusing exclusively either on PTSD or on the depression, dissociation and character pathology diagnostic criteria prevents the adequate assessment and treatment of traumatised individuals (Van der Kolk, 2000). This may be attributed to long-term PTSD symptoms remaining undiagnosed in the SANDF. Further exacerbated by the fact that men who develop PTSD symptoms may be perceived by others or themselves as weak and lacking in fortitude and thus, they may conceal their symptoms (Eagle, 2006).

A twenty-year longitudinal study uncovered that a substantial number of veterans who were diagnosed with PTSD shortly after combat, still suffered from PTSD seventeen years later (Solomon et al., 2006). Similar conclusions can also be drawn from findings of Bradley et al. (2005), evidencing that a majority of patients continue to suffer post-treatment from residual symptoms. The nature of combat may also determine post-deployment mental health sequelae and require specialised pre-deployment training, as well as specialised treatments that address these complex issues as suggested by Thompson & Jetly (2014). Despite South Africa's violent combat history between the armed statutory and non-statutory forces, very few psychological studies or far-reaching treatment interventions that can be applied outside a deployment debriefing framework, aimed at addressing these forces' enduring overt or underlying traumatic stress response trajectories have been conducted. In this study, Black SANDF members' experience of traumatisation, from pre-integration combat exposure as re-activated by current military experiences, on their intra and interpersonal relational dynamics and overall functional capacity, was explored. The functionally paralysing manifestation of this repressed and unresolved trauma has necessitated an understanding of how these members live with residual undiagnosed PTSD symptoms.

1.4 Aims of the study

The broad aim of this research was first, to investigate the lived experience of traumatisation among Black SANDF members and how this enduring experience of undiagnosed PTSD affects their everyday life as members of the SANDF. Specifically, the purpose of the study was to understand how Black SANDF members make sense of their experience of trauma and its consequent effect on their relational patterns and daily coping. Accordingly, the following research questions were formulated:

1. How do SANDF members understand the concept of trauma?
2. How do SANDF members cope with feelings associated with the experience of these trauma-related responses in their daily functioning?

3. How do SANDF members relate with family, friends and relatives when past traumatic experiences are reactivated?

In light of the research aim of elucidating Black SANDF members' experiences and understanding of the functionally, relationally and psychologically impairing consequences of traumatisation, a qualitative method of research within the realm of phenomenology was considered the best fit. In qualitative research phenomenological approach is considered to be the most suitable to employ to shed light on the root cause of a phenomenon (Creswell, 2013). For this particular study, a phenomenological research approach is apt to explore, investigate and interpret the *lived experiences* of Black SANDF members who have been subjected to trauma.

The phenomenological approach entails a focus on experience in order to obtain comprehensive descriptions that provide the basis for reflective interpretation and analysis that portrays the essences of the experience (Neubauer et al., 2019). Furthermore, a phenomenological approach provided an understanding of the themes and patterns that emerged from attempting to understand the participants' experiences. Therefore, Black SANDF members who participated in the study were asked open-ended interview questions, such that their specific experiences could be explored (Christensen, Johnson, & Turner, 2015). By doing this, I could explore and interpret the experiences and feelings of Black SANDF members from their own point of view. The semi-structured interviews were conducted using an interview guide (Appendix 4). However, interview guides are developed iteratively, and questions are developed, tested, and then refined in accordance with what one learns from asking participants these questions (Warren & Karner, 2015). Thus, the interview questions guided the conversation and ensured that the interviewer focused on exploring specific aspects related to the lived experiences of the SANDF members (Christensen et al., 2015).

1.5 Justification of using IPA

Phenomenology, which pertains to human understanding and experiences, originated from the ideas of Edmund Husserl. Husserl (1970) surmised that the core meaning of entities in the world can be understood by intuition. The implication is that an individual's actions in the world can be understood through uncontaminated perceptions of previous experiences and viewpoints (Husserl, 1970). This thinking has led to substantial research in healthcare where the focus is on exploring individual lived experiences (Smith et al., 2009). In an endeavour to explore the lived experiences of traumatisation manifesting as long-term undiagnosed PTSD among Black SANDF members, interpretative phenomenological analysis (IPA) was employed.

IPA is guided by and assimilates processes or methods from phenomenology, which is concerned with the experiences and meaning of an individual, hermeneutics, a theory of interpretation, and ideography, which focuses on the particular rather than the universal (Smith, 1996). Accordingly, IPA explores how research participants make sense of their personal and social worlds in detail (Smith & Osborn, 2003). The most pivotal aspects of IPA include: the focus on what the meaning of an experience or event holds for a participant; an in-depth enquiry into the life-world of a participant; and an endeavour to explore the personal experience and personal perception or account of an event or object instead of an attempt to produce an objective statement of the event or object itself (Smith & Osborn, 2003). In employing the ideographic approach to answer the research questions, a small sample of up to 10 respondents can be used to enable the researcher to write up a single case or to explore themes shared between cases (Smith et al., 2009). Given that I was interested in understanding Black SANDF members' experiences of traumatisation as manifested in their undiagnosed PTSD syndrome, this approach appeared to be the most suited to allow for the emergence of experiential themes across different cases.

According to Creswell & Poth (2017) phenomenology studies participants' perspectives of their world while, endeavouring to describe in detail the content and structure of the subjects' experience. Furthermore, phenomenology allows the potential to grasp the qualitative diversity of the subjects' experiences and to attempt to interpret their essential meaning (Creswell & Poth, 2017). Thus, by employing IPA I explored the meanings of Black SANDF members' experiences of psychological disintegration as a result of combat traumatisation to some extent through a number of accounts given by the research participants. Furthermore, IPA enabled both participants and myself to arrive at an intersubjective co-constructed understanding of SANDF members' experiences of traumatisation. An interpretation of the participants' experiences occured through open dialogue that allowed for the sharing and interpretation of unique perspectives and ultimately, an understanding of multiple perspectives across various themes (Smith et al., 2009). This afforded an in-depth understanding of the psychological defenses they employed, which shaped their psychic structure, in an endevour to cope with the myriad demands of their military obligations on their cognitive, relational and general psychological functioning (Burrell et al., 2006). Accordigly, the consequences of truamatisation manifesting in undiagnosed PTSD on the lives of some Black SANDF members and the resultant relational, functional and characterological impairment was described from their experiential reality through comprehending the way that they make sense of their experiences and their world. To achieve this aim, I endeavoured to 'get inside' the participant's experience (Neubauer et al., 2019).

1.6 Anticipated contribution of the study

The contribution of this study is to generate insights into Defence mental healthcare, providing information to inform policy and change psychological programmes and clinical practice in the treatment of long-term PTSD. This could be incorporated into the SANDF's psychological wellness programmes and form part of Comprehensive Health Assessment (CHA) intervention tools. The findings from this study may be beneficial in guiding military mental health practitioners to establish treatment programmes aimed at psychological relief and integrative meaning making of members' unique clinical presentation of sydrome of undiagnosed PTSD. Intensive proactive psychological programmes could be developed following the training of mental health care practitioners in understanding how enduring unresolved trauma underlies Black SANDF members' manifest psychological, physical, behavioural and occupational presentations.

1.7 Outline of chapters

In Chapter 1, the study was introduced. Furthermore, the aims, problem statement and structure of the research were outlined. The next three chapters serve as a literature review of Object Relations Theory (ORT), combat trauma and PTSD, as well as phenomenology. ORT and ORT in relation to untreated trauma of the psyche is explained in Chapter 2. PTSD and the theoretical understandings of combat related trauma and PTSD from psychonalytic and self-psychology perspectives are reviewed in Chapter 3. In exploring these concepts, the internal defensive dynamics of the patient with PTSD syndrome are explored theoretically as a means of understanding the manifestation of those dynamics that play out unconsciously in this disorder. By exploring some of theoretical understandings of PTSD, specifically that PTSD is possibly a representation of a disintegrated psyche as a defense against psychological failure in environmental provision, some theoretical light is shed on what can be expected in the manifestation of underlying undiagnosed PTSD symptoms in response combat trauma.

In Chapter 4, the origins, philosophical principles and implications for research of phenomenology are discussed. An exploration of the methodological procedures employed to conduct this study constitutes Chapter 5. The chapter includes a rationale for the sample, a description of the interview procedure for data collection and detailed descriptions of the theoretical underpinnings of phenomenology and IPA. The steps followed during the IPA of the interviews are also outlined. Finally, the interviewer's bias and ethical considerations are discussed.

The findings of the study are presented in Chapter 6. The themes elucidated from each participant as well as an analysis of the themes across all nine participants are provided. In Chapter 7, the common experiences of each participant facilitated an engagement of a discussion with the literature. Thus, the

findings were explored within the existing theoretical understandings of trauma induced psychic organisational structure of persons presenting with PTSD, specifically from an ORT perspective. The limitations of the study and recommendations for possible future research are also discussed in this chapter.

A theoretical overview of ORT, which emanated from psychoanalytic theory, constitutes the next chapter.

CHAPTER 2: OBJECT RELATIONS THEORY

2.1 Introduction

Object relations theory emanated from psychoanalytic theory. However, the theory deviates from Sigmund Freud's belief that humans are motivated by sexual and aggressive drives, but rather proposes that humans are primarily motivated by the need for contact with others: the need to form relationships (Goldstein, 2001). Object relations theory in psychoanalytic psychology explicates the development of a psyche in relation to others in the environment during early life. During the 1940s and 1950s, British psychologists Klein, Fairbairn, Winnicott, Guntrip and others expanded on object relations theory. Object relations theories are related primarily to developmental processes and relationships prior to the oedipal period. Individuals are believed to interact not only with an actual other, but also with an internal other, a psychic representation that may be a distorted version of some actual person (Welch, 2004). Object relation theories offer a conceptual understanding of the psychic developmental role of interpersonal relating in affect regulation, which is pivotal in the face of trauma. These theories are predominantly concerned with the manner in which people develop in the context of their emotional connections with others (Schore, 1994). In this chapter, an overview of the *object* in Klein and Fairbairn's theories, object relations perspectives on psychic developmental arrest, self-psychology and psychopathology, and pathology in relation to untreated trauma of the psyche as expanded on in object relations theory is provided.

2.2 Object relations theory: An overview

Object relations theory has provided a most concise observation and understanding of the mother-infant relationship and the development of a self in the dyad (Caparrotta & Ghaffari, 2006; Charles, 2006; Goodsitt, 1983; Lane, 2002). The emphasis in object relations theory is on the integration of copious representations of the self and other as objects, rather than on the need for biological relief as in drive theory (Caparrotta & Ghaffari, 2006). Moreover, object relations theory has shifted from drive theory's intrapsychic emphasis to the development of the psyche in relation to others (St. Clair, 1986). More specifically, object relations refer to a theory of intrapsychic activity based upon the internalisation of functional aspects of the experience of others and the way they relate to one another in the mind (Mills, 2010).

Object relations theory argues that the manner in which adults behave is largely shaped by their experiences during infancy. The past relational experiences or images of a significant other are transformed into objects in the unconscious mind of the infant. These objects form the internal representations of what relationships or people should constitute (Fairbairn, 1952). These internal object

representations that are used by the unconscious mind of the infant to create a template of what to anticipate from others is carried into adulthood. For example, if adults had experienced neglect at the hands of a caregiver in childhood, they would expect others who reminded them of the neglectful caregiver to behave in the same neglectful manner (St. Clair,1986). Therefore, adults develop an internalised representation, that is, an object from early childhood experiences of how others should behave towards them. These representations guide relational experiences accordingly. To reiterate, internal objects are formed on the basis of patterns repeatedly experienced in the caretaking environment that may accurately represent the actual external person, namely, mother, father or significant other. These representations comprise the *good* and *bad* experiences of those individuals. The goal involves those aspects being assimilated and reconciled into a mental representation that is able to both disappoint and please (Siegel & Forero, 2012).

According to Klein (1946) these internal representations can be part- or whole-object related. Part-object relating is associated with infants, and later adults, who have not fully developed the capacity for *whole-object* relating or are unable to see the whole person, but rather relate to others in accordance with the function of their parts. In other words, they tend to perceive people as good or bad (Klein, 1946a). A mother who has a good breast that feeds the infant and a bad breast that leaves the infant hungry and deprived is an example of part-object relating. The latter forms an internal representation of the mother as being either good or bad. When infants are engaged in whole-object relating, they are able to represent the mother as a whole person, rather than representing her as a function of either a good or a bad breast, as in part-object relating (Klein, 1946b). Whole-object relating allows the mother to be perceived as good and bad; that is, although the internal representation of the mother is ambiguous, the infant is able to tolerate it. While these experiences may form the template for future relationships, it is possible to alter these early set patterns during later experiences in an adult's life. However, the internal object representations can wield a strong influence throughout an individual's life (Fairbairn, 1952; Lane, 2002). In essence, an object may be sentient, affective, perceptual, imagistic, or conceptual, such as an object representation, or what may be equated with an internal object, which is often the contents, attributes, and functional properties of others who are assimilated into psychic structure (Mills, 2010).

Object relation theorists' view of disturbance also differs from that of the classical Freudian model. In this regard, psychological disturbance is considered to relate to damage to the self and structures of the psyche. Similarly, early developmental deficits are thought to impede the formation of a cohesive self, thus preventing integration of the psychic structures (Welch, 2004). Objects and their relations occur on the level of personality formation and lend order to psychic organisational structure that affects communication between people, hence the term object relationships, and within interrelationships with

a whole host of others, as well as external systems. Object relations are also causally determined and correlated with various forms of psychopathology and human suffering (Mills, 2010).

Soldiers with PTSD engage in maladaptive behaviours that undermine self-cohesion and originate from developmentally arrested self- and object-representations in individuals with primitive psychic organisations (Parson, 1984). Therefore, object relations theory posits that pathological behaviour in adults stems from pathological relationships with caretakers in infancy (Mullin, Hilsenroth, Gold & Farber, 2017). One enduring effect which is important for the definition of trauma is that basic trust is destroyed, with resultant enduring disruption of the understanding of oneself and the world (Levitt, 2010). Trauma is not merely a relational term because it connects inside and outside, but also because in trauma a fundamental holding object relationship breaks down.

Despite the ackowldgement of the widening of knowledge that object-relations theory has brought in the understanding of the pathogenic role of trauma, the fact that the concept of trauma has become less distinct as a result is criticised. Object-relations theory models, however, illuminate that with the collapse of the internal supporting object relations, arises the feeling of utter abandonment and the disruption of any and all affective bonds and internal communication, as a result of which the trauma cannot be integrated (Levitt, 2010).

A synopsis of the fundamental principles of object relations theories follows. Although those developed by Klein and Fairbairn are complex, incomplete and oftentimes internally inconsistent, they remain significant within the object relations movement.

2.3 The object in Klein's theory

Klein accepted Freud's sequential stages of psychosexual development, but conceptualised her theory in relation to what she termed positions (Burch,1988). Klein constructed two positions: the paranoid-schizoid position and the depressive position. She perceived each of these as structures of object relations, anxieties and defenses; the three elements change in accordance with the position (Burch, 1988). Klein was of the opinion that the death instinct is dominant at the beginning of life and thus, she perceived any anxiety experienced by the infant as an unmediated response to the internal representation of the death instinct. As anxiety characterises both positions, it is referred to as persecutory-anxiety and depressive-anxiety in relation to the paranoid-schizoid position and the depressive position, respectively (Quinodoz, 1993). It is noteworthy that Klein (1959) posited that the anxiety expressed in these positions centres on and relates to the mother or the mother's breast as an object.

2.3.1 The paranoid-schizoid position

The paranoid-schizoid position occurs between birth and four months of age. It is characterised by the infant being subject to oral aggressive impulses and part-object relating rather whole-object relating. During this phase, the dominance of the death instinct evokes internal anxiety and the infant's fears are of the paranoid kind. The ego is fearful that the self and the ideal object with whom it identifies will be destroyed. The mechanism of projection is employed as a defense in an attempt to assuage the anxiety that the infant experiences internally. Feelings of aggression are projected onto the object. Furthermore, this projection leads to a phantasy of the bad object (Quinodoz, 1993). The infant experiences the distorted image of the object or the phantasy as real. The object is perceived as dangerous and has the ability to retaliate and harm the infant. This fear of the object is known as persecutory anxiety (Klein, 1935). As a result of the projection, the infant experiences the threat as originating from without. However, alleviation from the anxiety is not acquired when the death instinct is projected onto the object, but it is subsequently introjected and gives rise to paranoid anxiety (Burch, 1988). When the infant perceives the frustration or threat to the satisfaction of needs originates from the object, the object also becomes persecutory. The external persecutor is also internalised by means of introjection and becomes the internalised bad object. Therefore, the persecutory object becomes threatening from both within and without simultaneously by means of the mechanisms of projection and introjection. When comfort is provided to the infant and needs are satisfied, happier emotions are evoked. These feelings are perceived as originating from the good object. Anxiety about the persecutor culminates in the ego splitting off from the bad object to eliminate the source of danger. This split also serves to preserve the good object. Splitting as a defense marks the schizoid position (Quinodoz, 1993). Consequently, through splitting, projection and introjection, the ego strives to part inner and outer persecutory and ideal objects as far as possible while maintaining control over both of them.

It is evident that during this phase of development, tolerance of frustration is insufficient and emotional reactions are extremes of good and bad. Development within the paranoid position is a function of the amount of innate aggressiveness and libido with which the ego is born, and of the consistency of good feeding and good overall handling, which directs the degree of frustration to which the infant is subjected (Summers, 2014). Similarly, frustration intensifies fear of the object, intensifying the bad-object relationship and leading to greater difficulties in bearing negative experience. Ultimately, it is the relative strength of the early object relationships, Klein believed, that determines the outcome of the paranoid position (Summers, 2014).

2.3.2 The depressive position

The infant's recognition of the mother as a whole object from approximately five months of age onwards marks the onset of the depressive position. This phase is characterised by integration, ambivalence, depressive anxiety and guilt. The primary task involves establishing a good and secure whole internal object in the core of the ego. The psychic reality of the infant is influenced slowly by the gradual attainment of knowledge of the external reality during this phase. Identifying with the good object guides the infant to a greater awareness of dependency on the external object as well as the ambivalence of instincts and aims. Mourning is one of the primary characteristics of this phase (Quinodoz, 1993). The loss of the breast and all the good that it represented is mourned and the infant feels responsible for this loss. Now with an awareness that the object about which destructive phantasies had been entertained is one and the same as that which is loved, the infant agonises that its destructive impulses endanger the good object. The protection thereof is synonymous with the survival of the infant's own ego. However, the anxiety elicited has become depressive in nature. Although the persecutory anxiety abates during this phase, it does not disappear altogether. Appreciation of dependency on the object intensifies the need to possess the object and this is experienced as a phantasy of assimilation (Quinodoz, 1993).

The super ego, which is employed from the very primitive age of five or six months, is that part of the ego that controls dangerous impulses (Klein, 1959). At the crux of the depressive position is loss and mourning: mourning the separation of self from the mother, mourning the loss of the narcissistic phantasy where the child's ego was the world, mourning the objects it has hurt or destroyed through aggression and envy. However, from the ruins there arises first the feeling of guilt, then the drive for reparation and love (Etherington, 2020). Reparation may be explained as the expected outcome associated with the depressive position as it is an indication of the capacity to resolve the conflict between love and hate. This conflict, with resultant feelings of guilt and fear, elicits a response in the infant to make reparation with the loved object who has been destroyed by aggression in phantasy (Burch, 1988; Klein & Riviere, 1964). Reparation is a perceived healthy and non-defensive attempt to dissolve what has been done in phantasy. It serves the purpose of drawing infants into closer touch with reality as they continually realise that the mother continues to be available despite their destructive phantasies (Burch, 1988). Furthermore, the integration of the good and bad objects is facilitated as infants realise that they are part of the same person. Thus, as infants' own psychic reality is uncovered, they gradually test the power of its own impulses and the object's resilience. The limits of hate and love are discovered and increasingly more ways of influencing external reality are discovered. The infants' relation to reality is established in this manner. A successful outcome in working through the depressive

position is dependent on their capacity to master the internal chaos and securely establish a good internal object (Klein, 1940).

In light of the foregoing, it may be deduced that Klein conceptualised that psychic development originated from the interaction between internal and external influences. She perceived the external reality and psychic reality as constantly interrelated, as facilitated by the mechanisms of projection and introjection, which are experienced as unconscious phantasy. However, she noted that the extent to which external reality is able to negate anxieties and sorrow relating to the internal reality varies with each individual (Klein, 1940). Furthermore, Klein (1959) was of the opinion that there is much oscillation between the two phases of development and their characteristics persist throughout life. In this regard, Klein's positions are not distinct stages of development in which once the stage has passed the associated phantasies disappear. Crises can prompt regression to one of the positions in all individuals, especially if initially they were not worked through adequately (Burch, 1988; Klein, 1959). The implication is that, once again, the state of regression, phantasy, projection and introjection play a central role. However, if good object internalization is well established, the infant will be able to sustain whole object integration. Severe pathologies are likely to be manifest if there has been a notable incapacity to work through one or both of the positions (Summers, 2014).

2.3.3 Mourning and manic defenses

As noted previously, reparation is infants' attempt to abate pain associated with a real or imagined loss that has been experienced by them. However, Burch (1988) stated that when reparation fails to abate the pain, infants may employ other defenses. The most notable of these, as formulated by Klein, is the manic defense by which infants minimise the loss through phantasies of omnipotence. This process enables denial of the significance of the good object through devaluation. Obsessional repetition or ceaseless efforts at reparation is another defense that may be employed. Burch (1988) argued that the sense of omnipotence that the infant may experience is maladaptive because denial of the external world impairs reality testing and prevents mourning. In addition, internalisation of the good object is hindered. Denial of harm to the object also prevents the infant from experiencing a healthy impulse towards reparation, sorrow and guilt.

Burch (1988) explained that losses in adulthood may bring the early mourning process back to consciousness in that good objects feel lost again and paranoid fears are restored with a sense of persecution. If defensive tendencies dominate the manner in which society comes to terms with the disaster, the victims often feel excluded and blocked out or left alone with their experience. This undermines their feeling of security again and renders them vulnerable to retraumatizations or condemns them to remain silent since they could never expect to meet with understanding (Levitt, 2010). By

situating Klein's work on wartime analyisis and larger theory of psychic reparations in the political climate of wartime Europe, her writings point to the ethico-political dangers inherent in reparative endeavours, which name the object and narrate its injury and repair in accordance only to the perimeters of one's own self. Laubender's (2019) postulation that there might be an advantage to foregoing the injury or repair framework implicit in reparative agendas, may explain the phenomenon of undiagnosed PTSD despite presenting clinical syndrome given the history of the SANDF.

Klein perceived this collapse and deterioration of the inner world as a state of mental illness that is often unacknowledged because of its prevalence (Burch, 1988). Burch added that sometimes the sorrow and distress of mourning may be interrupted by periods of elation that are manic in character and a consequence of phantasies of having incorporated the idealised object. An incapacity to mourn dictates denial of love for both internal and external objects, the outcome of which is a blunting of emotional life or an absence of feelings of love while hatred still reigns freely. Klein curtailed the pathogenic significance of parental anxiety, ambivalence and character pathology. Fairbairn, in reaction to this omission in Klein's work, included parental deprivation as the absolute cause of psychopathology (Mitchell, 1981).

2.4 The object in Fairbairn's theory

Fairbairn posited that natural objects searched for prior to any deprivation include other people (Mitchell, 1981). Fairbairn espoused that there is a naturally unfolding maturational succession of needs for various kinds of relatedness with others, from infantile dependence to the mature intimacy of adult love (Mitchell, 1981). Fairbairn spoke of the internalisation of objects merely as the result of the general integrative tendencies in the early oral period. He referred to a general internalisation of both good and bad objects during the early months of life in response to frustrations in external relationships with others. In an attempt to deal with frustrations in oral relationships, the individual engages in the incorporation of the object as a process. If children encounter later complexities in their relations with others, they return to these early incorporated objects and regressively reactivate their relations with them. Fairbairn believed this is preceded by frustration, departing from Klein's view that all experiences with an object eventually become internalised (Mitchell, 1981).

In 1943, Fairbairn proffered a second view of the first internalisation in which he focused on motives that were purely related to object relations and defense (Mitchell, 1981). Fairbairn further emphasized the proportion to which parents who are emotionally absent, intrusively chaotic and inconsistent pose a considerable psychic dilemma for the child. Consequently, based on the necessity to preserve the illusion of the parents as real figures in the world, a first in a succession of internalisations, repressions and splits occurs (Mitchell, 1981). The child separates and internalises the bad part of the parents, which ensures

that it is the child who is bad and not the parents. Fairbairn added that every child needs to experience their parents as understanding the world, just and dependable. When they fail to experience them in this way, children transfer the problem to themselves by adopting the burden of *badness* (Fairbairn, 1943). The *badness* of the parents' undesirable characteristics is now in them and they become bad objects with whom the ego identifies through primary identification. In this manner, environmental (external) security is acquired at the expense of sacrificing emotional (internal) security. Another feature of this initial internalisation process is the preservation of the phantasy of omnipotent control. If the *badness* remains inside children, they maintain hope of omnipotent control over it (Fairbairn, 1943).

A secondary process of internalisation follows the initial internalisation of the parents' *bad* aspects, which Fairbairn termed the moral defense. This involves the formation of good internal objects (Mitchell, 1981). Fairbairn reasoned that as a consequence of the initial internalisation, children feel that they are irrevocably and unconditionally bad. They do not feel unloved because of any impediment or difficulty in the mother, but because they are bad and unlovable. The moral defense involves the internalisation of the parents' good and ideal aspects to create the possibility of internal goodness (Mitchell, 1981). The identification with the good objects serves as a defense against the badness children feel subsequent to the initial internalisation. The experience of children involves the notion that they have been bad and unworthy of their parents' love, but that they can be good through identification with their good objects (Mitchell, 1981).

Fairbairn argued that the self-accusations and perfectionistic strivings are not intrinsic punishments for phantasised wrongdoing and instinctual gratifications as viewed within the classical model. They result from the double process of internalisation comprised of the moral defense in which children protect themselves from the core feeling of helplessness and despair in response to the absence of relatedness with their parents (Mitchell, 1981). For Fairbairn, relations with internal objects are intrinsically masochistic. Bad internal objects are cast as persisitent tempters and persecutors, while good internal objects offer no real gratification, but merely a refuge from relations with bad objects. Accordingly, the restored ego does not need attachment to internal objects but can turn to relationships with real others in the external world (Mitchell, 1981). Splitting then becomes a consequence of the proliferation of internal objects to which different parts of the ego become attached with resultant fragmentation of the original ego (Greenberg & Mitchell, 1983). As Fairbairn connects dissociation to the origin of internal objects, part of the self therefore remains directed toward the real parents in the external world, seeking actual responses from them whilst also redirected toward the illusory parents as internal objects to which it is bound (Mitchell & Black, 1995).

An area bearing on the nature and function of objects wherein Klein and Fairbairn differed is the viewpoint on the ultimate source of pathology in human experience. Klein posited that the root of

pathology lies in the instincts, particularly the death instinct and its derivative, aggression. Klein added that the earliest anxiety for children is persecutory; they experience the threat of their own annihilation as the victim of their own projected aggression (Mitchell, 1981). On the contrary, Fairbairn asserted that the root of psychopathology is maternal deprivation. According to Fairbairn, central anxiety involves the preservation of the link to the object in the face of deprivation. Furthermore, all psychopathology is understood to be derived from the ego's self-fragmentation in the service of preserving that link and defending against ungratifying aspects.

2.5 Object relations and psychic developmental arrest

As alluded to previously, object relations theory includes an understanding of the mother-infant relationship and the development of a self in that dyad. When infants are failed by their mother by not being able to receive and modify her own persecutory anxieties, they are compelled to introject their own unmodified anxiety as well as hold the mother's projections (Bion, 1962; Lawrence, 2002; Williams, 1997). Williams (1997) asserted that the mother's unbearable projections are experienced as an intrusive object or foreign body by the infant. The mother's anxiety is introjected by her infant who experiences this as traumatic, resulting in a considerable amount of distress (Bion, 1962). Failure of a mother's capacity for reverie results in developmental arrests within the self-representation of the infant (Winnicott, 1974). Developmental arrests are infantile emotional states that adults regress to when the psyche feels overwhelmed. Therefore, adults are experienced as being emotionally arrested at the age during which they experienced maternal failure and results in adults who have not emotionally matured (Stolorow & Lachmann, 1980). Due to developmental arrests, adults are perceived as being erratic where during one moment they act appropriately, but revert to childish behaviour during the next because emotionally they are stuck within two years of the age of their infantile woundedness (Stolorow & Lachmann, 1980). Arrested development can also find expression in the inability to recognise the self, distinguish its own wishes from those of others and self-regulate. When there is an impediment in self-regulation, infants attempt to self-soothe by attuning themselves to the mother. Attuning to the mother's needs fosters a sense of being understood, connected and as having cohesiveness, but this may also be a defense against breaking down (Bion, 1962; Winnicott, 1974). The process of self-regulation in relation to the mother further denies infants' self from fully developing as they have to submit to their mother's needs, thus denying infants' own process of need fulfilment.

Infants have an internalised conflict through which to work. While they need to be attuned to their mother, which could result in self-annihilation, they need to preserve psychic survival, which entails preserving and separating their self from their mother's self (Charles, 2006; Krueger, 2001; Lane, 2002). In an attempt to resolve this conflict, a defense mechanism such as splitting, for instance, occurs a consequence of part-object relating. The mother is idealised and perceived as good while the infants

engage in self-criticism and are perceived as bad (Goodsitt, 1997; Hinshelwood, 1994; Joseph, 1985; Klein, 1946a; Segal, 1957). Anything that is perceived as causing the mother pain and suffering is seen by infants as their fault even though they attempt to deny their own murderous rage towards the mother. The more rage they feel, the more they perceive themselves as evil and bad, which is manifested symbolically between the infants and their mother. In other words, even though infants have very little sense of self at this stage, their sense of self develops. Furthermore, the development includes a symbolic image of themselves and their mother, which is perceived as either good or bad (Hinshelwood, 1994; Segal, 1957; Winston, 2009).

The mother's capacity to understand her infant through attunement, which is the mother's ability to connect to, understand and meet her infant's needs, is essential because interference in the process will affect the infant's ability to symbolise (Charles, 2006; Hinshelwood, 1994; Krueger, 2001; Lane, 2002; Ritvo, 1984; Schwartz, 1986). The process needed for symbolisation permits the infant to create a transitional object, an object of psychological comfort (Winnicott, 1974) from the illusion of good mothering (Hinshelwood, 1994). The formation of a transitional object demonstrates that the infant has the ability to symbolise because the infant is able to represent the mother in an object that is separate from the mother herself. In the absence of this separate psychic space, the object becomes confused with the object representation in the mind of the infant; this is known as symbolic equation (Segal, 1957). While Segal conceptualised this breakdown in symbolisation proper as a result of inadequate containment, like Klein, she did not explore this in terms of psychological trauma. This has been the work of contemporary psychoanalytic theorists, who understand trauma to erode the capacity for symbolisation proper, leading to a collapse o f distinction between symbol and symbolised characteristic of symbolic equation. This leads to a self-perpetuating cycle in which the traumatic experience, by rupturing internal containment, erodes symbolic functioning, on which psychic repair is dependent (Garland, 1999a).

Klein ascribed development and psychopathology to the interaction between the infant's ego and internal and external objects (Bacal & Newman, 1990). It follows that psychological trauma is felt to be caused by internal objects, either in the form of hateful bad ones or neglectful good objects (Young, 1999). In this way inner realities shape the way external realities are perceived so that frustrations and discomforts are experienced as if they are hostile, attacking forces (St. Clair, 2004). Bacal and Newman (1990) noted that Klein's emphasis was on instincts in the form of phantasies and inner objects, with minimal focus given to the role of the environment and modification through good objects. Klein believed that failure to master and work through the early phases of development may result in varying degrees of aberrance. However, she acknowledged that real objects provide a crucial moderating function and that the closer the content of internal objects is to the real object, the less the pathology

(Klein, 1932). Problems that may be encountered and pathology that may develop are subsequently discussed through a self-psychology lens, which emanated from object-relations.

2.6 Self psychology and psychopathology

Bacal and Newman (1990) view object relations theories as a bridge to self psychology. Object relations theory as used in this study signifies a systematic effort to account for personality development and pathology on the basis of unconscious subjective experience of internal objects serving various psychic functions and constituting the structural organisation of the self (Mill, 2010). Kohut's self-psychological theory is about the object and its functions as absorbed under the general category of self-organization, regulation, and transformation attributing to the enlistment of *selfobjects*, which are the evoking, responding and sustaining experiential nexus of the internalized functionality of objects that affect the structural cohesiveness of the self (Mills, 2010). Kohut, like all other object relations theorists, viewed early object relationships as the key to the formation of psychological structure, but he conceived of the psyche as a self structure rather than as an organization of ego mechanisms (Summer, 2014). In accordance with this perspective, psychological disturbance is regarded as involving damage to the self and structures of the psyche. Self-psychology views the development of psychopathology as being steeped in how patients have internalised their objects. This not only fits well with object relations theories, but also expands on the object relations understanding of the interpersonal dynamics between a person and another (Bacall & Newman, 1990; Wolf, 1988).

The focus in self-psychology is on acquiring a cohesive self-structure because an infant may have a self-representation that is fragile and vulnerable, lacking stable boundaries and cohesiveness (Miller, 1991; Stolorow & Atwood, 1992). Similar to object relations theories, self- psychology posits that the presence of others including the mother is necessary to function as self-objects for maintaining and reinforcing a healthy narcissism (Kohut, 1971; Lichtenberg, 1991). A self-object fulfils the necessary psychic life-preserving function that the self is unable to perform itself (Summers, 1994). Therefore, the self-object function explains the intrapsychic experience and not necessarily the interpersonal relationships that exist between the self and other (Krueger, 2001; Summers, 1994). The responsive self-object environment provides the experiences of living that enable the transmuting or internalisation of the infant's potential into a creative aliveness and realness to allow for joyful interests and self-affirming experiences (Geist, 1989). This means that the purpose of a responsive self-object setting or environment is to allow the infant to build self-esteem and self-regulation and experience a feeling of continuity over time and space that leads to a cohesive self (Kohut, 1971; Wolf, 1998).

If infants are exposed to a level of optimum frustration, they will gradually learn what they can appropriately control and what is out of their control (Kohut, 1971; Miller, 1991). Through this

developmental process, infants as a result of their developmental omnipotence become aware of the control they have over their own emotional states. This process can result in an experience of the self as a regulating agent. The infant establishes affect regulation and impulse control while discovering that emotions can be manipulated and discharged internally as well as through actions. Moreover, the infant comes to know that affects are experienced as something recognisable and sharable (Miller, 1991). However, expressions of affect by the mother that are mismatched to the infant's internal emotions are likely to result in confusion and unsymbolised internal states that are perplexing to regulate (Fonagy & Target, 2007). Kohut and Wolf (1978) proposed different types of pathological states of the self, which arise because of developmental failures. The fragmenting self is the consequence of an absence of integrating responses to the nascent self in its totality from the self-objects in childhood, which predispose the individual to states of partial fragmentation. These individuals lack the ability either to reflect on their difficulties without destructive or self-destructive acting out or to soothe themselves in non-addictive ways, which are the result of exposure to massive mirroring failure in infancy (Swartz, 2009). They are susceptible to chronic states in which they lose a sense of continuity of self in time and cohesiveness in space; a psychic condition that produces profound anxiety (Kohut & Wolf, 1978). On the contrary, the overburdened self is a self that had not been afforded an opportunity to merge with the calmness of an omnipotent self-object (Kohut & Wolf, 1978). Because it has endured the trauma of unshared emotionality, such individuals lack the self-soothing structure that protects normal individuals from being traumatised by the escalation of their emotions and especially by the escalation of anxiety. A world absent of such soothing self-objects is experienced as hostile and dangerous (Kohut & Wolf, 1978). This may be linked to soldiers' impaired relational capacity to soothe and be soothed following combat exposure.

2.7 Object relations theory on psychopathology in relation to untreated trauma of the psyche

2.7.1 Defenses in relation to trauma

Psychoanalytical theories on adjustment to trauma and specifically, ongoing interpersonal trauma often argue that one of the ways in which people respond to trauma is through a process of splitting (Van der Merwe & Swartz, 2015). The paranoid-schizoid position postulated within a Kleinian framework of object relations is characterised by part-relating of the infant toward the breast of the mother as a primary object that splits it into two distinct parts that are either good and satisfying or bad, frustrating and persecutory (Duckham, 2011; Kavaler-Adler, 2014; Potik, 2018; Summers, 2014). When infants are unable to deal with their own innate destructive and aggressive drives into annihilation or integrate the good and bad parts of an object as a whole because of an immature ego, they resort to primitive defense mechanisms such as projection, splitting, denial, projective identification, introjection and idealisation (Potik, 2018). These defenses drive the cycle of projection and introjection, which Klein

first termed and serve to defend the ego against irreconcilable trauma as manifest in persecutory anxiety that originates from the persecutory bad object (Duckham, 2011).

Klein referred to phantasised projections or introjections of objects as projective or introjective identification (Brown, 2010; Hinshelwood, 1994 Klein, 1946). A fundamental difference between Freud's projection and Klein's projective identification is that in the former case merely an instinct is projected, while in the latter, both an instinct and an object are projected: a bit of the ego becomes split off and deposited into an external container. In projective identification or once again, "in projection proper, as Freud had originated and Klein uses the term, detached impulses are attributed to objects; whereas in projective identification the attribution concerns actual segments of the ego" (Greenberg & Mitchell, 1983, p. 128). The splitting of the paranoid-schizoid position is so intense that good and bad objects are kept apart without the possibility of conflict and ambivalence. The infant's phantasised attacks on the external object, coupled with fears that the object is retaliating in return, are experienced as violent and bad in their entirety. The object's relation of aggression and reciprocal retaliation induces paranoid anxiety, which causes the infant to feel threatened by annihilation. To defend against the perceived threat of annihilation, the ego splits the bad object from the good in an attempt to protect the latter. A vicious cycle ensues where splitting leads to omnipotence and paranoid anxiety, which in turn is defended against by the object further splitting as excessively good or extremely bad, with alternating states of persecution and idealisation (Anderson, 1992; Klein, 1946).

Kernberg stated that psychological development is rooted in the continued cycle of "internalisations of object relations units and defenses against them" (Christopher et al., 2001, p.690), with aspects thereof often rendered unconscious. This explains how through the process of internalisation, these units end up characterising representations of the self, object and the drive motivational system (Christopher et al., 2001). Failure to integrate positive and negative self-and-object presentations constitutes digressive means of Kernberg's (1997) mechanisms of introjection and ego identity (Summers, 2014). A failure to establish an integrated self-concept results in what Kernberg conceptualised as the primary defense mechanism of splitting whose resolution may only be achieved through the pivotal developmental step in shifting from splitting to self-and-object integration (Summers, 2014). This process closely resembles object constancy and is referred to as total object representations (Kernberg, 2013; Summers, 2014).

Kernberg (1980) also identified principles such as diffusion in the sense of being split into a soldier and a victim; chronic unmet needs for mirroring and idealising as well as vulnerability to self-fragmentation experiences. The ongoing guilt that many soldiers may present with attests to the difficulty of removing the conflict between internalised good and bad objects as well as the incapacity of this defense to resolve the conflict between the internalised killer and the ideal of a good soldier

(Fairbairn, 1943/1986). Purcell (1996) gave an account of the double bind, in the wish to protect and be protected. When these protections fail, a soldier may develop a sense of primary abandonment, loss and guilt that can irreversibly split him into the person he was before who believed in relatedness and the person he became after the trauma who is inconsolable and totally alone. Purcell also noted that trauma reaches into the earliest stratification of object relatedness, eliciting feelings of shame and conflicts about control. In this sense, pathological post-traumatic dynamics are maintained in persistent vacillation on the edge of the depressive position between the feeling of helplessness and persecutory guilt feeling, which are accompanied by the splitting of internal structures in order to maintain the traumatic situation outside the mental space (Jovi, 2018).

2.7.2 The psyche-soma in relation to trauma

Individuals who have been traumatised and carry much shame often form a split between the idealised projected self, that is, the strong and proud survivor, and the essentially deficient or shameful authentic self, which is believed to underlie an inauthentic projected persona (Herman, 1997). It is the masked authentic self that is so bad, so shamed that it deserves being punished. Holocaust survivors described this split as “a double existence” or “double lives” (Kraft, 2004, p. 379). Survivors therefore exist in a dual reality, functioning in accordance with reality in everyday life. But from time to time, the psychic reality of the trauma breaks through and disrupts their lives (Levitt, 2010). In some areas of the psyche, the trauma destroyed the capacity to distinguish between fantasy and reality. Although Herman’s terminology is akin to that employed by Winnicott, she did not emphasise the parenting relationship, but understood this psychic split to occur because of a number of different traumas. Winnicott believed the true self is who we are in the truest sense; it is when we feel alive, invigorated and spontaneous. Furthermore, only the true self can be creative and authentic (Anderson & Winer, 2003). When individuals exist apart from the false self, they feel they are denying themselves. They feel empty, void, and non-existent in that they comply with what is expected or necessary, rather than what is personally meaningful. Winnicott was of the view that the false self develops when children are attuned to their caregivers, rather than when their caregivers are attuned to them. In addition, the manifestation of the false self is an act of compliance and an intimation of a wish to be loved (Anderson & Winer, 2003).

Winnicott (1965) added that when there is a presenting psychiatric disorder, personalities become disintegrated, patients lose their capacity to dwell in their bodies and accept their skin-boundary and patients are incapable of relating to objects. They feel unreal in relation to the environment and that the environment is unreal. Winnicott (1958) that the first real experience of being alone was being alone in the presence of the mother. Moreover, Winnicott (1965) employed the term ego-relatedness, which is a positive state deriving from trusting that the world is safe and reliable, to explain this. Guntrip (1995, p.

240) described this as feeling "a profound sense of belonging, a being at one with his world which is not intellectually thought out, but is the persisting atmosphere of security in which he exists within himself." Feeling extremely over-aroused by external and internal experiences means that many patients will never attain such stillness or *going-on-being*. This is particularly evident with hyper-vigilant traumatised patients whose brains and nervous systems unconsciously pick up signals of threat to which most people are oblivious (Tarter et al., 2009). A successful journey to healing for such patients seems to mean moving away from an over-reliance on mind-object or bodily second-skin attempts to hold themselves together (Corrigan & Gordon, 1995). Rather, they find a safer place internally wherein the psyche might reside in the soma. When this is not achieved, individuals have to override the signals of their bodies about the state of their emotions and rely immensely on their mind. This is typical of patients that Corrigan and Gordon (1995) described, like Winnicott, as relying on their minds as their primary objects, hence the term mind-object that they coined. Trauma evidently produces over-activity of mental functioning and a mind-psyche that is pathological, which prevents satisfactory and mutual interrelation of the psyche and soma and, which in turn impedes the feeling of a sense of aliveness in relation to the self and others.

2.7.3 War trauma and object relations

Kardiner and Spiegel (1947) alluded to the significance of emerging psychodynamic approaches that employ object relational and self psychological perspectives in relation to the devastating effects of trauma on the psyche. They further stated that these impairments result in the endopsychic view of an antagonistic world and an impoverished self. Wolf (1988, 1998), a proponent of object relations theory, found it particularly beneficial in understanding the impact of PTSD over the lifespan. Wolf (1998) added that during adolescence and young adulthood, de-idealisation of parental self objects occurs. Adolescents and young adults tend to turn to subcultures and heroes of cultural history for much needed self object sustenance. Wolf (1998) further revealed that military and combat life disturb this developmental requirement consequent to failure to provide healthy cultural values and heroes for idealisation in relation to the need to reintegrate into broader society.

In accordance with object relations theory, Kardiner and Spiegel (1947) describe the consequences of war trauma as a contraction of the ego, with consequent inhibition of the action system, which encompasses the way in which activity in relation to the outer world is integrated. In a potent description of the debilitating effects of trauma on service men, Kardiner and Spiegel wrote, "The new adjustment is erected on the ruins of what was once a rich reciprocal relation to the outer world. The ego is now impoverished" (p. 324). This results in an adverse effect on the ability to work, disorganisation, emotion and impulse dysregulation, lack of confidence and paranoia as the outer world becomes a hostile place.

Furthermore, the affected individuals may feel in persistent danger of being overwhelmed. This is manifested in the collapse of their capacity to negotiate their relationship with the world.

2.7.4 Loss in relation to trauma

Loss is one of the principles underpinning object relations theory, be it loss of life, possessions, integrity or beliefs. In object relations theory, the absence or loss of a sense of meaning is associated with the loss of the object. Guntrip (1968) stated that the importance of human living may be found in object relationships. An individual's life can only be said to have meaning on such a basis. Guntrip added that in the absence of object-relations, the ego itself cannot develop. Grand and Alpert (1993, p. 331) referred to trauma survivors' sense of loss of attachment and early object relatedness, and further proposed that "as Fairbairn suggests, the gravest threat to one's integrity is the state of objectlessness - that is of not being connected to anyone at all"(p. 331). Purcell (1996) noted a direct link between loss and an all-encompassing rage and potential violence directed at others. Therefore, the development of a soldier into an undiscriminating killer can be understood as a form of an internalising aspect of the external object. In the face of a traumatic collapse of psychic structure and object relationship, it is possible that the psyche may catch any available object to prevent an even worse reality of total objectlessness (Grand & Alpert, 1993).

When difficulties in obtaining and sustaining good object-relations are too pronounced, human relations are approached with considerable anxiety and conflict. Therefore, desperate attempts are made to deny this basic need (Guntrip, 1968). Psychic trauma leads to a loss of one's sense of being. This loss of one's sense of existence results from a disruption in giving traumatic emotional experiences an expression in language. Lacking in the feeling of attunement with others, the traumatized person loses a sense of context and of being-in-the-world. In the aftermath of trauma, context and a sense of being start to disappear with this loss of attunement because emotions are contextually determined and emotional attunement with others is so central to our sense of humanness (Storolow, 2007). Kernberg (2004) asserted that the more unyielding and neurotic character traits are, the more they reveal that a past pathogenic internalised object-relation has become fixated into a character pattern and thus, its defenses. Krystal and Niederland (1968) found that this translates into a loss of all benign introjects including those that allow survivors to engage in consistent benign relationships or nurturing behaviours. There is inescapably some loss, grief, and mourning with all traumatic experience, and a potential for trauma with all object loss. Embedded in unconscious fantasy, psychic trauma thus evokes past trauma and is entertwined with the psychic consequences of object loss (Blum, 2003).

Fairbairn (1943), who played a central role in the development of the object relations theory of psychoanalysis, proposed that soldiers have both a strong attachment to their bad objects in their

repressed state and an acutely repugnant reaction to the release of bad objects and the consequent breakdown of defenses. Fairbairn added that it is enhanced by separation-anxiety, which is intensified by the separation of the dependent individual from his objects while in the military, a condition that is reduced in totalitarian regimes that exploit infantile dependence and make the individual dependent upon the regime. In democratic societies, however, soldiers are less able to transfer dependency onto a regime or military organisation and consequently, suffer more during separation. Fairbairn noted that therefore, when a traumatic experience triggers the release of bad objects for the soldier, the following failure of defenses and coping strategies occur: the occurrence of psychopathological symptoms is directed by a return of bad objects, which have been repressed. Accordingly, the return of bad objects implies a failure of the defense of repression. Therefore, the impulse for an individual to resist any event that will evoke the release of bad objects is strong and mirrors the manner in which individuals with PTSD industriously avoid traumatic cues that might evoke terrifying memories, affects and images. In Farbairn's view, these overwhelming experiences are all attached to bad objects.

Kaplan and Sadock (1991) noted that the accessibility of social support may influence the development, severity and duration of PTSD. In object relations theory, this social support may be compared to the mother's holding capacity with regard to the infant. Traumatic events create levels of psychic stimulation that the individual is inept to master. Furthermore, a severe blow is dealt to the total ego organisation. Individuals experience this as a sudden loss of effectual control over their environment, thus resulting in an altered conception of the self in relation to the world (Kardiner, 1959). Haley (1993) stated that this manifests in numbed detachment in the face of annihilation anxiety where no internal or external good objects are experienced, thus resulting in a disorganised ego through psychic numbing, profound underlying anxiety and disorganisation. This can lead to an inability to identify and work through memories and affects, which contributes to somatisation, passivity and the inability to verbalise guilt about atrocities. Moreover, Haley espoused that impairment in a soldier results not only from the loss of transitional objects but also the loss of faith in traditional authority figures, which the military as an organisation may be internalised as, and the resultant vulnerability to regression and/or seduction by archaic internalised superego role models. Trauma and object loss are prone to be aggregated, especially in disaster, and may lead to loss of one's former identity, with an associated loss of self-confidence, self-esteem, self-reliance, ideal self, and altered ego ideals (Blum, 2003).

2.8 Summary

An overview of object relations theory, expanding into self-psychology theory, which includes views on the development of a self in relation to the other and a relational capacity with one's internal and external world, was provided in this chapter. A synopsis of the role of the nature of self-object relations, inherent associated defenses and resultant self and relational psychopathology in relation to untreated

trauma to the psyche, was also elucidated. The chapter includes psychological developmental arrests as a result of unresolved self-object developmental phases and its implication on psychic trauma. The diverging points and commonalities of different object-relations theorists, namely, Klein and Fairbairn, in understanding the defenses entailed in emotional development and the use of internal self-objects as well as the implications of that on psychic development and the capacity to form relationships, are also outlined. Finally, object relations theory on psychopathology in relation to untreated trauma of the psyche was discussed.

In Chapter 3, the construct of PTSD is discussed. More specifically, a psychiatric and psychoanalytic theoretical overview of PTSD in relation to combat.

CHAPTER 3: POST-TRAUMATIC STRESS DISORDER

3.1 Introduction

Although the syndrome of post-traumatic stress disorder (PTSD) can result from various stressors, the focus of this study was on military trauma in the SANDF. Given that the unique context of warzone engagement, which entails chronic threat, multiple and lengthy deployments and loss, there is a growing need to understand whether and to what extent knowledge about PTSD derived from studies of civilian trauma exposure is generaliseable to the military (Yehuda et al., 2014). Black SANDF members seem to present with a clinical picture of PTSD syndrome, high chronicity and co-morbidity, which have remained undiagnosed. These symptoms are merely understood as members presenting as ill-disciplined or dysfunctional by those in positions of authority within the SANDF. This misattunement to their plight and misdiagnosis may be attributed to the unique nature of combat and deployment-related trauma, including lengthy and repeated deployments, chronic threat, and multiple trauma exposures which may have different biological and psychological implications compared to civilian traumas (Yehuda et al., 2014). Studies of refugee populations have confirmed a clear linear relationship between the number of traumatic events and symptoms of PTSD and depression. These studies propose a specification of the dose-response model, in that it is not the severity of a single traumatic event that is linearly related to symptoms of chronic PTSD, but the severity of previous cumulative trauma exposure (Neuner et al., 2004).

The historical perspective on trauma reveals that since the earliest involvement of psychiatry with traumatised patients, there have been vehement arguments about the aetiology of trauma. One may ask whether the trauma is organic or psychological. One may also question whether trauma is caused by the event itself, by its subjective interpretation or by pre-existing vulnerabilities. Finally, some may wonder whether trauma patients are malingerers who suffer from moral weakness or whether they experience an involuntary disintegration of the capacity to take charge of their lives (Van der Kolk et al., 1996). In accordance with object relations theory, Kardiner and Spiegel (1947) described the result of war trauma as a contraction of the ego, which affects the way in which activity in relation to the outer world is integrated. Advances in understanding biological aspects of PTSD have been consistently made, and there has been growing convergence regarding the major brain, neurochemical and neuroendocrine systems involved in deployment-related injuries such as PTSD (Yehuda et al., 2014).

The way in which clinicians and researchers regard trauma has changed. Authors such as Young (1995) have asked whether this shift reflects a change in the symptomatic expression of traumatic stress in Western culture over time. Growing interest continues in understanding how characteristics of different combat theatres may contribute to new and unique clinical presentations (Yehuda et al., 2014),

this may partly explain why PTSD has remained undiagnosed in the SANDF. Through this study, a net can be cast as far as briefly considering symptomatic expression of traumatic stress reaction in African culture, given that the sample comprised Black SANDF members. The Xhosa of South Africa call the psychological wound of combat the *kanene*, with reference to the warrior's insight into the burden he carries. The Zulus call it *Ukuhlanya*, which means to wonder around with no direction and to lose one's bearings. The African conceptualisation of combat PTSD bears both geographical and moral/spiritual meaning. This is asserted as an indication that therapeutic treatments for traumatised soldiers will be effective only to the extent that their moral and spiritual issues are addressed on their own terms and not just primarily as symtoms of a psychiatric condition (Brooke, 2017). While not being able to answer these questions with any certainty as they are beyond the scope of this study, they nonetheless inform the underlying dynamics of the research questions that were explored in this study.

3.2 Post-traumatic stress disorder (PTSD)

Vivid descriptions of reactions to traumatic events span many centuries, though their nature has shifted over time (Jones, 2005). Post-traumatic stress disorder was first certified as a diagnosable psychiatric disorder in the third edition of the *Diagnostic and Statistical Manual of Mental Disorder*s (DSM-III) and International Classification of Diseases, 10th edition (WHO,1992). Its very existence continues to attract debate, with several authors maintaining that culturally determined, understandable emotions to traumatic events are being pathologized (Summerfield, 2001). Traumatic experiences can often be assimilated without the development of a pathological response. When this psychological process fails, post-traumatic stress disorder can develop, with pathological fear structures characterised by excessive response elements such as avoidance, physiological reactivity, and resistance to modification (Ehlers, 2000). PTSD involves symptoms of re-experiencing, avoidance, and hyperarousal associated with a traumatic event (Spies et al., 2020).

Several studies have revealed that PTSD is among the most common psychiatric disorders among military personnel. The National Vietnam Veterans Readjustment Study (Kulka et al., 1990) found that an estimated 20 years after the Vietnam war, 15.2% of Vietnam veterans still suffered from PTSD (Van der Kolk et al., 1995). Furthermore, the interrelation between direct exposure to combat conditions and post-traumatic stress symptoms has been well established. The National Vietnam Veteran's Readjustment Study (NVVRS), conducted in 1990, approximated that the lifetime prevalence of full PTSD is 30.9% and 26,9% among male and female veterans, respectively (Weiss et al., 1992). Seal et al. (2009), revealed a diagnosis of PTSD was determined for 21.8% of veterans of deployments to Iraq and Afghanistan. In general an estimate of 3% of the adult population has PTSD at any one time (McManus, 2007). Lifetime prevalence is between 1.9% and 8.8%, but this rate doubles in populations affected by conflict (Alonos, 2004), such as the military population. The interrelation between combat

exposure and PTSD is well established in the literature, and studies have consistenlty found that personnel who deploy in a combat role or have combat exposure are at higher risk of PTSD (Sundin et al., 2014). The prevalence of PTSD has still been established to differ across different militaries, ranging from 4% to 17% for those in the United States returning from the Iraq War and from 3% to 6% for those returning in the United Kingdom. Prevalences in other countries of the world are, however, less well documented (Fear et al., 2010). According to Hines et al. (2014), thirty studies reported the prevalence of probable PTSD cases from samples that had deployed to Iraq, 10 studies reported the prevalence on samples that had deployed to Afghanistan, and 15 studies reported the prevalence on samples that had deployed to both Iraq and Afghanistan. There was co-occurance in prevalence of probable PTSD cases between samples deployed to Iraq and Afghanistan, however, studies of samples deployed to Afghanistan tended to report a lower prevalence, compared with studies of samples deployed to Iraq. The combined estimate for Afghanistan samples was 7.1%. Iraq-deployed samples had a combined estimate of 12.9% and samples deployed to both Iraq and Afghanistan had a combined estimate of 10.4%.

Van der Kolk (2002) explained that exposure to events that overburden the organism's coping mechanisms can damage the self-regulatory systems needed to assist the physiological and biological changes to return to a normal state after the traumatic event. This explains the association between PTSD and physical pain symptoms, with an estimated 15% to 35% of persons with chronic pain also suffering from PTSD (Clark, 2014). Furthermore, PTSD is also strongly associated with generalised physical and cognitive health symptoms attributed to mild traumatic brain injury (Reisman, 2016). To make a clinical diagnosis of PTSD there are a number of criteria which need to be assessed and met.

3.2.1 Diagnostic criteria for PTSD

The PTSD diagnosis was firstly listed as a codable syndrome in the third version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) (American Psyhiatric Association, 1980). Since the introduction of the fifth edition of the DSM (DSM 5), symptoms of persisting negative cognitions and mood were added as a further cluster of symptoms. DSM-5 lists the 20 symptoms needed for PTSD to be diagnosed, separated into four groups. All symptoms must be associated with the traumatic event (American Psychiatric Association, 2013). The first cluster constitutes the presence of one or more of the following intrusion symptoms associated with the traumatic event: recurrent distressing dreams; dissociative reactions, that is, flashbacks; recurrent, involuntary and intrusive distressing memories; and intense psychological and/or physiological distress at being exposed to internal and/or external cues that symbolise or resemble an aspect of the traumatic event. While the second cluster includes persistent avoidance of stimuli associated with the traumatic event(s), the third comprises negative alterations in cognitions and mood associated with the traumatic event(s) and the fourth, marked alterations in arousal

and reactivity associated with the traumatic event(s) (American Psychiatric Association, 2013). The symptoms of PTSD result in severe health restrictions and can seriously impact quality of life (Haagsma et al., 2012).

Although scientific research on PSTD was primarily based on veterans of the Vietnam War, the DSM-III, DSM-III-R, DSM-IV and DSM-5 do not identify war-related PTSD as a subtype of the PTSD classification. Most Vietnam War veterans present with delayed-onset PTSD. Consequently, the interval between the event and the symptoms may be measured in years (Garland, 1998). One does note that the DSM-5 removed the syndrome from the classification of *anxiety disorders*, however, it has retained its label as a disorder under its new classification, *trauma and stressor related disorders*.

The first DSM-5 criterion for PTSD asserts that the individual's response to the event must involve intense fear, helplessness and/or horror (American Psychiatric Association, 2013). Theoretically, in most cases, soldiers will not fulfill this first criterion. They are trained primarily to respond cognitively or tactically, and not emotionally. They are expected to control their emotive reality and execute their military commands and thus, do not have the option of displaying intense fear, helplessness and horror Brewin et al., 2009). While the diagnostic system has endeavoured to capture this aspect of traumatisation in universal and specific terms, the debates about the adequacy of this criterion (Criterion A) in DSM-5 has also extended to whether this set of affects is sufficiently exhaustive. This also supports this study's operational construct of undiagnosed PTSD with its on focus on the impact of long-term untreated military trauma. Among deployed members, it is possible to develop PTSD after one incident, however, there is growing evidence that various deployments or various incidents lead to a higher risk of developing it (Yehuda, 2014). Prevalence rates ranged from 4% for British veterans to 9–20% for US veterans (Thomas et al., 2010). However, service members in the German Armed Forces (GAF) showed lower prevalence rates, which range from 2.9% for deployed service members to 3.2% for deployed service members who had been exposed to combat (Trautmann et al., 2017). According to Wittchen et al. (2012) presumably, nearly half of all GAF military personnel who suffer from PTSD after deployment are neither diagnosed nor reported. This is in aid of the premise of the operationalisation of the construct of undiagnosed PTSD in this study. Yehuda et al. (2014) further suggest that in the armed forces of other nations, it is also likely that the estimated number of unknown cases is higher than reported.

Furthermore, there are two specific additional sub-categories of PTSD worth considering. The first is PTSD with dissociative symptoms as a reaction to trauma-related stimuli. Dissociation refers to shifts in consciousness, identity and memory which can manifest as either 'depersonalisation' or 'derealisation'. People who experience PTSD with dissociative symptoms have a high probability of presenting as complex, because of possible high levels exposure to repeated or prolonged trauma

(Greenberg et al., 2015). Complex PTSD, therefore, can be expected among soldiers as they are trained not to explicate themselves from danger but to confront danger combatively, thus making the exposure to trauma recurrent (Herman, 1992).

3.2.2 Complex/chronic PTSD

Complex PTSD as proposed in Herman's seminal work (1992) encompasses seven diagnostic categories including a history of being subject to totalitarian control that may last from months to years, alterations in affect regulation, consciousness including dissociation and re-experiencing, self-perception, perception of perpetrator, relations with others and systems of meaning. Courtois (2004) developed a comprehensive diagnosis of complex trauma which she explicated as the incapacity to self regulate, self-organise and/or draw upon relationships to regain self integrity. In the formulation of complex post-traumatic stress, Herman (1992) further asserted that the impact of exposure to multiple traumatic events over a prolonged period generally involves the development of chronic somatic problems.

Herman (1992) conceptualised complex PTSD in a slightly varying way. She established three areas of disturbance on a different level to that of simple PTSD. First, the symptom profile appears more complex, heterogeneous and enduring. Second, the affected person develops changes in personality. Third, trauma survivors exhibiting complex PTSD evince a distinct vulnerability to harm, which can be equated to the nature of military obligations in reference to this study. Persons suffering from enduring unresolved trauma may present with disturbed beliefs involving the self and relationships that impair characterological stability (Ford, 1999). Honing et al (1999) noted that the most significant long-term impact of trauma is often manifested in the form of persistent character traits that may have originated as coping responses to the trauma. Reich (1990) also observed that patients who suffered from chronic PTSD were inclined toward deleterious personality change.

Shay (1994) who examined the subtle phenomenology of PTSD symptoms posited that PTSD symptoms are easily confused with those of other disorders, which has resulted in historical misdiagnoses. In this regard, Shay proffered that numbness, mistrust, hallucinated voices and the social withdrawal of combat PTSD are easily mistaken for schizophrenia. In addition, alternating states of numbness and intrusive re-experiencing have resulted in veterans being misdiagnosed with bipolar disorder. PTSD symptoms also include a multitude of understated qualities that are difficult to articulate such as the loss of effortless and confident control over perception, memory and thought, which is an essential part of feeling sane (Shay, 1994). Shay further detailed several ways in which veterans feel impaired that are difficult to explicate and comprise the persistence of factors from combat exposure. Shay's use of language in his description of the persistence of aspects of experience, function and affect,

for example, survival skills, isolation, betrayal and meaninglessness as well as the loss or impairment of other functions represents his attempt to define PTSD in ways that are near to the veteran's experiential reality. Shay is among those clinicians whose studies mirror Herman's (1992) attempt at a detailed understanding of trauma survivors' experiences, which is partly furthered by appreciating complex PTSD rather than reducing patients' problems to a tedious list of symptoms.

The symptom profile of complex PTSD takes cognisance of the loss of emotional, social, cognitive and psychological competencies that either failed to develop sufficiently or that deteriorated due to prolonged exposure to complex trauma. The treatment for complex PTSD, then, stresses not only the reduction of psychiatric symptoms, but equally, improvement in key functional capacities for self-regulation and strengthening of psychosocial and environmental resources (Cloitre et al., 2012). A proposed criteria for a diagnosis of complex PTSD by the *International Classification of Diseases and Related Health Problems* (ICD-11), was set to indicate the heterogeneity of PTSD. This would require satisfaction of the criteria for PTSD plus symptoms of mood dysregulation, negative self concept, and persistent difficulty in sustaining relationships and feeling close to others. Individuals could thus meet the diagnostic criteria in one system but not in the other owing to the differences in the presenting clinical syndrome of PTSD (Maercker, 2013).

The World Health Organization released the 11th version of its diagnostic system, the ICD-11 in June of 2018. This release included alongside a revised version of PTSD, a new diagnosis of Complex PTSD (CPTSD) which was accepted in 2019 (Cloitre et al., 2020). The ICD-11 diagnosis of CPTSD owes its origins to the first formulation of complex PTSD by Herman (1992), in particular the notion that repeated and multiple types of interpersonal trauma from which escape is difficult or impossible have a manifest effect on the capacity to regulate emotions, on self-identity and on relational capacities. The CPTSD clinical picture includes both PTSD and DSO and implies that sense of threat and disturbed sense of self are dynamically and integrally related to each other over time (Cloitre et al., 2020).

This may lead to psychic splitting as a post-traumatic response often co-occuring with shame, which are both pivotal to CPTSD and DESNOS. Furthermore, both syndromes are a response to prolonged or chronic trauma (Ford & Courtois, 2009; Ginzburg et al., 2009; Uji et al., 2007). CPTSD affects both soldiers and their families and thus, new intervention approaches are imperative. A phase-based approach that entails stabilisation techniques, education and social skills training may be more effective in helping these soldiers integrate their experiences, adapt to civilian life and their role in their families, and resume their productive lives (Ford & Courtois, 2009). Greenberg (2009) asserts that often people who experience what is sometimes also termed delayed-onset PTSD do indeed suffer with sub-threshold symptoms well before six months post the index traumatic event and over time the burden of symptoms increases as the individual fails to get sufficient support or effectively re-establish their pre-trauma

routine. For purposes of this study, this comes close to the operationalisation of the SANDF members' presentation with undiagnosed PTSD, comorbid with some CPTSD symptoms. More especially those symptoms that render the sense of threat and disturbed sense of self dynamically and integrally related to each other over time (Cloitre et al,. 2020). The construct of undiagnosed PTSD is fitting as not only have traumatised Black SANDF members not been assessed for PTSD, but there have also been no treatment interventions to alleviate their symtoms of PTSD.

3.2.3 A brief overview of combat exposure and PTSD

The significant impact of the Vietnam War on the psychological health of veterans led to the current classification and definition of trauma in relation to PTSD (Young, 1995; Van der Kolk et al., 1996). Careful research and documentation that led to the coining of what is now termed PTSD began in earnest after the Vietnam War when a significant number of American war veterans suffered from undiagnosed psychological effects of war-related trauma. With time, the effect of trauma on people has evolved from various names such as *railroad spine, traumatic neurosis, cardiac neurosis, shell shock, war neurosis* and *combat neurosis* to the current label of PTSD (Fischer-Homberger, 1975). In the American Civil War, this psychic wound was called *soldier's heart*, which aptly names the traumatised centre of the emotional lives, morality, aesthetics, and capacity for intimacy, in essence what is called the soul (Tick, 2005). Figley's (1978a; 1978b) work was a catalyst in shaping thinking about the effects of war trauma and contributed to the inclusion of PTSD in the DSM-III (Figley, 1985). The evolution of early conceptualisations of traumatic effects on the psyche to the more recent notions of PTSD have been traced, revealing a clear thread of the identification of what is currently represented by the classic four symptom clusters (American Psychiatric Association, 1994, 2013; Wilson, 1994). The primary issue involved in PTSD involves the incapacity to integrate the reality of particular experiences and the resulting repetitive replaying of the trauma in images, behaviours, feelings, physiological states and interpersonal relationships. From the time of its first inclusion in the DSM-III, this psychiatric classification has been reportedly marred by controversy. The DSM-III PTSD diagnosis was perceived as not being the result of careful factor-analytic studies of the clinical syndrome picture of people suffering from traumatic neuroses, but a compilation of symptoms that was arrived at on the basis of literature searches, scrutiny of clinical records and a thoughtful political process (Van der Kolk et al., 1996).

Figley (1978b) addressed the debate between the *stress evaporation perspective*, which posits that any stress from combat *evaporates* upon returning home as Freud thought, and the *residual stress perspective,* which holds that not only can combat-related stress reactions be expected, but may be severe and could affect large numbers of veterans. Figley argued that in the 1970s, studies revealed that combat was a factor in postwar psychological maladjustment. This was demonstrated in veterans who

possessed poorer coping skills and suffered higher rates of unemployment, more stressful family relationships, higher rates of drug and alcohol abuse, hostility, guilt, depression, sleep difficulties and nightmares. Laufer et al. (1985), found correlations between experiential aspects of war stress and PTSD symptoms. They demonstrated that combat exposure resulted in higher rates of intrusive imagery, hyper-arousal symptoms and re-experiencing effects. They further revealed that the imagery surrounding the experience often preyed on these men for years in dreams and memory. Laufer et al. (1985), divided PTSD symptoms into two main categories: first, *re-experiencing* that entailed intrusion such as troubling thoughts about military experiences, nightmares and thoughts of death as well as hyper-arousal, which was marked by irritability, poor sleep, angry outbursts and anxiety symptoms; and second, a denial-based disorder, which was predominated by numbing including loss of interest and meaning, numbness and not caring about others as well as cognitive difficulties, for example, confusion and memory difficulties.

Horowitz (1976) asserted that some individuals with PTSD alternate between periods during which re-experiencing intrusive symptoms are more prominent and those during which denial-numbing symptoms are more evident. Kulka et al. (1990) found that male veterans with PTSD are two to six times more likely to abuse alcohol in comparison to those without PTSD. Moreover, men who suffer lifetime substance abuse are four to five times more likely to present with current or lifetime diagnoses of depressive disorders, manic episodes, panic disorders, generalised anxiety disorder and antisocial personality disorder, thus suggesting that substance abuse may be a self-medicating attempt to cope with psychiatric symptoms. Kulka et al. (1990) further revealed that veterans with PTSD or substance abuse diagnosis also presented with more chronic physical health problems. The amount of trauma exposure was an indicator of worsening PTSD, which could be linked to poor social and occupational functioning. Longitudinal studies on the effect of deployment on the United States military, which allowed individuals to act as their own control, led to considerable rates of morbidity (Tanielian & Jaycox, 2008). The number of women in the military has increased during the last few decades, with a concurrent expansion in the roles of women on deployment; as a consequence, women are experiencing higher rates of war zone exposures (Woodhead, 2012). Comparatively very little research has focused on PTSD in women deployed to Iraq and Afghanistan. Two studies looked at the interaction between sex and combat exposure for PTSD and found that women with high levels of exposure were at higher risk of PTSD, compared with men at the same level of exposure. Women have been shown to experience the exact PTSD rate as men, even when the level of trauma exposure is similar (Luxton, 2010; Skopp, 2011).

Research in military psychology has shown that when affected psychologically, women tend to request help more readily than men do and consequently, evade much of the long-term mental suffering that male soldiers encounter as a result of post deployment missions (Breslau & Davis, 1987; Crum-

Cianflone, & Jacobson, 2013; Gallegos et al., 2015; Maguen et al., 2012). Schell and Marshall (2008) noted that data support the claim that fear of discrimination thwarts United States military service members significantly from seeking treatment. Similar to the SANDF, the United States military uses information about psychiatric diagnoses and mental health treatment to determine whether members are suitable for deployment (Hoge, 2010). Hoge added that members forego treatment to evade any potential harm to their military careers. Compared with male soldiers with similar occupational obligations and exposure to violence, women soldiers did not present with escalated levels of PTSD during and three months post their deployments (Munsey, 2009). The occurrence of subsequent life stressors or traumatic events has been shown to increase the likelihood of military personnel developing PTSD in response to a prior traumatic event (Andrews et al., 2009; Frueh et al., 2009). Taylor (1998) noted that premorbid motivations clearly influence the rate of self-exposure to traumatic events and vulnerability to PTSD. In general, PTSD remains a significant problem among service members after a foreign assignment (Wittchen, 2010). Clinically observed undiagnosed symptoms of PTSD amongst members of the SANDF with maladaptive coping defenses further exacerbate the impairment of their emotional, relational and functional capacity. As a result of the lack of treatment of trauma from previous political military experiences, current traumas activate past traumas thus ensuring their course of PTSD is chronic. In addition SANDF members present with a proclivity toward violent behaviour, as shown in other studies in Africa (Jones, 2012). According to Klostermann et al. (2012), these enhanced violent reactions can be particularly associated with the hypervigilance symptom cluster of (combat-related) PTSD. In accord with this, in a study conducted in the DRC by Hecker et al. (2013), results indicated a relation between war-related trauma exposure and current (reactive) aggressive behavior as mediated by PTSD symptom severity and appetitive aggression.

Internationally, an increase in suicide has consistently been observed when PTSD goes unnoticed and thus, untreated (Card, 1987; Jakupcak et al., 2011; Sareen et al., 2007). Recent studies conducted in the United States have revealed higher rates of veteran suicides than previously thought; as high as 5,000 to 8,000 a year (Kemp & Bossarte, 2013). Research in the UK has demonstrated that delayed-onset PTSD is not unusual amongst service members, can span over many years and is manifested through depression, behavioural changes and alcohol abuse (Howard, 2014). Statistics provided by the South African military for the purposes of a report by Stotts (2002) evidenced that there were 2,040 suicides and attempted suicides in the army between 1990 and 2001, mostly among former armed force members. The high rates of behavioural problems members present to the psychology and social work officers in the SANDF suggest an unconscious self-annihilation in the form of self-destructive behaviour. Furthermore, it has been revealed that a stressful life history, particularly a prior history of traumatisation and neglect, is an important risk factor for PTSD (Cloitre et al., 2009)

3.2.4 Risk and protective factors in the development of PTSD

Although combat exposure may be unavoidable in military service members, other risk and protective factors also predict PTSD. Polusny et al. (2011) revealed that at baseline prior to deployment, 3.7% of soldiers deployed to Iran had probable PTSD. Among the soldiers who did not present with PTSD symptoms at baseline, 13.8% reported post-deployment new-onset probable PTSD. After accounting for pre-deployment factors, new-onset probable PTSD was predicted by exposure to combat and to the aftermath thereof (Polusny et al., 2011). Reporting more stressful life events post deployment was associated with increased odds of new-onset probable PTSD, while post-deployment social support was an important protective factor in the aetiology of PTSD. Furthermore, post-military factors related to the risk of developing PTSD include social support such as that experienced at homecoming, coping skills (Fairbank et al., 1995; Friedman et al., 1994), emotional sharing of experiences, re-establishment of a sense of belonging and safety, engagement in therapy with peers, avoidance of retraumatisation and continuity of treatment (Tomb, 1994). Emotion regulation (ER) is one predictor that has also repeatedly been identified as crucial for the development of PTSD (Chesney & Gordon, 2017). Renshaw (2011) also found that perceptions of threat mediated the association of combat experiences with PTSD, yet not that of post-battle experiences with PTSD. A sense of preparedness for deployment moderated the association of combat experiences with perceived threat such that troops with low levels of preparedness perceived high levels of threat regardless of combat exposure, whereas troops with high levels of preparedness perceived levels of threat that correlated with levels of combat that mediated the development of PTSD (Renshaw, 2011).

Although combat exposure is regarded as the leading stressor of war, some researchers have emphasised the importance of deployment-related stressors on PTSD; these deployment-related stressors include excessive heat or cold, concerns about and/or problems with family members back home, boredom, lack of privacy and problems with leadership (Booth-Kewley et al., 2010). These deployment stressors often surface for members in the SANDF; traumatic stress responses that are often deemed as signs of ill-discipline in soldiers. In accordance with the military code of conduct, commanding leaders apply disciplinary measures in response. Engekhard et al. (2007) further noted that noncombat stressors such as operational stressors, low-magnitude stressors and contextual stressors also play a significant role in the development of PTSD. Military personnel have been found to be more likely to develop PTSD if they discharged a weapon or witnessed an injury or death during their deployment. Discharging a weapon is likely to generate a traumatic memory directly associated with the negative event. The latter is considered to be a significant precursor to combat-related PTSD. It is probable that military service members who witnessed someone being injured or killed during deployment experienced intense fear at that time (Engekhard et al., 2007). Consequently, PTSD remains

undiagnosed in the SANDF because it is assumed that because members are not always in direct combat during their peacekeeping operations, they cannot develop post-traumatic stress-related responses.

Post-deployment support, subsequent life stress and comorbid psychological problems are among the personal factors that have been regarded as possible risk factors for PTSD (Polusny et al., 2011). A favourable recovery environment after exposure to trauma may serve as a protective factor. Social support, for instance, is associated with a decreased PTSD risk in both the general population and military settings (Brewin et al., 2000; Ozer et al., 2003). High levels of social care and support may promote feelings of self-reliance and self-security among military people, which protect against PTSD. Solomon et al. (2015) show a connection between feelings of loneliness and a lack of social support among traumatised soldiers, and emphasize the importance of social support to abate feelings of loneliness. They continue that the fact that combat-related PTSD stems from belonging to the nation makes it critical for soldiers to receive social support not only from their families and friends, but from their nation as well, as part of their healing process.

3.2.5 Combat-related PTSD in South Africa

Seedat et al (2003) conducted a study on the prevalence of PTSD amongst SANDF soldiers stationed at home units after returning from a two-month peacekeeping deployment operation. Self-reported data from 198 soldiers from two separate bases in the SANDF in KwaZulu-Natal revealed that 26% of the participants met the diagnostic criteria of PTSD. The symptoms identified included emotional numbing, avoidance of conversation, feelings and thoughts about the traumatic event, emotional distress when reminded of incidents and unwanted memories of the events. These results suggested that although combat remains a factor in the development of psychological distress, the experience of noncombat trauma may play a more salient role in the development of PTSD in this population. Consistent with previous studies, the findings demonstrated that despite exposure to highly stressful and/or traumatic events as well as significant distress and impairment resulting from PTSD, the majority of military personnel did not seek help. Fears of disadvantageous career consequences, somatisation of psychiatric symptoms and stigmas associated with mental illness in servicemen and unit leaders may delay the presentation of PTSD in clinical settings (Gabriel & Neal, 2002). As these individuals continue to get deployed, studies have shown diminished mental or physical health status before combat deployment is strongly correlated with an increased risk of new onset of PTSD symptoms after deployment (LeardMann et al., 2009). Sharp et al. (2015) summed up that across military studies, one of the most frequently reported hindrances to help-seeking for mental health problems is concerns about stigma. This clinical picture is still evident among Black SANDF members, thus resulting in increased probable undiagnosed PTSD cases characterised by overall impairing functional decline.

Connell (2011) found a high level of PTSD (33%) among former national servicemen and revealed the first attempt to evaluate the psychological impact of the border wars during apartheid on veterans. Kaplan et al. (2002) revealed that decreased motivation to serve and irresolute ideological commitment to the goals of conflict have been strongly associated with PTSD and may account for the high prevalence. Members of the SADF possibly had a low motivation for combat since participating in the border wars was not a personal ideological choice but a legislative stipulation. Moral Injury (MI) has been shown to play an important role in the development of PTSD in service members. MI consists of shame and guilt as a result of a clash between prior beliefs and values with war experiences during deployment (Jinkerson, 2013). Studies have reported on numerous situations that may lead to MI when service members are confronted with ethically ambiguous situations created by modern warfare or deployment situations, such as shooting at enemies, being directly responsible for an enemy's death, or seeing women and children wounded and being unable to help (Litz, 2009). In contrast to this, Waller (2006) found that many child soldiers in the DRC adapted well to the violent environement of armed groups. The plasticity of the brain and continued development of a moral mindset probably enhance the development or increase of appetitive aggression under the circumstances of armed conflict (Elbert et al., 2006; Maedl et al., 2010). In yet another study by Hecker et al. (2012), exposure to violence and PTSD symptom severity were found not to be related to appetitive aggression.

Furthermore, servicemen conscripted had an increased risk for PTSD (Kaplan et al., 2002). This may be due to their relative psychological vulnerability and the absence of long-term social ties, which could assist in absorbing the aftermath of combat exposure. This is applicable to some of the SANDF members as they joined the armed struggle forces at this time. The South African experience of the aftermath of the border war may reveal a similar chronicity to that found in the 1995 national co-morbidity study in the United States (Kessler et al., 1995). The chronicity of PTSD in Connell's (2011) study is suggestive of a need for longitudinal studies that trace the influence of combat exposure, pre-existing traumatic experiences, treatments, social support and post-war traumatic events on the incidence and course of PTSD in South Africa (Connell et al., 2013).

3.2.6 The impact of combat related trauma in South African combatants

In their study Ertl et al. (2014), demonstrated a positive association between combat related trauma, mental illness and maladjustment in a sample of Ugandan child soldiers. Whislt Gear (2002) had found increased unemployment rates in US veterans and in former combatants in South Africa, respectively. Militarised masculinity has also been a factor in perpetuating civil wars in African countries such as Angola, Rwanda, Sierra Leone, and Liberia. As Dolan (2002) found in his research, machismo is also utilised as a gateway to recruit child soldiers in Africa into civil wars. The hegemonic masculinity of SADF soldiers was predicated in part on the suppression of Black men (and women). This implied that

the employment of the military in state repression meant that many Black men were forced into the 'role of a non-man', experiencing the powerlessness of knowing that White male soldiers had the prerogative to violate their lives at will (Clowes, 2003). This was before former soldiers from liberation movements such as MK, AZLA, APLA as well as those of the apartheid state, SADF were reintegrated into a national SANDF (Gear, 2002), which translated into a national force comprising members with bleeding psychological wounds from their previous and continuing combat exposure.

According to Gear (2002) South African former and current combatants' violence towards wives, children, and other family members remains one of the under-researched, undocumented, and untold costs of South Africa's war of liberation. This suggests a complex link between gender identity, combat trauma and displacement of violence from the military battlefield to the domestic setting, although more specific research is needed in this area. A study conducted by Mashike and Makalobe (2003) indicates that South African former combatants self-report symptoms akin to those described under the diagnosis of PTSD. According to Goldstein (2003) these members had seen people being killed or had killed themselves, and some were affected by these memories 13 years after democracy. Some found it difficult to sleep at night because of terrifying nightmares or had resorted to drug abuse to numb PTSD-related symptoms. This pattern of self-medication remains prevalent among Black SANDF members. According to Goldstein (2003), the suppression of distress can be linked with aggression, anger, and other explosive emotions. Furthermore, cultural norms force men to endure trauma and strive to gain mastery over its effects in order to claim the status of 'manhood'. Combat experience has also left many soldiers emotionally distressed, which has been further compounded by their frustration at not being understood by their families, their communities, and society at large (Abrahams, 2006). They are also saddled with the stigmatisation of having fought for the struggle but not having anything to show for it (Shapiro, 2012), with regards to rank promotion for most Black SANDF members. According to Abrahams (2006), as well as Gear (2002), the failure in psychosocial support to deal with combat-related PTSD has compromised the emotional, psychological, and social well-being of many soldiers.

Doherty's (2015) examination of memoirs from conscripts of the South African 'Border War'documents a whole-hearted engagement with PTSD wherein the authors paint a picture of PTSD as an enemy within. This enemy implodes in slow motion before their eyes, but largely unidentified by society, and therefore invisible, even from those who suffer most directly from its effects. Doherty (2015) quotes one of the conscripts who poignantly stated that war trauma remains an unrecognised, cancerous growth in the heart of South African society that threatens to undermine every effort to solve the country's problems. Doherty (2015) explicates that the adoption of PTSD in dealing with war neurosis also needs to be understood in the context of how 'trauma' and psychiatric treatment for trauma were handled within the SADF during the Border War. The anecdotal evidence of the role of psychology

in the SADF is that trauma was given minimal recognition by the military authorities at the time. Mental health professionals had an ambivalent status in the army at the best of times, as psychological problems were dealt with as discipinary offences. This is still evident within the current SANDF. Though in the late 1980s, the SADF seemed to have developed protocols for "psychological debriefing" the implementation of these procedures was not particularly thorough, and have not improved to date. Traumatised conscripts have carried their psychic wounds into the new South Africa (Tal, 1996), as Black soldiers have carried theirs from the armed struggle into the SANDF. Thus, all these soldiers' experiences of combat trauma were silenced under the previous and current military regime and have been marginalised and even stigmatised by the discourses of the new South Africa (Tal, 1996).

3.3 Psychoanalytic perspectives on PTSD

3.3.1 Early psychoanalytic thinking

Sigmund Freud, a pioneer of psychoanalysis, displayed an interest in traumatic events during two periods: between 1892 and 1896 when he analysed the causes of hysterical attacks, and after World War I when he turned his attention, somewhat briefly, to the aetiology of the war neuroses. His original theory postulated actual sexual experiences during infancy and early childhood as the cause of all trauma and the basis for neurosis. In his later work with war veterans, Freud acknowledged the role of actual experiences in the development of neuroses and distinguished between traumatic neuroses and anxiety neuroses on the basis of whether a neurosis was caused by a real occurrence or an imaginary experience. According to Freud (1919/1955a), while traumatic neuroses were a result of real experiences such as accidents, death and combat, anxiety neuroses were the result of sexual and aggressive fantasies based on witnessing the primal scene early in life. Starr and Aron (2011) thoroughly interrogated the challenges to Freudian theory posed by the war neuroses of World War I. Freud, however, went on to state that he knew of no proof that war neurosis can be explained to the exclusion of any admixture of sexual factors, specifically castration fear. In his short paper, *Thoughts for the times on war and death* (1915/1957), Freud acknowledged that not only is everyone convinced of their own immortality in the unconscious, but that in the death of another, even when it is someone we love, the survivor experiences a victory. He further stated that in addition to the impact of the traumatic event is the task of mourning for others and for the self, for the individual's own lost world, pre-trauma life and identity as well as guilt feelings. Freud also compared the fear of losing one's own life with the fear of taking someone else's life.

This suggested that individuals may also be traumatised by the violence they mete out to others. Therefore, a soldier may bear the conflict of being both the victim and perpetrator of his traumatic violence. Accordingly, psychic pain is opened for traumatic guilt alongside traumatic fear. Freud was

of the view that the pathogenic agency is invested in the patient's memory of the trauma. When the attached emotion of traumatic experiences finds catharsis, memories of the events become ordinary recollections and are accessible to the conscious mind. However, a cathartic discharge does not always occur and undischarged memories are said to enter a "second consciousness" (Freud, 1986, p.153) where they become secrets and are either isolated from the conscious personality or available to it in a highly summarised form. The paper, *Beyond the Pleasure Principle* (1920/1955b) is a reflection of Freud's experience with soldiers who had survived immensely frightening experiences during World War I and who exhibited a repetition compulsion in recurrent memories and re-enactments of some of the most frightening moments of the experience. They may have needed to do this in order to master the anxiety produced.

Freud thus conceded that there is a split between the conscious and unconscious. He asserted, "I am not aware, however, that patients suffering from traumatic neurosis are much occupied in their waking lives with memories of their accident. Perhaps they are more concerned with not thinking of it" (1955, pp. 12-13). Therefore, those experiencing traumatic neurosis have almost no control over the experiences of their memories and accordingly, memories are given expression during the unconscious (dream) state. Therefore, unlike anxieties or fears, trauma cannot be directly addressed by the individual (Freud, 1955b). Such fright for those suffering from traumatic neurosis, as referred to by Freud, occurs most often through the repetition of dreams that return the individual to the moment of trauma.

Freud (1981) developed the concept of an ego conflict (Ich-konflikt) between the peace ego and the new war ego. Simmel (1994) further developed this perspective in the frame of the new ego-psychological approach, underscored the importance of the type of traumatic situation and distinguished between traumatic neurosis in peacetime and wartime. A remarkable difference was bound to the fact that the soldier developed a *military ego* as a consequence of functioning in a military unit. This dictated a change in his civilian superego and the development of a form of a child-parent relationship to his superiors, which implied regression. His superiors would assure him protection and guidance in a situation that was both unknown and dangerous. If this was accompanied by disappointment, the soldier would experience abandonment in the same manner as children when abandoned by their parents. Subsequently, this became a precipitating cause for a traumatic response due to the loss of an inner protective agent. The outer, dangerous situation became overwhelming. Simmel placed emphasis on the other in the traumatising process and foreshadowed modern object-relational perspectives on traumatisation (Laub &Podell, 1995).

3.3.2 Psychoanalytic paradigm shifts and developments in relation to trauma

Ulman and Brothers (1988) and Scharff and Scharff (1994) documented developments and shifts in classical psychoanalytic thought and the prominence given to the role of fantasy in the development of trauma. These authors stated that Freud's underestimation of the role of actual traumatic experiences in the development of adult psychopathology was challenged in the writings of many classical psychoanalysts including Ferenczi (1913/1952), Anna Freud (1967) and Masson (1984), all of whom placed emphasis on the reality of early childhood traumatic experiences.

In line with Freud's later appreciation of the role of real experience in the development of the symptoms of trauma, the revisionist school of thought, which includes the work of Kardiner and Kelman with war veterans (cited in Ulman & Brothers, 1988), represents a shift from the role of fantasy in the psychogenesis of symptoms in response to exposure to traumatic experiences. This view posits that reaction to trauma occurs as a result of the disruption in adaptational functioning, which results from "a pathological alteration in images of the self and the outer world" (Ulman & Brothers, 1988, p.59). The unconscious meaning of exposure to the trauma of combat is understood in relation to the individual's sense of failing to live up to an idealised sense of self. A pertinent contribution of this approach includes the shift in the individual's sense of uniqueness and strength to one of vulnerability, worthlessness and dependency. By shifting focus from the isolated experience to the traumatic situation, Freud endeavoured to understand trauma better. This theory further proposes numerous paradigmatic traumatic situations that are inherent to the development of each individual. These situations give rise to overpowering helplessness, which may be regarded as the basic traumatic situation to which other traumatic situations relate. In that way, the situation of danger is the recognised, recollected and expected situation of helplessness (Freud, 1936). We see a resemblance between Freud's reasoning here and the trauma theory developed by the Norwegian psychoanalyst Harald Schjelderup in the thirties (Sletvold, 2011; 2014). He, too, perceived the sense of helplessness in a danger situation as the main constituent of the traumatic situation. This comprises both the interaction of internal and external situations as well as the inter-structural nature of all traumatic situations (Baranger et al., 1988).

Fairbairn (1943) emphasised that, although the individual is constantly dependent upon relationships with others in the outside world, the nature of this dependency shifts from one of absolute dependency to one of inter-dependency that is mutually beneficial and respectful. Consequently, trauma results in a regression that Scharff and Scharff (1994) referred to as "the most fundamental trauma" which is "that the child cannot count on being held securely and with respect for the body, the mind, the emotions, and the essence of the child" (p. 62). Therefore, it precipitates regression to the earlier state of immature dependency that involves early intrapsychic conflicts and affects the manner in which individuals relate to inner and external objects in their world directly. Dependency is connected to helplessness: Freud

hypothesised that when the *stimulus barrier* is breached, the mental apparatus is flooded with excitation, causing a feeling of helplessness (Van der Kolk, 1987).

Neoclassical theorists including Jacobson and their contribution to the theory of trauma is important in terms of her emphasis on the process of regression as a result of a traumatic experience as well as her emphasis on the effect of trauma on the sense of self. Jacobson (1959) declared that, due to the experience of trauma and the resultant narcissistic regression, the patient's initial self-representations, organised in accordance with a healthy sense of self-respect, are altered to form new self-representations based on a painful sense of self as worthless and humiliated. Winnicott (1965) believed that it was the environment's emotional holding and responsiveness to the arousal of psychological and bodily states that enabled the psyche to indwell in the body and for the psyche and soma to become intimately entwined. In effect, these theorists described the phenomenon of being faced with limitations and complete helplessness. From the first day of life, people live in a state of delusional blending with the object, time and space. In essence, growing up is a process of relinquishing omnipotence through the process of grieving. Trauma is a rupture in this gradual process; the breakdown in the area of reliability in environmental provision at the stage of near absolute dependence (Winnicott, 1989). A traumatic event has much the same effect on the already mature personality structure; feelings of complete helplessness and pain reactivated in this way trigger the reactivation of massive projections and a return to the paranoid-schizoid position. This gives rise to narcissistic self-sufficiency (Rosenfeld, 1987), which leaves little capacity for being and resting, that is, immature ego development.

Once Freud had moved away from the notion that all anxiety was derived from undischarged libidinal excitement, he placed anxiety firmly within the ego (Garland, 1998). The ego can distinguish between anxiety experienced in an actual situation of danger, that is, automatic anxiety and anxiety experienced when danger threatens, namely, signal anxiety. The latter warns of an impending situation of helplessness. According to Garland (1998), once the threat of annihilation has been encountered face-to-face, something is altered: once the ego has been traumatised or raptured it "can no longer afford to believe in signal anxiety in any situation resembling the life-threatening trauma: It behaves as if it were flooded with automatic anxiety" (p. 17). She referred to this as a crucial factor in the loss of symbolic thinking in the area of the trauma, which is a marked feature of the behaviour of survivors.

Garland (1998) stated that universal anxieties that are potentially traumatic for anyone have a single distinguishing feature: the separation from or the loss of anything that is believed to be crucial to life including life itself. Kohut (1977) called this distinguishing feature of trauma *disintegration anxiety*, an unnameable dread associated with the impending disintegration of a coherent self. Ulman and Brothers (1988) who grounded their work on the tenets of Kohut's theory of self-psychology, asserted that neither the reality nor the fantasy results in trauma, but rather the unconscious meaning of the real occurrence

causes trauma by changing the individual's experience of the self in relation to self-objects. The notion that the traumatic experience shatters the individual's sense of self in ways that are intolerable lies at the core of Ulman and Brothers' (1988) theory of trauma. The self is perceived as the core of mental activity and plays a vital role in organising the meaning of experience. Therefore, the trauma takes on an unconscious meaning, which challenges and threatens an individual's sense of self, which is subsequently symbolically represented in the symptoms of trauma.

Kohut (1977) made reference to two types of disintegration by drawing a distinction between a fragmented self and a depleted self. According to Mollon (2001), fragmentation manifests in a child whose mental and physiological state is not regulated adequately by the caregiving environment. Schore (2002) postulated that at all points in the life span, a fragmented self is a depiction of a self system that is in intense, dysregulated sympathetic hyper-arousal, which is understood to be a condition of excessive energy exertion, an explosive disintegration of the core or nuclear self. The subjective experience of this hyper-energetic state is that of an organismic panic, which Pao (1979) explained as a shock-like reaction in which the ego's integrative capacity is temporarily paralysed.

On the contrary, Kohut's depleted self characterises an organismic state of dysregulated parasympathetic hypo-arousal, dissociation and excessive energy conservation, which is subjectively experienced as an implosion of the self in which there is not enough energy in the brain/mind/body system to form the interconnections responsible for coherence. This would be clinically manifest as as a depressive disorder that accompanies a state of conservation-withdrawal and is marked by high levels of dissociation (Weinberg, 2000). Schore (2002) explained that there is a concurrent loss of both modes of self-regulation, interactive regulation and auto-regulation in this condition. While the former subjectively manifests as a lingering state of intense hopelessness, the latter manifests as helplessness. Trauma induced impairment of the self and self-regulation capacity have implications for deficits in other structures of the psyche.

3.4 Psychoanalytic theoretical concepts linked to the nature of trauma

3.4.1 Dissociation and repression as defense mechanisms

The psyche's typical reaction to a traumatic experience is to withdraw from the scene of trauma. If withdrawal is not physically possible, then a part of the self must be withdrawn, thus requiring that the otherwise integrated ego splits into fragments or dissociates. Van der Merwe and Swartz (2015) suggested that shame and dissociative splitting form part of the same psychological process. Dissociation is a normal aspect of the psyche's defenses against the potentially damaging impact of trauma. Kalsched (1996) referred to dissociation as a trick that the psyche plays on itself and added that

it permits life to go on by apportioning the unbearable experience or trauma to different compartments of the mind and body, especially the unconscious aspects thereof. This means that the elements of consciousness that are usually integrated are not permitted to integrate and the experience itself consequently becomes disconnected. The psychological defense of dissociation against the experience of intolerable pain carries a great internal toll as the psychological sequelae of the trauma continue to haunt the internal world (Kalsched, 1996). Kalsched further asserted that dissociation is not a passive, benign process but rather a direct attack by one part of the psyche on the other parts, which entails a good deal of aggression. Contemporary psychoanalysis recognises that where the inner world is charged with violent aggression, primitive defences are present too. The energy for dissociation stems from this aggression. Target (1998) explained dissociation as the opposite of mentalisation in which the ability to reflect on one's own or the other's mental states is decreased. Thus, an undifferentiated, narrow, rigid and empty image of the inner states results. Davies and Frawley (1994) explicated dissociation as submission to the inevitability of overwhelming and even psychic deadening danger. Moreover, Shauer and Elbert (2010) observed that peri-traumatic dissociation is a strong predictor of the development of PTSD. They further noted that based on evolutionary or genetically wired responses to extreme threat, dissociation is more likely to occur when there is an experience of some kind and physical restraint or entrapment. There seems to me to be a striking resemblance between Freud's early formulations and a contemporary view of dissociation as "the primary unconscious defensive process, replacing repression" (Stern, 2010), empahasises that what is defended against is not so much a particular feeling but *to be a certain person*, "someone who felt disappointed, bereft, frightened, humiliated, shamed, or otherwise badly hurt or threatened" (p. 13).

In Bion's (1962) theory of thought, how sensory experience is transformed by a certain function of thinking known as the alpha function into mental contents is explained. This is known as the *furniture of dreams* and is suitable for further mental *digestion* (Bion, 1962). A feature of post-traumatic conditions involves the individual's inability to think about the event; in essence, thinking about the event becomes the event itself. These individuals usually do not dream; if they do, their dreams involve reliving real events, which are unchanged by the work of the dream. Bion (1970) explained that dreaming is unconscious emotional thinking required to transform the primitive emotional experience into something that can be thought, known, felt, suffered and repressed. When beta elements, which comprise raw soma or psyche data, cannot be elaborated mentally and transformed into alpha elements, which are elements of dreams and thoughts, and dream thoughts, they cannot in effect be repressed. Something that has not yet been represented mentally cannot be repressed. According to Bion (1962) an inability to dream the emotional experience thus places the psyche in an intolerable emotional disturbance that has to be acted out and expelled through defenses such as projective identification, somatic disorders, addictions and perversions. The traumatic event has not been assimilated into the

everyday experience and it cannot be disposed of in everyday speech, and free associations or metaphors; rather, thinking is concrete and devoid of symbols. To be able to symbolise something, one must first complete the process of grieving it (Segal, 1986a). The grieving process marks the intricate process of integrating experience into a higher level and moving from the paranoid-schizoid position into the depressive one. What is seen as the re-experiencing of the traumatic event is a consequence of a disintegrated pathological process described as the impairment of thinking and the possibility for symbolisation, assimilation and attribution of meaning.

3.4.2 Non-integrated traumatic experience

Non-integrated traumatic experience impinges itself through re-experiencing and is once again, suppressed or split. Depending on the complexity of the psychic defenses, namely, the maturity of personality, it has three recourses: to move into the body, the sensory sphere or enactment. These are manifest in psychosomatic dysfunction, perceptual hallucination or symptomatic action (Britton, 1998). The difference in relation to psychotic disintegrative processes may be found in the quality and/or strength of defense mechanisms. According to Bion (1958), dissociation in comparison to splitting entails regard for natural lines of demarcation between whole objects. The individual suffering from a psychotic process and the psychologically traumatised individual both employ projective identification to free themselves from beta elements and are not capable of symbolisation and suppression. By means of projective identification and pathological splitting, psychotic patients attempt to free themselves not only of the object, but also and deliberately of all ego functions that correspond to the onset of the reality principle, which constitute primary thoughts, consciousness, attention, judgement and in particular, those elements with linking functions (Grinberg et al., 1974). In this way, bizarre objects are created, comprising beta elements as well as parts of the ego, superego and external objects. While the psychotic individual exists in a world surrounded by bizarre objects, the traumatised person is surrounded by damaged objects, which are beyond repair and cannot be integrated into the personality; their life becomes a theatre in which the traumatic scene is constantly playing (Jovic, 2018). The process of integrating traumatic experience may be comprehended as the impairment of ordinary processes for translating external experiences into internal contents: introjection, identification and assimilation.

3.4.3 Non-assimilated traumatic experience

Heimann (1942) explained the term assimilation employed in this context. Accordingly, internal objects are created by introjection and are accessible to the ego for identification; by assimilation they form part of the ego, reinforce it and ensure skills, attitudes, qualities and defenses that are now at the ego's disposal through identification with internal objects. On the contrary, objects that remain non-assimilated become foreign bodies within the personality. The split non-assimilated parts comprise large

fragments of experience, specifically traumatic scenes, fragments of object relationships directly related to trauma such as basic trust, a sense of belonging, and re-examining the meaning and value of social institutions in individuals who have survived extreme traumatic experiences. Therefore, externalisation through the re-enactment of traumatic events serves a function of gaining control over the traumatic experience (Fenichel, 1941) and traumatising bad internal objects.

3.4.4 Internal objects and positions

In the language of internal objects, the clinical manifestation evidencing the dynamics of the pathological process is subsequently explained. On the level of unconscious phantasy, the function of thinking, the material container, is regarded as an omnipotent good internal object that understands, appeases and brings comfort, warmth and peace. The traumatic process appears to damage this internal object and creates an impression that understanding is impossible and separated or alienated from others. This may be described as the collapse of the empathic process (Laub & Auherhahn, 1993). On the level of unconscious phantasy, in the primary process space, this impairment is experienced either as an own attack on the good object or impossible to defend against the attack of the bad object. This forms the basis of the profound unconscious guilt feeling. The good internal object is destroyed along with the functions it ensures: trusting others, self-confidence, relationship towards one's own body, adequate perception of time, regulation of basic needs and the capability to think and symbolise. This mechanism can be understood by Klein's use of the language of positions. Furthermore, in this process, the paranoid-schizoid defense mechanisms are dominant, namely, splitting, projective identification and denial. It is noteworthy that these mechanisms serve to defend one from intolerable emotions from the depressive position such as the feeling of ultimate helplessness, which represents regression to the prime narcissistic injury, which is the feeling of the separate existence of objects (Jovic, 2018). These defense mechanisms underpin the maladaptive defenses with which Black SANDF members survive in defense against their intolerable emotional anguish manifest in their PTSD syndrome.

3.5 Summary

In this chapter, a psycho-diagnostic overview of PTSD, which also examined complex PTSD was presented wherein the undiagnosed clinical syndrome observed in the SANDF falls. Subsequently, combat exposure and PTSD as well as studies on combat-related PTSD internationally, across Africa and in South Africa were discussed. A psychoanalytic perspective on PTSD and psychoanalytic paradigm shifts in relation to trauma were also presented to account for Black SANDF members' psychodynamics in response to trauma. This is in light of the fact that ORT is grounded in the psychoanalytic perspective.

The focus of this study was on Black SANDF members' experience of how long-term undiagnosed PTSD secondary to traumatisation affects their capacity of functioning and self-object relating. Interpretative phenomenology was employed to explore how SANDF members experience these feelings. Interpretative phenomenology is examined in Chapter 4.

CHAPTER 4: PHENOMENOLOGY

4.1 Introduction

In this chapter, phenomenology as the methodological framework that was employed in this study is discussed. Qualitative research in the field of psychology, the philosophical concepts and methodology of phenomenology as well as a justification for employing this framework in the current study are explained.

Phenomenology has its roots in the philosophical work of Husserl (1859-1938) and subsequently, Heidegger (1927-1962) who departed from the philosophical underpinnings and adopted a more hermeneutic and existential dimension (Giorgi, 2010). Englander (2016) expressed the view that science rests on the method developed in a phenomenological philosophy because this specific method is best suited for disclosing the subject matter under study. In phenomenology, the following distinct foundational concepts are inherent to the philosophical underpinnings: *lebenswelt* (lifeworld), *being-in-the-world*, *intentionality* and *choice* in human existence (Moran, 2000). Phenomenological methodology affords researchers the opportunity to comprehend the lived experiences of individuals, either in their day-to-day experiences or of a particular phenomenon (Giorgi, 2010). Husserl noted individuals are connected meaningfully with everything else in the world (Vagle, 2014). Therefore, phenomenology lends itself to uncovering the essential *structures* of experience and the essence of a particular phenomenon that is being explored (Dowling, 2007; Langdridge, 2007). Lived experiences are utilised to define the universal structures, that is, the essence of the phenomenon (De Chesnay, 2014). In the current study, the disclosure of psychological meaning in the *Lebenswelt* and *being- in-the-world* of the participants was explored.

4.2 Positivist to post-positivist methodology

During the past few decades, debates within the human sciences about *which* methods provide the best form of knowledge while addressing the unique characteristics of humanity have been prominent. These debates have permitted shifts in thinking from a primarily positivist conception of science to a post-positivist one (Willig, 2008). The former has its roots in the social theories of the 19th and early 20th centuries, specifically in the works of Auguste Comte and Emile Durkheim (Taylor et al., 2015). This view searches for facts or causes of social phenomena and thus, knowledge may be defined as those things of which one is absolutely certain (Willig, 2008).

Psychology as a discipline was pioneered on the facts embedded in the positivist, natural scientific approach (Valle, King & Halling, 1989). Initially, psychology was modelled as a natural science that

viewed behaviour and experience as dichotomies on a continuum (Langdridge, 2007; Taylor et al., 2015). Freud and other classical theorists were medically trained professionals who started to explore the concepts of mind and body. To give credibility to the study of the human psyche, psychology had to be modelled on a natural science template because only studies in the latter field were regarded as credible (APA, 2013). While behaviour depicted the objective, specifically the observable and accessible aspect of human interaction and experience, thoughts, emotions and sensations portrayed the subjective, that is, the internal and inaccessible aspect (Langdridge, 2007). As the study of the human mind and behaviour within the positivist realm, psychology became synonymous with behaviourism (Taylor et al., 2015). Many researchers found it difficult to accept the fixed belief that only observable behaviour was worth studying, particularly when much of what is central to human experience was accordingly neglected in this approach (Converse, 2012; Langdridge, 2007; Willig, 2008).

Consequently, a post-positivist theory of science emerged in opposition to the standing tradition that knowledge is an absolute truth that argued human experience does not possess undeniable truths. Instead, acceptance of a knowledge claim rested ultimately with the community to whom researchers present their results for acceptance (Polkinghorne, 1989). The primary difference between post-positivism and positivism is the notion that there is no unified view of science (Creswell, 2007; Langdridge, 2007; Polkinghorne, 1989; Willig, 2008). The school of post-positivism is not one founded on a set of propositions but is rather based on an attitude about knowledge in which there is no correct prescribed method that has to be followed. Consequently, science may become a creative search to arrive at a deeper understanding by employing whatever approaches are conducive to addressing particular subject matter or questions. Neuman (1997) noted that methods of scientific enquiry obtain their validity and reliability from their participation in a particular system of inquiry.

4.2.1 The shift towards qualitative research in psychology

For many decades, psychologists were of the view that objective measurement, identification of psychological variables and associated statistics were predominant ideas of research (Langdridge, 2007; Willig, 2008). Part of the empirical approach that conforms to the biomedical model to which modern medicine has attributed its success involves employing objective methods of exploring psychological variables (Willig, 2013). However, researchers have asserted that there is an extreme overestimation of the contributions empirical research has made to the study of human behaviour (Yardley, 2000). Social medicine developed and presented an alternative model to understand health and illness: behavioural principles to health problems were proposed, which led to the discipline of behavioural medicine (Yardley, 2000). This discipline prepared the way for the sub-discipline of health psychology. Health psychology encompasses the biological, psychological and social aspects of studying human interactions. These aspects are incorporated into the *biopsychosocial model* (Yardley, 2000).

Initially, psychology conformed to empirical methods, the comparison of groups, the measurement of people and statistical analyses (Lyons & Chamberlain, 2006). However, many shortcomings of the empirical approach were exposed, which allowed the emergence of other approaches that compensated applied studies within the realm of human behaviour and experience (Willig, 2008). Thus, qualitative methods increased in the realm of social sciences. Qualitative research has enabled psychological research to explore the meanings individuals ascribe to life, health, death and illness as well as the lived experience of these constructs from an individual's perspective rather than focusing exclusively on group comparisons and the classification of behaviours (Lyons & Chamberlain, 2006). Consequently, researchers are able to shed light on individuals' lived experiences of particular phenomena, which is difficult to realise with quantitative methods (Lyons & Chamberlain, 2006).

Many differing approaches are employed in qualitative research including grounded theory, discourse analysis, conversation analysis, phenomenology, ethnography and hermeneutics (Langdridge, 2007; Willig, 2008). A shared attribute of these approaches is the vested interest in understanding the phenomena under observation or in question, each with its own theoretical and methodological approaches (Elliott, Fischer, & Rennie, 1999). Phenomenological research, which focuses on the structures of human experience or the structuring principles that give shape and meaning to the individual's lifeworld, is an example thereof. Hermeneutic research concerns itself with the historical meaning of experience as well as its developmental and compounding effects on the individual and society (Polkinghorne, 1989; Smith, 2008). The evolution of phenomenological research with reference to its central theoretical tenets and application to the current study is subsequently discussed.

4.3 The development of phenomenological psychology

4.3.1 The philosophical tenets of phenomenology

Edmund Husserl (1859-1938) is credited as the principal figure in the development of phenomenology. Husserl's aim was academic in that he intended to provide a rigorous and impartial study of things as they appear and accordingly, arrive at a consequential understanding of human consciousness and experience (Converse, 2012; Valle et al., 1989). He criticised the positivist and empiricist conception of the world as an objective universe of factuality (Smith & Dunworth, 2003). Husserl (1970) further argued that the *objectivistic illusion*, which he had referred to as empirical research, concealed the constitution of human experience in their primary lifeworld or *lebenswelt* (Kvale, 2003). Therefore, he developed a method to gain access to an individual's lived world so as to acquire knowledge of invariant structures of consciousness (Dowling, 2007; Smith & Dunworth, 2003). He focused more on *pure consciousness* by exploring it as an independent realm (Polkinghorne, 1989).

Husserl believed experience, was an integrating activity of consciousness comprised made up of meaningful and ordered understanding (Smith, 2008). Experience was viewed as transpiring on a spectrum and therefore, ordered into units and identifiable wholes. Furthermore, it was developed in accordance with built up along the lines of types (*eide*) or *essential structures* (Dowling, 2007). Although Husserl attempted to make philosophy a rigorous science, he could not reach an absolute fact-based consciousness (Converse, 2012). However, he paved a smooth the way for his successors to make significant imperative contributions to the development of a valid phenomenological theory of consciousness and method as a description of life-experiencing-the-world (Willig, 2008).

Merleau-Ponty (1908-1961) subsequently extended Heidegger's understanding of Husserl and focused attention on the relationship that embodied the condition of human existence and structures of experience (Polkinghorne, 1989). This existential turn transferred Husserl's realm of pure consciousness to one of contingencies of history and embodiment (Polkinghorne, 1989). This is particularly valuable for the present study because a trauma-induced disintegrated psychic state, as manifest in PTSD, is often felt as an embodied experience rather than within the realm of pure consciousness (Maroda, 1999). Merleau-Ponty distinguished three orders of structure that are pertinent to the lifeworld of an individual, which interact with the environment in various ways (Van Manen, 1990). He argued for investigations of human science to shift towards psychological meaning: from the ubiquitous notion that all individuals experience a phenomenon in a certain way to the idea that all individuals have unique experiences (Dowling, 2007; Polkinghorne, 1989; Van Manen, 1990). Therefore, phenomenology addresses the varied structures of orientation towards the world that constitutes human experience and through which experience is ordered and made meaningful (Creswell, 2007). Consequently, throughout interactions, people endeavour to realise meaning from their experiences, which may range from simple, literal meanings to implications for their identity and life's meaning (Smith, 2019).

4.4 Phenomenology as methodology

In any research process, it is imperative for qualitative researchers to ensure their epistemological stance is clear in order to achieve coherence (Taylor et al., 2015). The current study is rooted in hermeneutic phenomenology, an epistemological stance that links the phenomenological and hermeneutic positions. As previously noted, phenomenology concerns itself with how individuals ascribe meaning to their subjective world, thus resulting in knowledge being derived from human experience (Bryman, 2008). It is important for researchers who work in the traditional Husserlian way of phenomenology to appreciate and understand the quintessence of experience without prejudice by casting aside preconceptions, namely, bracketing to allow for the phenomenon under study to develop. In Heidegger's hermeneutic phenomenological stance, researchers are not required to bracket their experience or understanding because Heidegger (1962) was of the opinion that it was impossible to set

aside one's own experience and understanding. Furthermore, he maintained that knowledge of human experience is actually derived from interpretation rather than essence (Creswell, 2007). Heidegger did not accept the notion of language being the medium of direct access to understanding phenomena, but rather proposed that individuals exist in a particular context of their world and thus, assign meaning and interpretations of their experiences in accordance with the context of their world. This interpretative approach to knowledge production resulted in the interpretative stance or hermeneutics in phenomenology.

4.4.1 Hermeneutics

The hermeneutic epistemological stance posits knowledge production is obtained through interpretation (Dahlberg, 2004) because hermeneutics is concerned with how individuals experience and interpret meaning subjectively. It also takes into account that researchers' interpretation may also have an effect on the participant's context because researchers are individuals with their own experience (Bauman, 2010). Researchers are invariably influenced by their own preconceptions of the phenomena under study. Thus, when assuming a hermeneutic position, the researcher's preconceptions and context are viewed as integral to knowledge production in conjunction with the participant's experience (Bauman, 2010; Dahlberg, 2004). This facilitates a creation of knowledge through dialogue and the interpretation of both the researcher and participant's experiences (Dahlberg, 2004).

The hermeneutic-phenomenological position seemed most appropriate for the present study for several reasons. Psychoanalytically informed trauma theorists interpret human functioning as located ineradicably in personal developmental history and shaped by the unconscious and conscious aspects of the psyche. The distinct sets of meanings events hold for the individual concerned make it traumatogenic (Garland, 1998; Laub & Auerhahn, 1993). Formulating trauma impact entails careful exploration of the manner in which the individual describes the traumatic event and their response to it. These may include the language they employ, emphases, omissions, affective tone and fantasy material with the aim of uncovering pre/unconscious associations with the trauma and the manner in which intrapsychic constellations have shaped and/or mapped onto the experience. Finally, a strongly ideographic approach is followed in which formulation of personality constellation and dynamics as well as attention to unconscious and conscious meanings are important. Consequently, a hermeneutic rather than an empirical descriptive approach was regarded as important for this study.

The research questions formulated for the present study are concerned with exploring Black SANDF members' subjective understandings and experiences of their PTSD symptoms in response to traumatic military experiences. Moreover, the study endeavoured to describe their physical, emotional and cognitive experiences thoroughly as well as how they coped with the experiences. While exploring the

experiences of the participants, I became aware, particularly because I worked at the SANDF as a clinical psychologist, that this process was dependent on both the participants and researcher's interpretative stance. The hermeneutic stance provided a unique opportunity because it considered the researcher's preconceptions of undiagnosed PTSD and its impairing deleterious course on the participants' functional and relational capacity, which afforded me the opportunity to utilise knowledge as an asset in the production of knowledge of the phenomena under study (Bauman, 2010).

4.4.2 Limitations of hermeneutic phenomenology

Objections have been raised against the hermeneutic-phenomenology approach because of the conflict between phenomenology's emphasis on describing participants' experiences in essence (Husserl, 1970) and the significance hermeneutics places on interpretation as the generation of knowledge (Dowling, 2007). When considered separately, both of the epistemologies are limited. Bauman (2010) stated that when researchers use the hermeneutic position and focus on interpretation, participants' experiences may be lost through interpretation. Similarly, when working strictly within the traditional phenomenological position, it is imperative for researchers to bracket off personal experiences, which appear unrealistic (Dowling, 2007) and may result in a descriptive experience devoid of the richness that interpretation provides (Bauman, 2010). However, combining both processes afford researchers the opportunity to access human experience closely. Moreover, the interpretation component adds depth and meaning to understanding experience (Pringle et al., 2011).

In the discussion that follows, the methodological assumptions through which any hermeneutic phenomenological investigation is approached are examined. Furthermore, the operation of the transcendental attitude and processes embarked on by the researcher so as to answer the research questions and investigate the phenomena under study are explored. In particular, how the participants described and understood trauma as a concept as well as how the effects of a traumatic stress response, as manifest in PTSD, were experienced in their emotional, cognitive and relational functioning are considered.

4.5 Interpretative Phenomenological Analysis (IPA)

Interpretative phenomenological analysis (IPA) was thought to be the fitting methodological approach for this study. Phenomenology comprises different research methods including hermeneutic phenomenological inquiry, descriptive phenomenological analysis and interpretative phenomenological analysis. IPA enables the process of understanding the meaning ascribed by an individual to their *lived experience* of a particular event or phenomenon (Smith, 2004). It places individual participants at the centre, or in the role of the expert, of their own experiences, thus allowing them to tell their story in

considerable detail (Reid et al., 2005). By exploring the meanings and experiences of the individual, the researcher is afforded an insider perspective of the phenomenon under study (Smith et al., 2009).

4.5.1 Philosophical assumptions of IPA

Two essential theoretical components inform IPA: phenomenology and symbolic interactionism (Smith, 2019). Phenomenology affords the construction and implication that human beings are not merely innocent bystanders in an objective reality. Rather, it argues that humans construct their own biographical narratives by interpreting and understanding the world around them in a way that makes sense to them (Brocki & Wearden, 2006). Phenomenological methodology gives the individual the opportunity to share a personal account of an object or event that provides a subjective view rather than objective statements of the event or object (Smith et al., 2009).

Symbolic interaction involves how researchers understand the meaning individuals ascribe to events that are of central importance to social scientists. However, it also takes into account that meanings are only obtained through processes of interpretation (Smith et al., 2009). This suggests that the manner in which people perceive an event or experience is perhaps directly reflected in how they talk about and behave in relation to that specific event or experience (Payne, Dean & Smith, 2006). The main aim of IPA is to understand the individual's view of the world and associated cognitions to acquire an *insider's perspective* of the phenomena in question (Smith et al., 2009). In essence, IPA focuses primarily on the individual's experiences, perceptions and understanding of their experience (Brocki & Wearden, 2006).

The notion of interpretation is a principal component of IPA (Smith, 2019). IPA asserts that it is impossible to gain access to an individual's internal or personal world without the use of a researcher or interpreter (Englander, 2012; Groenewald, 2004; Smith & Osborn, 2003). Accordingly, access to the individual's internal world is dependent on the researcher's ability to conceptualise and make sense of the individual's personal world through a process of interpretative activity (Smith & Osborn, 2003). Interpretative activity is crucial because the researchers' preconceived ideas can influence how they perceive the individual's narrative. Furthermore, the interpretive process can occur at different levels. First, individuals should offer their interpretations of the phenomenon and associated cognitions and meanings in their own words (Smith & Osborn, 2003). Once this is achieved, the second level of interpretation is conducted during which the researcher attempts to understand the individual's comments. The researcher's capability to interpret and analyse is dependent on how well individuals are able to verbalise and articulate their thoughts and experiences to the researcher (Smith & Osborn, 2003).

4.5.2 Hermeneutic assumptions of IPA

Hermeneutics may be described as the theory and practice of the interpretation of the meaning of texts (Smith, 2011). The interpretative positioning of IPA draws on the theoretical perspectives of three hermeneutic theorists, namely, Heidegger, Schleiermacher and Gadamer (Larkin et al.,2006; Smith, 2008; Smith et al., 2009). Building on the strength of Schleiermacher's theories of interpretation, Heidegger merged his understanding of phenomenology with the theories of hermeneutics. Heidegger posited that human existence is bound up entirely and indissolubly in the world that comprises people, things, language, relationships and culture. This resonates with the concept of *Dasein* where being-in-the-world is explored through being with others (Horrigan-Kelly, Miller, & Dowling 2016). Moreover, through *Dasein* individuals can be understood as relational beings who exist alongside others. Within this context, the self is thus formed through dialogical interactions with others in the world. Moreover, the exploration of shared experience is crucial in developing phenomenological insights (Smith & Eatough, 2019). Within this relational context, individuals may be imagined as giving form and meaning to one another through words (Gibson & Sullivan, 2012).

Therefore, it is impossible for anyone, for example, researchers and participants to choose to transcend or disconnect from these ineradicable facets of their lives in order to reveal some fundamental truth about lived experience (Larkin et al., 2006). In this respect, all enquiry starts from the enquirer's perspective, from the premise of his or her experience. In an endeavour to set aside or bracket preconceptions and assumptions in advance of an enquiry, IPA researchers work from a Heideggerian perspective and attempt not only to appreciate their basic understanding of a particular phenomenon, but also acknowledge that an awareness of these *fore-conceptions* may not be realised until the interview or analysis has started; in other words, until the phenomenon has started to emerge (Smith et al., 2009). Consequently, IPA researchers are encouraged to adopt a "sensitive and responsive" approach to data collection and analysis that permits the researcher's preconceptions to be challenged and adjusted by the data (Larkin et al., 2006, p. 108). This careful attention to the cares and perturbations of the participant forges a dynamic or cyclical form of bracketing, which is similar to the more familiar processes involved in reflective practice, and occurs as part of the research process (Smith et al., 2009). In this respect, while it may be possible to bracket scientific and theoretical presuppositions about the topic of interest, even these assumptions may only emerge once a researcher has started to engage with the data. Therefore, IPA researchers comprehend that all questioning and interpretation carry assumptions based on prior experience that govern the extent of what can be disclosed.

This implies that what is captured of another's experience employing IPA will always be indicative and temporary rather than absolute and definitive because regardless of how much effort the researchers employ, they cannot deny the contextual basis of their own experience completely (Larkin et al.,2006).

Although a perfect understanding of the experience will always remain concealed, ultimately, a rich and nuanced comprehension of the phenomenon should be unveiled based on acute interpretative effort and insights (Moran, 2000).

Smith et al. (2009) summarised IPA's articulation of the co-dependency of interpretation and phenomenology aptly. They stated that in the absence of the phenomenology, there is nothing to interpret and without hermeneutics, the phenomenon cannot be seen. IPA researchers do not attempt to produce an impartial or definitive account of a phenomenon and only claim to access a version of the experience as participants make sense of it through their narrative accounts (Smith & Osborn, 2008). Similarly, the researcher's own resources and experiences, which Smith (2004) referred to as the biographical attendance of the researcher, are required to make sense of what is said. However, a layer of resistance that creates a dynamic tension throughout the research process can be found within this biography. In order to resolve this, researchers make use of their own contexts as sources of insight while endeavouring to be unequivocal about the influence of their perspectives on the analysis and interpretation of the narrative (Finlay, 2008). However, at first, the researcher's preconceptions may not be evident and may only become clear through further engagement with the text and an openness to engage in reflection (Smith et al., 2009). This implies that a researcher's prior lived experiences, assumptions, worldview and presuppositions have an effect on their interpretations. Therefore, IPA research is not purely objective. It is imperative that the researcher acknowledges this and attempts to explore and address their fore-structures reflexively so as to create transparency (Goldspink & Engward, 2018).

Consequently, IPA appreciates that the researcher's engagement with the participant's text has an interpretative element. It assumes an epistemological stance through which careful and explicit interpretative methodology, it becomes feasible to access an individual's cognitive inner world. From a hermeneutic perspective, IPA regards the interpretation of lived experience as undergoing a double hermeneutic process (Smith & Eaton, 2007). Sullivan et al. (2012) explained a double hermeneutics process as one of interpretation that emphasises that as individuals seek to make sense of and interpret their experience, so is it imperative for the researcher to interpret the individuals' interpretation of those experiences. Accordingly, Wagstaff et al. (2014) argued that the interpretative role of the researcher in IPA is at variance with classical phenomenology and can taint studies through bias. Similarly, Giorgi (2010) debated that the flexible and interpretative element of IPA is incongruent with Husserlian pure phenomenology as a methodological science. However, Smith (2010) argued that flexibility in IPA is a fundamental tenet and strength as it allows researchers to use their own experience-based interpretation to add value and clarity.

In practical terms, the hermeneutic process may be viewed from two vantage points. First, the researcher endeavours to make sense of the participant's meaning making. Second, while researchers assume an empathic stance towards participants, they are expected to adopt a very critical questioning stance when analysing the text (Smith & Osborn, 2008). By employing a double hermeneutic process, it is suggested that IPA allows researchers to master the distinction between discourse and cognition (Smith, 2019). Pringle et al. (2011) added that double hermeneutics may be a beneficial tool for in-depth analysis to capture the participant's worldview. Thus, the researcher may be envisaged as being located both inside and outside of their research (Goldspink & Engward, 2018).

4.5.3 Ideographic assumptions of IPA

Ideography is concerned with distinct experiences of particular individuals and the particular contexts in which those experiences occur (Smith et al., 2009). This ideographic nature may be contrasted to the nomothetic approach whose purpose is to uncover the universal laws of experiences (Eatough & Smith, 2008). The ideographic nature of IPA is demonstrated in two ways: First, it focuses on a specific event or phenomenon and second, it focuses on a specific participant (Larkin et al., 2006). In this way, the meaning participants attribute to experiences remains theirs and cannot be generalised to others. Thus, the researcher may find it difficult to understand one case as much as possible before moving on to the next. Findings from the first case are set aside, as far as is possible, through dynamic bracketing to approach each individual's unique story sensitively (Smith et al., 2009). Adopting an ideographic approach permits researchers to search for existential understandings of how individuals create meaning. This is vital for research that explores meanings and insights that take shape from the relationship between individuals and their lifeworld (Larkin, Shaw, & Flowers, 2018).

However, Smith and Osborn (2008) explained that IPA has changed somewhat in this respect over the years. They suggested, for example, that themes from the first case could be employed to inform subsequent analyses of the other cases. However, a stricter adherence to the ideographic approach has been articulated in more recent writings (Smith et al., 2009). Finally, a cross-case analysis is conducted. However, during this final stage, the analysis attempts to remain faithful to the individuals by demonstrating the particular lifeworlds of participants who have recounted their experiences while also revealing more general themes (Smith & Eatough, 2007). Accordingly, a picture is constructed of the general as well as the particular experiences of individuals (Smith & Osborn, 2008). To afford the researcher in-depth information of the specific, semi-structured, in-depth interviews are conducted with a small number of participants. This allows in-depth examination of the data in which differences and similarities emerge (Gibson & Hugh-Jones, 2012).

4.5.4 Description of IPA

IPA focuses on acquiring an understanding of an individual's lived experience (Shaw, 2001) as well as how that particular individual makes sense of that particular personal experience (Smith, 2004; Smith & Osborn, 2003). The phenomenological feature refers to an individual's experience of an object or event; the present study sought to understand the experiences of traumatisation manifesting in enduring undiagnosed PTSD among Black SANDF members. The interpretive element of the method is related to the assumption that gaining access to an individual's world depends on and is complicated by a researcher's own preconceived ideas (Smith et al., 2009). Interpretation is imperative to make sense of the *other's world* (Smith, 2004). This suggests that while individuals attempt to make sense of their experiences, the researcher endevours to make sense of the individuals who are making sense of their own personal worlds. Consequently, IPA undertakes in-depth qualitative analyses and a process of explication to examine cognitive processes. A description of how the analysis was conducted is discussed in Chapter 5.

4.5.5 Characteristics of IPA

A study must have certain characteristics so as to employ IPA. The research must be *ideographic, inductive, interrogative and hermeneutic* (Smith; 2004; Smith et al., 2009; Smith & Osborn, 2003). *Ideographic* research initially engages in a detailed examination of one case or participant until some degree of saturation has been realised before the researcher advances onto the second case (Smith et al., 2009; Willig, 2008). This process continues until all the cases of the particular study have been examined. Only once all the cases have been examined may the researcher conduct a cross-case analysis on the meaning units and themes of each individual case for convergence and divergence (Willig, 2008). Smith (2004) proposed that a small sample of between three and 10 participants be used for this type of analysis. At this early stage of the study, the researcher should have accomplished two important goals of IPA: first, to allow the reader to make clear sense of the emergent themes with the participant's assistance and second, to arrive at an understanding of something about the lifeworld of the particular participant whose experience has been shared (Smith, 2004). The *inductive* feature entails the use of techniques that allow for the emergence of unanticipated or unpredicted themes during the analysis (Smith et al., 2009). Therefore, hypotheses based on literature are not generated in IPA, but broad research questions that lead to a larger data set for analysis are examined (Willig, 2008). In addition, IPA is *interrogative* so as to ensure the accuracy of the information presented, rather than presuming that what is presented is fact. IPA permits further interrogation of the text until a level of saturation has been reached, which allows the research to contribute to the existing body of literature as unique perspectives emerge. Though smaller samples are needed in IPA, the depth of the analysis allows findings to be discussed in relation to broader psychological literature (Smith et al., 2009).

Another feature that differentiates IPA from other categories of phenomenological research is that IPA is strongly *hermeneutic*. Hermeneutics is considered to be the theory and practice of interpretation as it presupposes that description without interpretation is impossible (Larkin et al., 2006). IPA considers the meaning individuals ascribe to their experiences and the researcher's interpretations in attempting to make sense of an individual's lived experience (Smith et al. 2009). Thus, IPA is referred to as a double hermeneutic approach as it accepts that the researchers' perspectives of a phenomenon can be influenced by their personal experiences and worldviews. Researchers are encouraged to assume a responsive stance towards data gathering and analysis to enable personal preconceptions to be challenged and adjusted by the data (Larkin et al., 2006). Consequently, new questions develop about the text and new meanings begin to emerge (Smith et al., 2009). The circular process of probing, uncovering meaning and further probing experiences is referred to as the hermeneutic circle (Converse, 2012). While the hermeneutic circle allows an individual's experience to be communicated more comprehensively and accurately, the discovery of the unexpected is still promoted (Smith, 2004).

4.5.6 Critique of IPA

IPA has many advantages. The foremost thereof is its ability to unveil phenomena not previously accounted for or expected (Englander, 2012; Groenewald, 2004). Often research commences with a particular hypothesis or aim that needs to be realised. However, like most qualitative research methods, IPA is more flexible and open-ended, and affords participants an opportunity to discuss aspects of various experiences the researcher may not be expecting (Willig, 2008). This leads to the uncovering of phenomena, which may not have been identified previously by other researchers, thus expanding existing theories (Groenewald, 2004; Shaw, 2001). Consequently, IPA can be positioned as being data-driven rather than theory-driven; this is its inductive feature. If new data are uncovered, they may be added to the pre-existing theories on the specific phenomenon (Willig, 2008), thus contributing to academic knowledge and theory. In addition to the openness and flexibility of the method, the researcher is also required to be more open-minded and flexible through the participants' recounting of their stories without being biased by any imposed preconceived ideas (Smith, 2004). IPA can also uncover experiences that are unique to an individual as well as reveal shared experiences among participants. IPA thus enables the integration of unshared subjective aspects of experiences with the shared experiences within a sub-culture of the sample (Willig, 2013).

However, IPA depends excessively on the researcher's involvement in the process of interpretation or meaning making of the data (Smith, 2004; Smith et al. 2009). It is imperative that the researcher first understands an overall picture of the information shared by the participants and subsequently, identifies meaning units and themes (Willig, 2008). Scrutinising the data can be time consuming because researchers need to identify themes and then extend beyond these themes to code and explicate the data,

while constantly monitoring their own bias (Smith, Flowers & Larkin 2009). The researcher should not prejudice the data by over-interpreting what the participants have related. This process entails revisiting the original transcripts or accounts continually to ensure that they are themed and coded as the participant intended.

In addition, Willig (2008) identified five key limitations of IPA, which are thus summarised. First, talking about an experience may not necessarily constitute a description of the experience. Second, for a participant, command of language can actually mean that language precedes an experience and as such it shapes the description of experience itself. Third, with its focus firmly on the capacity to use language, IPA may result in excluding potential participants who do not have appropriate language skills. This stratum of potential participants' experiences of a particular phenomenon may be disregarded. Fourth, an absolute focus on appearances, without casual context, which is not regarded as part of IPA, inhibits our understanding of phenomena. Finally, IPA is concerned with cognition, which could be mistaken to imply a Cartesian worldview. The latter is actually inconsistent with certain aspects of phenomenological thought.

4.6 Justification for choosing the phenomenological research approach

Giorgi (1985) argued that as quantitative research does not deal directly with experienced phenomena, many pivotal aspects of a phenomenon that is lived and experienced can be overlooked or distorted by quantitative methods. This argument is also espoused by philosophers and psychologists who are of the opinion that the positivist model is too objective, reductionistic and mechanical for an exploration of experience (Byrne, 2001; Groenewald, 2004; Smith, 2019).

Research literature on military traumatic stress reactions, manifesting as PTSD with comorbidity, presenting differently to expected standard diagnostic criteria (see Chapter 3), has revealed how complex an understanding of this phenomena can be. These studies are beneficial in that they have provided a framework wherein researchers, mental health care practitioners and families of Black SANDF members suffering from PTSD secondary to traumatisation can begin to comprehend, to a certain extent, predict and adaptively manage the devastatingly impairing long-term effects of the disorder. There is a dearth of research on the experience of Black soldiers living with undiagnosed PTSD in the African context. Phenomenological studies are imperative to provide more authentic and psychologically rich understandings of what it is like for Black soldiers to have certain experiences and reactions that stem from their enduring undiagnosed and continuously activated PTSD. Phenomenological studies strive for an understanding of the psychological realm that comes into being at the convergence of consciousness and the world of human experience. Employing phenomenology

to explore traumatisation manifesting in undiagnosed PTSD was apt because it is the meanings that the participants attach to their experiences that were sought after (Van Manen, 2017).

Therefore, key to psychological well-being are questions about how Black SANDF members-in-the-world interpret and create their own realities in such circumstances. The investigation of the experience of accessing treatment as well as the management of members with PTSD can only be addressed within the context of a phenomenological system of inquiry and from an interpretative understanding of human existence in the world. Such methodology may extend the prevailing notions of this experience so that mental healthcare practitioners and researchers can show greater sensitivity and appreciation of a particular member's lived experience of undiagnosed PTSD. This knowledge has implications for rehabilitation as well as health and mental health professionals. Furthermore, knowledge based on the existing empirical research will not only be extended and deepened, but in a few cases, also contextualised to the African military context.

4.7 Summary

In this chapter, the epistemological basis, that is, positivistic, post-positivistic and constructionism as well as the philosophical influences of the field of phenomenology were explored. The chapter encompassed understanding phenomenology as a methodology in the field of psychology. The history of its evolution from conception to acceptance as a valid and trustworthy approach to understanding phenomena in research was explicated. In accordance with the phenomenological tradition, the current study assumed participants as beings-in-the-world who strive to achieve authentic being within the demands and constraints of human existence; in particular, being a soldier living with undiagnosed PTSD. The suitability of an ideographic approach in which formulation of the participants' personality constellation and dynamics, and attention to unconscious as well as conscious meanings of trauma was explained. Thus, a hermeneutic approach rather than an empirical descriptive approach was adopted in this study.

Therefore, a reduction of the individual to an isolated variable, hypothesis or presenting syndrome was rejected. Rather, a holistic integration of the individual and his or her world, through a process of analysis of both the experience and interpretation of the world, in context was sought. Furthermore, IPA and its applicability to the current study was discussed. A discussion of the methodology or strategies employed to conduct the research forms the focus of Chapter 5.

CHAPTER 5: METHODOLOGY

5.1 Introduction

A phenomenological approach was adopted in this study in an attempt to answer the research questions. Research using IPA generally makes use of data obtained from semi-structured interviews that allow participants to describe their experience in detail (Smith et al., 2009). In this chapter, the aim of this study and explicit specific phenomenological procedures that were followed are outlined. Furthermore, a detailed explication of the methods involved in recruiting participants as well as the collection and analysis of the data is presented. The ethical considerations of the study and a reflexive statement in an attempt to situate the researcher in the research process are also discussed. Finally, the validity and transferability of phenomenological research are explained.

5.2 Aim of the study

The broad aim of this phenomenological inquiry was to explore the *lebenswelt* or lifeworld of traumatisation manifest in long-term undiagnosed PTSD from combat exposure among Black SANDF members from an object relations perspective. Specifically, I intended to access understandings and descriptions of how they made sense of having experienced trauma and its consequent effect on their relational patterns and daily coping.

The research questions that were formulated are as follows:

- How do SANDF members understand the concept of trauma?
- How do SANDF members cope with feelings associated with the experience of these trauma-related responses in their daily functioning?
- How do SANDF members relate with family, friends and relatives when past traumatic experiences are reactivated?

The extent to which personal and family factors of the members influenced the experience of and the severity of the relational impairment was also explored. In addition, an understanding of how Black SANDF members coped with their undiagnosed PTSD experiences was of interest as this could provide insights into the development of experience-near therapeutic interventions for this population group.

5.3 Recruitment in phenomenological research

The rationale involved in the selection of participants in phenomenological research differs from that of statistical sampling theory (Polkinghorne, 1989). Statistical sampling involves making inferences from a group of participants to a population, which requires that participants are selected randomly from

the population under investigation (Durkheim, Terre Blanche, & Painter 2006). The purpose of phenomenological research is to describe the construction of an experience, rather than the characteristics of a group who have had the experience under study (Willig, 2008). This prerequisite is important because the experience of undiagnosed PTSD subsequent to traumatisation for Black SANDF members was explored in the present study. Specifically, the focus was on how the symptoms of PTSD manifest emotionally, cognitively, physiologically and relationally, rather than on the characteristics of the members who participated in the study.

Consequently, the participants were selected because they were able to provide a variety of rich descriptions of their understanding of traumatic responses to combat exposure from previous and current military experience as well as experiences in relation to the manifestation and effects of undiagnosed PTSD (Smith et al., 2009). Accordingly, I chose members who were involved in former statutory and non-statutory armed forces and who had been exposed to combat trauma during their past and current SANDF operations.

While the participants were required to have experienced trauma in relation to past and current military experiences, they also had to possess the capacity to render full and sensitive descriptions of their experiences (Englander, 2012; Groenewald, 2004; Willig, 2008). Participants whose ability to express themselves is impoverished, have poor vocabulary and/or suffer from forgetfulness are generally not ideal participants for phenomenological inquiry. These participants may lack the ability to describe or convey the depth of experience that is required when being interviewed (Kruger, 1979).

5.4 Research procedures

In this section, the specific procedural steps followed to conduct the present study are discussed. This comprises the recruitment of participants, data collection method and processes of data analysis.

5.4.1 Procedure for recruiting participants

For sampling purposes, criterion-based selection methods were employed (Ponterotto, 2005). This sampling method was preceded by a recruitment process. According to Gibson and Hugh-Jones (2012), both selection processes and sampling are vital in a qualitative study of this nature where the researcher sought to understand lived experiences of a particular population. For purposes of this study, the selection process involved identifying the population to be studied while the sampling involved selecting a smaller subset from the original population.

To identify the possible population of this study, social work officers employed in the military were invited to participate for purposes of recruiting participants from their client population. I prepared an

information letter (see Appendix 2), containing all the information about the study, with a request that I may be contacted by those social workers who were interested in participation. Individual briefing sessions were conducted with those social workers willing to participate during which more information was provided about the study. Discussions were open for the purposes of understanding, from a general perspective, the extent of social problems with which Black SANDF members often present with when seen for consultations, which may be driven by their undiagnosed traumatic distress.

This facilitated a process through which they identified and approached suitable participants for the study amongst their clients who had experienced traumatic combat exposure and presented with either anger management, relational difficulties, substance dependence, somatic preoccupation, or had poor overall functional capacity. My interest in the research topic was sparked by how members preferred to consult with social workers for presentations which seemed to be driven by a clinical syndrome that remained undiagnosed, and thus the involvement of social work officers in the recruitment process. Five informed and willing social work officers volunteered. As uniformed members of the SANDF, their ranks ranged from captain to major, they were of both genders, ranging in age from 32-44 years at the time of the recruitment process. Three were Black and two were Coloured. The social work officers were in various stages of their careers, but all had been working in the SANDF for over 5 years. Members who had consulted with the social workers and met the criteria of having experienced a traumatic military related event with either occupational, familial, anger related behavioural or substance related difficulties were informed of the study by the briefed social workers. They were asked to meet with me on the days I was onsite or alternatively, left their contact details for me to contact them.

The study was conducted at battalion military bases wherein the functional capacitation of infantry soldiers is administered with the support of military administrative, occupational and health support services. Infantry soldiers are a frontline combat force that comprise a battalion divided into different companies. While some potential participants arrived to meet with me on site, I contacted others to schedule a convenient time to meet with them at their respective sites. When I met the potential participants on different days at the two military bases, I explained the study in detail and requested them to sign consent forms if they were willing to participate. The process of informed consent was explained to the potential participants. This included the voluntary process, confidentiality and all the activities the study encompassed. This involved the completion of two screening instruments: the Rapid Diagnosis of PTSD toolkit and IES-R questionnaire for purposes of screening and inclusion criteria (Beck et al., 2008). The IES-R was also employed to provide more information about the participants' symptoms. They were not required to put their names on the questionnaires, but numbers were allocated to identify those who would participate in the study.

5.4.1.1 Selection criteria

The two inclusion criteria were first, an experience of a traumatic event related to military activities as evidenced in their responses to the four questions in the Rapid Diagnosis of PTSD toolkit. This screening instrument was to determine if participants had been exposed to trauma. It was an appropriate screening instrument as its adminstration must be followed by the Impact of Event Scale-Revised (IES-R) self-report questionnaire. Second, participants had to exhibit symptoms of undiagnosed and untreated PTSD as indicated by their pre-determined score for the IES-R questionnaire. The four questions in the Rapid Diagnosis of PTSD toolkit were asked prior to administering the IES-R to ensure that the individual had experienced a traumatic event. Subsequently, the IES-R was employed to arrive at a preliminary diagnosis. The IES-R is a revised 22-item self-report questionnaire that measures subjective distress of symptomatic and impairment severity caused by traumatic events. Items relate directly to 14 of the 17 DSM-IV symptoms of PTSD which reflects the classic tripartite model of PTSD (Beck et al., 2008). The IES-R has been translated into several languages and applied cross-culturally. Furthermore, it has proven to have good psychometric properties, showing strong internal consistency with alpha values of between 0.85 and 0.9 (Beck et al., 2008).

This scale was adequate for diagnostic purposes despite DSM-5 criteria for posttraumatic stress disorder somewhat differing from those in DSM-IV. In the DSM-5 the avoidance and persistent negative alterations in cognitions and mood category, retains most of the DSM-IV numbing symptoms, and also includes symptoms such as persistent negative emotional states. The alterations in arousal and reactivity cluster not only retains most of the DSM-IV arousal symptoms, but also includes irritable or aggressive behavior and reckless/self-destructive behavior (American Psychiatric Association, 2013). Thus undiagnosed PTSD symptoms screened for cut across both the DSM-IV and DSM-5 diagnostic criteria and informed the recruitment and selection criteria.

The participants had to obtain a total score of between 9 and 12 on each of the three sub-scale scores of the IES-R to meet the inclusion criteria. Those volunteers who met the criteria for undiagnosed PTSD were to participate in a face-to-face semi-structured interview. Those who scored a total less than nine on each of the three sub-scale scores were excluded. The protocols of the Rapid Diagnosis of PTSD toolkit and IES-R of those volunteers who did not meet the inclusion criterion of the IES-R score were destroyed.

The final sample comprised eight Black male and one Black female participant whose ages ranged between 42 and 55 years and who were from the lowest military rank to lowest ranking commissioned officer from the different forces that were integrated into the SANDF. They were not selected according to gender or rank as these did not constitute part of the inclusion criteria. However, these military

members had to have served in the SANDF from 1994 and been part of at least two deployment operations. This could be determined from the members' force numbers, which were required when they were consulting a social worker. Most of the participants were *privates* which are soldiers of the lowest military rank. They had served in the SANDF for many years and had been deployed at least twice externally and internally. They came from different provinces in South Africa and either resided inside or outside their military bases. Most of the participants did not live with their families.

While not a selection criterion, White SANDF members could not be accessed to participate in this study. At the time volunteering recruiting social workers did not have White members on their records to inform about the study for possible participation.

5.4.2 Data collection

5.4.2.1 The qualitative interview in phenomenological research

The semi-structured qualitative interview constituted the primary source for data collection. The complex and intimate descriptions, which encompassed the rich database for analysis, were collected through these open-ended interviews. In my capacity, as the researcher in this study and a clinical psychologist, I conducted the interviews and accordingly, collected the data.

5.4.2.1.1 Open-ended semi-structured interviews

The richest source of information related to human experience is derived from oral and written linguistic expressions (Converse, 2012; Terreblanche, Durrheim & Painter, 2006; Willig, 2008). Human experience is a domain of meaning; therefore, linguistic data have the most pertinent characteristics needed for understanding experience (Converse, 2012; Englander, 2012; Willig, 2008). Moreover, situations involving face-to-face interviews vary from situations that exist between texts and readers (Smith, 2004; Willig, 2008). Face-to-face encounters provide the best data for researchers who seek to understand the human structures of experience (Smith, 2004). In endevouring to understand the experiences of undiagnosed PTSD of Black SANDF members, semi-structured face-to-face interviews permitted close engagement and afforded the participants an opportunity to clarify what was not easily understood.

The interview as a method entails an implicit phenomenological mode of understanding (Groenewald, 2004; Smith, 2004; Willig, 2008). In contrast to structured questionnaires, the interview makes it feasible for participants to structure their own descriptions and emphasise what they perceive as important (Terreblanche, et al.,2006). Although open-ended questions place emphasis on certain themes, they also allow broad yet loosely defined areas of importance that the researcher had previously

identified to be explored (Terreblanche et al., 2006). Although I initially planned for each interview to last between 45 and 60 minutes, they became self-determining. In other words, although I had a basic idea of what I wanted to ask the participants, they could alter the content, direction and sequence of questioning, depending on how they preferred to express their experience (Willig, 2008; Yardley, 2000). Besides these defining features, the qualitative interview has a number of other advantages.

An advantage of the qualitative interview is the focus on the lifeworld or *lebenswelt* of the interviewees and their relation to it. The objective is to describe and understand the central themes of the participant's experience as well as the meanings of these themes (Smith, 2011; Willig, 2008; Yardley, 2008). To extract the themes, the researcher had to register and interpret what was said as well as how it was said while observing their vocalisation, facial expressions and other bodily gestures (Smith, 2011). Accordingly, the interviewer was intent on formulating implicit messages of what had been said by reverting ideas back to the participant for confirmation (Willig, 2008). This back-and-forth process of discussion and confirmation facilitated a dynamic process, thereby forming a relational space between both the participant and researcher wherein they endeavoured to understand each other.

A second advantage is the descriptive quality of the interview (Kvale, 2003), which endeavours to obtain many nuanced un-interpreted descriptions of various qualitative aspects of the participant's lifeworld (Converse, 2012; Smith, 2011; Willig, 2008; Yardley, 2000). This characteristic provides specificity in that the interview aims to describe specific situations and sequences in the participant's world instead of general opinions (Terreblanche, et al., 2006). It is imperative for the researcher to focus or guide the participant's sharing towards certain themes, but should not lead the participant towards certain opinions about the themes (Giorgi, 2010).

Being aware of all of these elements at play during the interview may be complicated, but provide the basis for new and unexpected phenomena to emerge (Giorgi, 2010). Researchers are warned against a tension that may be extant between this non-preconception attitude and the requirement of sensitivity to the topic under investigation (Converse, 2012; Giorgi, 2010). This tension necessitates a deliberate conscious naiveté on the part of the researcher (Kvale & Brinkmann, 2009). Certain statements made by the participant may frequently appear to be ambiguous or contradictory, which may lead to several possible interpretations. Thus, when this arose during the interviews, I made clear, as far as possible, the extent to which these ambiguities were due to a failure of communication in the interview or whether they reflected apparent inconsistencies, ambivalences and contradictions (Giorgi, 2010; Kvale & Brinkmann, 2009). A participant may even go to the extent of changing descriptions of and meanings about a theme in an interview. This may be due to new aspects of the themes that have been discovered of which the interviewees were previously not conscious (Englander, 2012). During the interviews, I

welcome this because it allowed for more depth and highlighted the interactional process between both parties.

The interview is an interchange between two people who react in relation to each other and influence each other reciprocally (Fosshage, 2009; Kvale & Brinkmann, 2009). In the specific situation, the relevant data may be constituted by the interchange created between the participant and researcher (Willig, 2008). This interchange may be characterised by positive feelings of curiosity and mutual respect or both parties may experience the situation as anxiety-provoking and accordingly, employ mechanisms (Giorgi, 2010). To address these conceptions, I became conscious of the interpersonal dynamics within the interactions. During the interviews, while I was sensitive to these interpersonal dynamics, I was also cognisant of my own shifts in how I engaged with each participant. During the data analysis, I also paid attention to elicited feelings (Englander, 2012; Giorgi, 2010; Willig, 2008).

Because of the researcher-interviewer dynamics that emanated during the research process, I paid particular attention to how I felt during each participant's interview. At times, it felt as though a participant may have been assuming a role, wherein they related what they believed I wanted to hear or what was socially desirable (Kvale & Brinkmann, 2009; Taylor et al., 2015). I responded to this by establishing a relational context in which the participants felt encouraged and free to reveal their experiences, rather than feeling the need to respond to perceived roles and expectations. A non-evaluative and reflective atmosphere conducive to openness, which should be established early in the necessary, was imperative (Willig, 2008). Moreover, a significant component of the interview process involved establishing some degree of trust by discussing motives, intentions, confidentiality and the overall research plan (Yardley, 2000). This was particularly important because I am a psychologist by profession and was previously employed in the force. Therefore, qualitative research interviews necessitated a consciousness of questioning, a consciousness of the dynamics of interaction between the researcher and participant, and a critical consciousness of what was said and interpreted (Kvale, 2003; Kvale & Brinkmann, 2009).

I conducted the interviews in accordance with the criteria of the qualitative research interview, which was outlined in section 5.4.2.1. Despite certain themes being emphasised in the interview, various opinions about those themes were not suggested. When meeting with the participants, I strived to establish a warm, non-evaluative and open atmosphere of trust and transparency. I made an effort to establish rapport during the initial interaction and interview and in a few cases, even prior to interview. Although the duration of each interview was self-determining, the duration of most was between 50 and 60 minutes. However, the interview with the first participant only lasted 30 minutes. This may be attributed to my anxiety over any distress that may have been evoked and my inclination to protect the participant.

The research interview was employed to tap into the participants' understandings and experiences of trauma, emotional and physical traumatic reactions, personal exploration and dealing with PTSD response experiences. The schedule of questions can be found in Appendix 4. The schedule was used as a "virtual map" (Smith et al., 2009, pp. 59) to guide me as an interviewer. It was not used to direct or restrict the flow of the interview in any manner. The interview schedule was organised in a manner that was most engaging for the participant; for example, broader questions were posed at the outset, and gradually more specific questions were asked. These questions were used mostly as a guide so that the interview was shaped by the stories the participants wanted to tell.

The areas that were focused on in the interview encompassed the broad themes outlined prior to the interview process, which are displayed on the information sheet. While conducting the interviews, I was cognisant of understanding the PTSD symptom experiences and how these manifested in their interactions with their internal and external world. The participants' perceptions of their physical, emotional, psychological and relational changes within themselves in relation to their undiagnosed PTSD syndrome were examined. I also explored how these changes were perceived to affect each participant and the consequences thereof on their lived experiences. These effects included characterological changes, relational patterns and functional, emotional and cognitive decline. Furthermore, the participants' perceptions of relational dynamics with themselves and within the organisation as well as other people in their lives outside of the SANDF were considered during the interviews. Therefore, the interview gave insight into the relational patterns that resulted from the participants' experiences in their interactions with others, specifically their family, friends and peers as well as authority figures from the previous armed forces and within the national force. The interpretations and meanings of these changes were also explored. Furthermore, the meanings ascribed to traumatic responses and the reported ways of coping with associated feelings and/or reactions were also examined.

It must be acknowledged, however, that a number of limitations are associated with the use of semi-structured interviews. Firstly, Brocki and Wearden (2006) and Hugh-Jones and Gibson (2012) acknowledge that, to a certain extent, the research is guiding the interview; therefore, the potential exists for the researcher to be biased. Secondly, it is accepted that rapport can be difficult to build in an interview setting, thus posing a challenge for the researcher (Gibson & Hugh-Jones, 2012; Smith et al., 2009). Finally, the researcher requires sufficient skill to ensure that questions are not asked in a leading manner and needs to encourage participants to explore and reflect on their experience (Smith et al., 2009).

5.4.2.1.2 Transcriptions

Once all the interviews were conducted, to immerse myself in the data, I transcribed them verbatim into written format and translated those that were conducted in isiZulu into English. In line with the IPA data analysis, I endeavoured to remain as faithful as possible to the experience of the participants, and to use participants' exact wording, including the semantic content of the interview, significant pauses, and hesitations. According to Smith et al. (2009), IPA does not compel transcription to include detailed records of the lengths of pauses or all non-verbal utterances. Verbal data are the expressions phenomenological researchers endeavours to explore (Smith & Osborn, 2008). The data are not regarded as sounds on the tape or ink on a page, but as meanings participants ascribe to what they have related. Thereby, verbal data are intricate and susceptible to modifications in their expression (Giorgi, 2010; Kvale & Brinkmann, 2009). Consequently, it is fundamental to exercise caution when the verbal data are transferred from the oral to the written mode (Englander, 2012).

The nine interviews were transcribed and re-read to appraise their suitability for phenomenological analysis. In assessing each of the transcribed interviews, I considered it appropriate to focus on all nine of the participants' interviews because of the rich descriptions and linguistic enunciation of the related experiences. The transcriptions contained all verbal and nonverbal information: verbalisations, tone and bodily gestures. Master and superordinate themes were identified during the analysis of the transcriptions. These are presented as findings in Chapter 6 and discussed in relation to the literature in Chapter 7.

5.4.2.2 Identification of broad categories of experience

Phenomenological understanding rather than empirical knowledge was emphasised in this study. Therefore, the focus was on eliciting and describing phenomena rather than explaining them. I was not interested in a cause-and-effect relationship between variables but sought a range of experiences that afforded an understanding of the experienced traumatisation manifest in undiagnosed PTSD phenomenon in Black members of the SANDF.

5.5 Analysis of data

Data analysis is an iterative procedure, which necessitates close engagement with data to enable the researcher to access an *insider's perspective* on the topic being explored (Reid, Flowers & Larkin, 2005). Each transcript was analysed and interpreted methodically. Clusters and themes within and between each participant's experiences were identified. Subsequently, the findings were reported and discussed by employing a narrative account of the participants' experiences. The interpretation of the findings was

presented in detail and supported with verbatim excerpts from the participants (Smith et al., 2009). Smith et al. (2009) described the steps of IPA as follows:

Step 1: Reading and rereading

I immersed myself in the data, with each participant being the focus of analysis. In keeping with the ideographic commitment of IPA, I conducted an in-depth analysis of each transcript by reading and re-reading it several times to familiarise myself with the data. I also listened to the audio-recorded interviews while following the content in the transcribed text. In this way, I was able to note the participant's tone of voice, hesitations, diversions and use of specific or extreme language. I noted emergent themes or notable aspects of the data in the margins of the transcripts by considering both the transcript and initial interview (Smith et al., 2009). These notes mirrored my initial observations, thoughts and reactions to each transcript. I found reading and re-reading the transcripts invaluable in that it helped provide clarity of the overall emergent picture the data was generating.

Step 2: Initial noting

This step entailed closer analysis of each transcript on a semantic and linguistic level. After reviewing the data further, salient themes began to emerge. I named these themes in accordance with the core features that they represented. Willig (2008) argued that themes should be named in a way that captures something about the essential quality of what is represented by the text. While some of the identified themes were named precisely as they were found in the data, others were named in line with shared commonalities. I noted all theme titles in the right-hand margin of the interview transcript. I also made a note of any interesting facts and details that surfaced during the initial analysis phase: thought processes, feelings and personal reflections on the process. This allowed me to maintain insight into my own feelings and thoughts, while also acquiring an understanding of how the participants made sense of their experience and the specific meanings attached to their experiences of traumatisation and thus undiagnosed PTSD symptoms. As I became increasingly immersed and familiar with the data, I noted and commented on the convergence in similarities, as well as remained alert to any differences in what the participants had related.

Step 3: Developing emergent themes

This step is distinguished by a reduction of the data and notes into meaningful themes. This step required me to break down the interview in order to analyse and identify emerging themes. It was during this step that my personal experiences emerged in the analysis because IPA focuses on including the researcher in the interpretation (Willig, 2008). Thus, emergent themes, a feature of IPA, were an outcome of both the participant's experiences and my interpretations of the information. Given my own

experience of working as a Black psychologist in the SANDF, I found it difficult not to identify with some of the participant's experiences. Thus, I had to monitor my feelings towards the participants and their transcripts constantly.

I made a list of the identified themes from the previous step to make sense of the relationships between them. As commonalities between themes were established, individual themes were clustered together into meaningful units to form themes. During this process, I referred repeatedly to the original transcripts to ensure that the themes reflected what participants had conveyed accurately, thus lessening the unexamined influence of my personal bias.

Step 4: Searching for connections across emergent themes

The themes that emerged in the previous step were compiled in the order they emerged and subsequently reorganised and rearranged to form clusters of related themes. Each theme was examined and connections between themes were identified. Smith et al. (2009) thus explained how superordinate themes are identified through the following processes: abstraction, which involves pairing like with like and developing a new name for the cluster; subsumption in which an emergent theme itself turns into a superordinate theme as it pulls other related themes towards it; polarisation in which transcripts are examined for opposite relationships; contextualisation during which the contextual or narrative components within an analysis are identified; numeration, which may be explained as the recurrence with which a theme is supported; and function that entails examining themes for their function. Furthermore, emerging themes were supported by quotations from the transcript (McCormack & Joseph, 2018). At this stage, initial thoughts were accompanied by contextual and reflexive notes as well as emerging themes and their quotations to produce an audit trail of data analysis.

Step 5: Moving to the next case

Steps 1 through to 4 were repeated with the interview transcripts of all the participants.

Step 6: Looking for patterns across cases

Following the analysis of all transcripts, I searched for connections and patterns across the cases. This step aided in foregrounding similarities and possible differences both within and between accounts. Thereafter, themes for each transcript were revisited to construct a final table that captured the master themes and superordinate themes as well as quotations to substantiate the themes (Table 6.1). I clustered the themes in accordance with the richness of data and their relationships to other accounts within the texts. At this stage, further reclustering and renaming was reached. Miles et al. (2013) stated that credible and trustworthy analysis entails and is driven by a display that is focused enough to allow a

viewing of a full data set in the same location that are arranged systematically to answer the research questions.

The analysis was a cyclical process during which I regularly moved between stages rather than proceeding linearly. In sum, the main stages of analysis involved the following:

- During several close readings of the data, detailed reflective comments were noted. Reflections noted while the interviews were conducted were also used.
- Codes were generated and assigned to data units. The language of the codes was kept close to the original data in order to keep close to the participant's experience.
- In order not to lose the detail and idiosyncrasies of the participant's experience, interesting quotations were highlighted throughout the transcript.
- Emergent themes were then assigned to capture my interpretation of the codes.

- Emergent themes were then written on to notes and along page margins
- The emergent themes were then clustered in a variety of compilations of collated themes until a final grouping was achieved that accurately reflected the participant's experience. Master themes were generated at this stage of analysis.

- A table that captured the master themes, superordinate themes and their associated quotations was then constructed. At this stage, further re-clustering and renaming could be achieved.

For an illustration of the coding process, please see the extract from one interview in Appendix 6. Following the analysis of each case individually, a group analysis was conducted thereby elicing patterns across participants. This stage of analysis consisted of the following steps:

- The superordinate themes for each participant were written with notes and an accompanying quotation.
- The master themes were then clustered and re-clustered until a pattern was reached that adequately reflected individual participants' experiences. Master theme names were assigned at this stage, which reflected the interpretative and conceptual level of analysis.
- The master themes and their superordinate themes were then transferred into a table with accompanying quotes/keywords from all participants.

5.6 Trustworthiness

Unlike quantitative studies, validity is not determined by whether another researcher uses exactly the same words or arrives at an identical description of data (Englander, 2012; Kvale & Brinkmann, 2009).

Rather, validity is indicated by whether a differentiation in wording can be understood intersubjectively to mirror an identical meaning and/or whether another researcher is able to identify similar essential themes to those which emerged through the original process of explication (Yardley, 2008). Validity has a direct relation to the trustworthiness of the study with regards to the confidence that can be placed on its outcomes (Kvale & Brinkmann, 2009).

5.6.1 Ensuring trustworthiness

Despite there not being a definitive set of criteria for determining the validity of IPA studies, many researchers (Elliot et al., 1999; Smith, 2011; Yardley, 2008) have guidelines for the evaluation of qualitative research. The guidelines suggested are not meant to be perceived as rigid rules that have to be followed. Rather, variations are anticipated and depend on the type of qualitative research approach adopted by a study.

The first guideline applies to the verification of findings through a transparent audit trail that provides a logical account of how the research progressed from conception to the final report. This process is employed to demonstrate the rigour of the research process (Smith et al., 2009). The audit trail in IPA research generally includes the research proposal, an interview schedule, the interview transcripts, interpretation comments and notes from a reflexive journal. A comprehensive audit trail can be found in the appendices, which include material relating to the recruitment process, interview questions, interview transcripts and the process involved in the data analysis.

A second guideline entails the verification of research findings (Yardley, 2008) through another reader. This is ordinarily performed by the research supervisor who ensures that the data has been systematically analysed and the findings accurately recorded. Consequently, I availed myself to supervision for input in relation to how I had analysed the transcripts and the themes that I had identified. During this process, the supervisor commented on the representation of certain themes and highlighted potential overlaps between themes. In line with the supervisor's feedback, amendments were considered and made.

The third guideline involves the supervisor ensuring that the methodology is sufficiently detailed, coherent and evidenced (Yardley, 2008). To ensure there is sufficient evidence, it is necessary that each documented theme is substantiated by participant extracts appropriately, thereby demonstrating how the theme manifested (Willig, 2008). To ensure the accuracy of the methodology, the rationale for choosing IPA as the preferred method was explained. In conjunction with the principles that direct the methodology, each identified theme was supported by the inclusion of a number of verbatim extracts.

5.7 Quality in IPA studies

The type of method dictates the framework for evaluation. A number of frameworks of evaluation for IPA studies can be employed (Smith, 2011; Yardley, 2008). The frameworks ordinarily include four principles: sensitivity to context, commitment and rigour, transparency and coherence, and impact and importance (Cohen & Crabtree, 2008; Yardley, 2008). The four principles are thus explained.

5.7.1 Sensitivity to context

It is important for qualitative studies to evince sensitivity to context in two ways (Yardley, 2008). First, an explicit command of relevant empirical and theoretical literature establishes sensitivity to context and therefore, attention to how these studies are interpreted is significant as it facilitates the creation of new meaning (Yardley, 2000). It is necessary for researchers to comprehend the theoretical underpinnings, philosophies, objectives and aims of a research approach because different research methods have varying aims and objectives. Knowing the differences enables a researcher to make an informed choice as to which method best fits the proposed research. Second, Yardley (2008) stated that sensitivity to the sociocultural settings and participants is crucial. This means that researchers should be cognisant of a participant's level of engagement based on what is seen as socially acceptable, which in turn is influenced by cultural and societal norms. Yardley (2000) explained the significance of the sociocultural environment by stating that most researchers acknowledge that language, social interaction and culture are significant for the meaning and function of all phenomena.

Sensitivity to context so as to ensure quality demonstrates commitment to handle the data in ways that exhibit sensitivity to theoretical and empirical literature as well as the participants' socio-cultural contexts (Shinebourne, 2011). Sensitivity to context was demonstrated in the present study by assimilating a broad range of empirical and theoretical literature related to two domains: first, object relations theory within the psychoanalytic paradigm and second, military trauma and PTSD. The theoretical underpinnings of object-relations theory and psychoanalytic perspectives on trauma and PTSD were explored in Chapter 2 and 3, respectively. Furthermore, the researcher appreciated that participant recall of events may be clouded by the value that they assign to the phenomenon of trauma. Therefore, the interview schedule was designed in a manner that allowed participants to explore the phenomenon from varying perspectives and reflect on the personal meaning that they ascribed to it. In addition, empathy was displayed during the interview process by making certain that the participants were comfortable and at ease to ensure that could engage openly with the researcher.

5.7.2 Commitment and rigour

According to Yardley (2008), commitment and rigour are measures of ensuring trustworthiness. Commitment is multidimensional in that it entails an immersion into the research topic, a willingness to develop skills related to the chosen research method continuously and an engagement with the relevant data. Rigour is concerned with the assiduousness of the process of data collection and analysis (Yardley, 2000). During the process of data collection, the relationship between researcher and participant is critical so as to attain insightful and relevant data (Englander, 2012; Yardley, 2008). Shinebourne (2011) asserted that commitment and rigour also entail prolonged engagement with the data to ensure immersion and thoroughness in all the steps of the research.

Both commitment and rigour were implemented in the current study. Commitment was demonstrated through the exploration of the relevant literature in Chapters 2 and 3. Commitment and rigour were also evidenced in the comprehensive explanation of the research design and methodology chosen to realise the research aims. Comprehensiveness was further enhanced by making certain that the emergent themes were substantiated by relevant quotations from the participants.

5.7.3 Transparency and coherence

Transparency and coherence also constitute part of ensuring trustworthiness (Yardley, 2008). Transparency is evidenced by the researcher detailing all components of the research process. This encompasses the recruitment process, interview schedules, interview transcripts and data analysis material. In addition, it is important for the researcher to provide reflexive notes for IPA studies because of the value ascribed to the researcher's interpretations (Yardley, 2000). In the current study, transparency was facilitated in various ways. First, an audit trail of the data analysis process was detailed. The interview transcripts and primary findings were audited by a research supervisor. Second, quotations and verbatim excerpts from the interview transcripts were included to enable readers to evaluate the suitability between the raw data and associated interpretations. Finally, given that reflexivity is important for transparency, a section was included to depict assumptions and other factors that could have affected the research process.

Coherence places emphasis on the integration of information in a logically coherent manner (Smith et al., 2009). Coherence was demonstrated throughout the current research process by explaining the rationale for the research question, reasons for the use of IPA, a systematic method of data analysis and the integration of the findings with existing literature. Transparency also entails a detailed description of all the steps taken during the research process. In the present study, this was enabled through the

detailing of the selection and recruitment of participants as well as the entire research process including the analysis of the data.

5.7.4 Impact and importance

Shinebourne (2011) stated importance and impact, which are holistic quality measures, are imperative in an IPA study. Yardley (2000) asserted that together they form the determining criterion by which any piece of research must be judged. Impact and importance are illustrated by the significance of the research findings in relation to the stated aims and objectives (Yardley, 2000). In other words, there has to be some form of significance and relevance of the findings of the study for the targeted audience.

5.8 Reflexivity

Reflexivity is a conscious awareness and explicit acknowledgement of how a researcher can influence the findings of a research project (Willig, 2001). In other words, reflexivity refers to "the processes in which researchers are conscious of and reflective about the ways in which their questions, methods and very own subject position might inform the psychological knowledge produced in a research study" (Langdridge, 2007, p. 58). IPA aims to realise a more enhanced understanding of a participant's personal experience even though the meanings derived from a participant's interview transcript do not reflect a participant's experiences entirely. Therefore, IPA appreciates that findings are also shaped by the researcher's preconceived ideas and assumptions as influenced by culture and society. It is thus suggested that IPA allows researchers to cut across the distinction between discourse and cognition (Smith, 2019). Thus, researchers may be envisaged to be located both inside and outside of their research (Goldspink & Engward, 2018). Reflexivity requires the researcher to determine these preconceptions and separate them from the phenomenon being investigated. Researchers are then able to become more aware of presuppositions and explicitly state their impact on the research findings. Instead of endeavouring to erase the influence of the researcher's perspective through detachment, it is embraced and addressed as a component of the process of generating knowledge (De la Rey, 1999; Wilkinson, 1988).

The process of reflexivity afforded me an understanding of my own interest in the research topic and allowed me to determine my own potential biases that may have influenced the findings. I acknowledge that I played an inherent role in the construction of knowledge in this dissertation. Researchers never simply collect their participants' perceptions, but rather they produce knowledge about them by means of a particular technology and social relations of production (Young,1980). I was cognisant of my background as a Black clinical psychologist in the SANDF with an interest in underlying trauma among

Black soldiers. I had occupied an office in one of these military bases and conducted Concurrent Health Assessments (CHA) of soldiers in multiple military bases across the provinces during which I observed similar presenting difficulties. Throughout this research project, I was aware of the influence and possible prejudices that those experiences might have had on the material presented in this dissertation. I worked in the SANDF for three years and became familiar with soldiers' political, familial, occupational, health and emotional difficulties as well as how these difficulties impaired their functioning. I had always wondered whether they received psychological interventions for the trauma from their military experiences and whether this could be related to the difficulties in managing to negotiate a meaningful life. The conception and formulation of the current study was inspired by my need to understand this so as to intervene and help alleviate the emotional distress these soldiers endured silently.

At the time of conceptualising this study, I had been employed in the SANDF for two years, a role that involved psychological and military obligations. During my time in the SANDF, when soldiers consulted for therapy, as referred by either their commanding officers or social work officers, they struggled to engage beyond a superficial level as they defended deep-seated intra-psychic pain. As a therapist grounded in psychodynamic psychotherapy, I struggled to ignore what constituted their contributing core conflicts and merely work superficially.

My academic training history is rooted in the psychoanalytically influenced position. I completed my master's degree at a university that was grounded in psychoanalytic theory and psychotherapy. The emphasis during my training was on making sense and meaning of my patient's maladaptive behaviours through psychoanalytic theory. It became apparent during informal conversations with colleagues and social workers that the soldiers, given their history, were perceived to be presenting with some pathology and to an extent, were impaired by it. Given my training background, this encouraged me to embark on a study of their psyche in relation to trauma. Consequently, I embarked on a broad literature search on studies of soldiers and PTSD in South Africa within the military academy and the military psychology institute to no avail. My aforementioned professional training and military experience as well as my unanswered questions led to this study.

When I started to collect data, I assumed that because the members were used to the process of CHA, physical and emotional ease of access would be possible. My assumptions were shattered when I observed how difficult this topic was for these service men and woman. I observed that it was emotionally laden and evoked a great deal of difficult feelings and may have been an unconscious cry for help for those who volunteered. During the first two interviews I conducted, these reactions were most likely partly responsible for my tendency not to explore deeper than the superficial. Furthermore, I was pressurised by an internal need to be gentle. On some level, I was colluding with the participants'

own wish to leave painful material repressed. However, after reflecting on this, I was able to understand what was happening between the participants and me. Accordingly, I was able to adjust my interviewing technique in order to allay the participants' anxieties of a *nameless dread* and sustain good rapport. This also modelled the notion that intense emotions are not annihilatory and can be survived.

In hindsight, I am aware that I may not have done those participants justice as they may have held back in response to what may have been my fear of their psychological distress. I experienced feelings of guilt that I may not done enough during my employment as a psychologist in the SANDF. As my competency as a psychology researcher was enhanced through the process of making meaning of the data already gathered, I learned a great deal was said in what was not said. It is noteworthy that it was not as easy to find willing participants as I thought it would be. The social-work officers did not get the anticipated rapid response from their clients for selection purposes. Once the process of administering the questionnaires for inclusion and exclusion criteria was completed and rapport was established, making arrangements for interviews with those who met the criteria was easy. Despite attempts at self-restrain, once the participants started talking about their experiences, they were honest in their pain in what felt like a cathartic cry.

When writing up the analyses, I took into account reflections on my own personal feelings and experiences that were encountered within the intersubjective space as I sat and engaged with the participants. Furthermore, in relation to data collection and analysis, I considered a number of methodological and ethical issues, which are discussed in a subsequent section. As a methodology, IPA resonated with me in terms of its interpretative position. I was in a position of advantage because I had the ability to interpret results. This may have influenced the research. I endeavoured to use this attribute to focus on uncovering novel and unanticipated information from the participants' stories.

While my interest was in unveiling the participants' experiences, I realised that their responses may have been influenced by several external factors. The participants knew that I was interested in PTSD and may have tailored their responses to meet the expectations they assumed I may have had. In addition, the participants' responses may have been determined by their perceptions of the value that others place on the phenomenon. Furthermore, my understanding and phrasing of questions may have played a role in framing the interview schedule and the participants' responses. The influence of my perceptions and experiences on the findings are noted in the section on reflexivity. Therefore, the findings of this study reflect a co-constructed version of reality for which both the participants and I were intersubjectively responsible.

5.9 Ethical considerations

Ethical adherence is a continual process in qualitative research. Consequently, guiding ethical principles are adhered to from the inception of the project until the completion of the final report (Orb, Eisenhauer, & Wynaden, 2001). In addition, in social research, the participant's psychological well-being and dignity need to be protected and taken into consideration throughout the research process. Therefore, I had to be sensitive to ethical ramifications relating to culture, race, gender, education and social groups (Yardley, 2008). Ethical guidelines caution researchers to be considerate of their participants, thus protecting both the researcher and participants throughout the entire research process. In appraising the ethical considerations for the present study, informed consent, protection of participants, confidentiality, anonymity and accountability were relevant (Yardley, 2000).

5.9.1 Informed consent

Each participant was provided with information about the research: the manner in which it would be conducted, what was required of them, the role of the researcher, the duration of the interviews and their rights as participants. The social work officers who were briefed about the study identified and approached suitable candidates for the study amongst their clients who presented with anger management, relational difficulties, substance dependence, somatic preoccupation and poor overall functional capacity. Members who met the criteria were informed of the study and were referred to me on the days I was onsite or alternatively, left their contact details for me to contact them. The research aims and process were explained to each participant prior to them signing an informed consent. In addition, potential participants were informed that they had the right to withdraw from the research at any stage without any adverse consequences.

They were also allowed time to deliberate over their participation and have aspects of the research that were unclear to them clarified. To ensure that participants were well informed of the research process, I allowed them space to ask questions about the study, my expertise and interests, and express any concerns they may have had regarding their participation (Yardley, 2000). In order to ensure honest and satisfactory participation, it is important for researchers to be honest and open while interacting with participants as this build's rapport and confidence (Yardley, 2008).

Once the informed participants had decided to participate voluntarily in the study, they signed informed consent letters (Appendix 1). These letters indicated that participation was voluntary, their confidentiality was assured and they could withdraw from the study at any time. Furthermore, the letters made provision for the participants to give consent for the interviews to be recorded and have their words used anonymously in the final report as well as in any future publication(s) on the research

findings. At no stage were the participants pressurised to answer any uncomfortable questions. There were afforded some de-briefing time following the interviews during which some containment was facilitated. Contact details of consulting psychologists in their military bases were shared with them in case they needed continued therapeutic input.

5.9.2 Protection of participants

It was imperative to show sensitivity so as not to alienate the participants' experience of traumatisation by displaying any form of judgement. Prior to the interview, I assured the participants that they only needed to disclose what they felt comfortable with and that the interview would be conducted at their pace. I ensured that good rapport was established so that the participants felt safe to share their experiences of how PTSD symptoms from traumatisation manifested intra-psychically and inter-psychically. Furthermore, the recruitment process guaranteed that all the participants were well informed of what the research was about and what their participation entailed.

5.9.3 Confidentiality and anonymity

Confidentiality may be defined as the process of endeavouring to keep information secret or being trusted with private information (Taylor et al., 2015). In qualitative research and more particularly phenomenological studies, eliciting personal experiences is essential for the investigation and thus, it is imperative to keep personal information anonymous to conceal the participant's identity from the public (Yardley, 2000). Anonymity was maintained in the research report by making use of pseudonyms. The names of the participants themselves were not revealed in the verbatim transcripts. Any information that may have led to the identification of the participants has been altered to maintain anonymity. In addition, participants signed a consent form giving permission for the interviews to be audio-recorded (Appendix 2). They were assured that once transferred electronically from the dictaphone, the recordings would be deleted. Furthermore, any information would be kept confidential on a password protected computer. This was adhered to.

5.9.4 Accountability

The possibility of evoking certain painful feelings in relation to the participants reliving traumatic experiences was a risk. To contain possible emotional distress, debriefing sessions were offered post-interview. Although follow-up sessions with other psychologists were offered, they were not required at the time the study was conducted or subsequently. The debriefing sessions at the end of the interviews, which the researcher conducted, allowed for some reflection, containment and psycho-education with regards to adaptive coping skills in particular. In cases where it would have been deemed necessary to have follow-up counselling or psychotherapy sessions, referrals would have been made to psychologists

in the participants' respective units. The cost would have been covered by the participants' military medical aid. The participants were also informed how their questionnaire responses and interviews would be utilised. Furthermore, they were told that they could have access to the results of the completed study should they be interested. They were informed that once all the data were analysed and interpreted, it would be written up in a research report, which would be available to the academic community for the purposes of the researcher's doctoral thesis. The participants were assured that no identifying details would be included.

5.9.5 Dissemination of results

It is my intention to make the thesis available to the military health unit to facilitate the development of effective mental health care programmes. The purpose of this report is not be to expose the secrets or weaknesses of the institution to the readers, but to recommend improvements for psychological services within the SANDF. The participants were also informed that findings and recommendations would be sent to the Chief of Army for dissemination to the Psychology Directorate. The participants were also informed that the objective is to use this information to influence military mental well-being policy and develop relevant wellness programmes. Anonymity is assured as participants' names will not be mentioned in the report.

5.10 Summary

An outline of the specific methodology employed in this study was presented in this chapter. The aims and research questions were outlined. Subsequently, procedural steps adopted in the study to ensure suitable participants were selected for the study were provided. The importance of semi-structured open-ended interviews in qualitative research was discussed. Furthermore, how data were collected from the participants and analysed so as to answer the research questions were detailed. In addition, the trustworthiness and quality of IPA studies, reflexivity and ethical procedures were explained. In the next chapter, the findings are presented. In particular, the participants' demographic information as well as themes and meanings that were extrapolated from the data, as prescribed by phenomenological inquiry, are elucidated.

CHAPTER 6: FINDINGS

6.1 Introduction

The purpose of this study was to explore the lived experience of traumatisation and secondary long-term undiagnosed PTSD from combat exposure among Black SANDF members from an object relations perspective. Specifically, the aim of the study was to understand how they make sense of their experienced trauma and its consequent effect on their relational patterns and daily coping. This included examining how Black serving members with varying experience understood and experienced their symptoms of undiagnosed PTSD and how they coped with the unresolved trauma. In order to acquire this understanding, IPA was employed to make meaning of the responses to the questions on the interview schedule that were acquired from the research questions.

These questions, accompanied by an extensive literature review, helped to shape the interview schedule (Appendix 3) that was employed. Furthermore, it was continually referenced as part of the revisory, namely, frequentative analytic process. The guidelines for conducting IPA research detailed by Smith et al. (2009) facilitated in guiding the analysis and creating levels of coding that led to the emergence of themes and sub-themes throughout the data. Themes were identified within individual transcripts as well as linked across cases. The themes were not only flagged for convergence across cases but were also noted as being related to individual cases.

The purpose of this chapter is to provide a phenomenological and interpretative narrative of the research findings. The common themes extracted from the data as they emerged within and across cases from the interpretative analysis are presented. The themes constructed from the semi-structured interviews that were conducted with nine voluntary participants, whose brief biographical background is provided, are presented to provide insight into the course of psychological, emotional, relational, physical and occupational impairment of chronic psychic trauma among a group of Black SANDF members. An endeavour at meaning making of the process of military and psychological integration revealed that the members' lived experience was that of organisational, psychic and self disintegration secondary to traumatisation.

A structured overview of the clusters of themes that were identified is presented in Table 6.1. Nine master themes emerged during the analysis, which are presented in an interpretative narrative in Section 6.2.1. While the Black SANDF members' experiences were afforded a voice, the phenomenology of the experiences emerged in the themes. The extracted themes are employed in the next chapter to provide the basis for discussion in which the findings are related to the existing literature, which was previously reviewed.

The nine master themes are as follows:

- SANDF as a traumatising system perpetuating PTSD
- Undiagnosed PTSD symptoms
- Failed psychic integration of trauma characterised by psychic splitting and numbing
- Lived experience of trauma
- Impoversished relational patterns
- Impaired emotional connections with family
- Employing psychic defenses to cope with symptoms of trauma
- Loss of overall well-being
- Feelings of shame and fear about symptoms of trauma

Each theme had its own set of superordinate themes too.

The themes reflected qualitative findings for the broad research questions:

- How do SANDF members understand the concept of trauma?
- How do SANDF members cope with feelings associated with the experience of these trauma-related responses in their daily functioning?
- How do SANDF members relate with their family, friends and relatives when past traumatic experiences are reactivated?

In the following section, the participants are introduced: their personal details are provided as well as their elevated scores of symptom criteria for PTSD as determined from their responses on the IES-R questionnaire.

6.1.1 Description of participants

The serving men and woman who were interviewed identified themselves by their previous statutory and non-statutory armed forces. They had different ranks in the SANDF: ranging from low to lowest military rank, namely, one *staff-sergeant*; seven *privates* and one low ranking commissioned officer who was a *lieutenant.* The participants came from different provinces and either lived inside or outside their military bases. Most of the participants did not live with their families. They had served in the SANDF for many years and had been deployed externally and/or internally at least twice.

> **Participant 1** was a 45-year-old private and a former member of APLA. At the time of the interview, he was divorced and lived with his 21-year-old daughter. He cited irreconcilable differences with his ex-wife as the reason for his divorce, particularly in relation to poor

communication and lengthy periods of absence from home during deployments. He alluded to role reversals during his absence: his wife assumed the role of the man of the house, which was difficult to re-negotiate on his return. She reportedly complained of him being disengaged from familial responsibilities and not caring about her. Participants 1's responses on the IES-R indicated prominent intrusive and increased physiological arousal symptoms as well as elevated avoidance and numbing symptom criteria for PTSD.

The interview with participant 1 revealed a lived experience of undiagnosed PTSD from chronic trauma characterised by troubled sleep and memories of repressed traumatic experiences. He felt like a burden to the system for reporting to the sickbay frequently with chronic pain and emotional distress, for which he could not be treated adequately. He shared that he has resorted to sleeping tablets to help him sleep, whilst others have resorted to alcohol to heal themselves from 'stress'. He not only experienced the SANDF as structurally and psychically disintegrating, but also dishonest and injurying. He mentioned not only being a victim of a traumatising system, characterised by divisive and unfair practices, but was shot by one of their own, who opened fire on them whilst on deployment. There was an erosive quality to his underlying PTSD syndrome, steeped in loss of: meaning in life; work as a soldier; physical and mental health; self and family. His divorce he understood as a result of the SANDF being a system that disintegrates families. He had won custody of his grown daughter which comforts him, as he no longer has trust in an intimate partner's intentions towards him. He had thus chosen not to be in romantic relationship but to focus on investing on his daughter's education. There was an element of feeling he is damaging in relationships and towards anyone he loves and thus cuts off as a defense against being damaged or damaging. He equated his survival, basically being alive to military skills, with no life skills or sense of belonging outside the military. The military, despite being 'bad' seemed to be the only object he could hold on to and in which he found a sense of being. There was something depleted, low and distant about him, despite his polite and corporative demeanour. We spoke at length, but the emotional and object content of his internal world felt impoverished as he was forthcoming with his lived experience, but it felt like he had not much to give. What came to mind was a deadened internal world or internal annihilation, which is interesting as he shared a story of one soldier who had collapsed to his death at the gate a few days prior. He related this to emotional distress and the organisation's lack of attunement to soldiers' plight of emotional distress and latent physical or behavioural manifestations thereof. This for him justified his manner of coping by partial adaptation and repression of distressing, situations, thoughts and memories for fear that they'll overwhelm you and you may end up dead.

Participant 2 was a 52-year-old, with a rank of a private. He was a former SADF member. He was married and lived outside the base with his family. He has two children and a third

had passed away. He stated that he would not allow his son to join the force because he feared it would change his character. His score for intrusive and increased physiological arousal as well as elevated avoidance and numbing symptoms was elevated on the IES-R, suggesting significantly functionally impairing symptoms of PTSD, even years after an impact event.

Participant 2, like participant 1 would not be drawn into relating his experience of combat exposure prior to integration into a national force. He only offered that he was left with memories of a lot of blood shed and many lost their lives. For him demobilisation was not an option as he only had military survival skills and no life skills to be able to integrate into civilian life. This struck me as odd, and I realised the military was their world, which can be linked to their internal self-object representation and how this manifests externally as compounded by psychic trauma. There was an element of dependence on authority, and partial adaptation to frustration of occupational and psychological needs, despite leaders being experienced as persecutory objects. His weak ego strength also made him wait passively for decisions to be made for him when it came to nominating himself for promotional courses. There was a child-like quality of cognitive and emotional functioning to him given his age. This raised flags of poor executive functioning due to cognitive decline secondary to chronic trauma. Following on the pain I felt, that he could not express over career frustrations and stuckness, he mentioned memories from pre-integration combat exposure which he tries hard to forget and only meets in his dreams, which causes him troubled sleep. I interpreted this link as emotional distress for not being recognised for the self-sacrifice and psychic woundings from prior combat exposure experiences. He emaphasised the importance of avoiding people who are reminders of the past military struggles as they will send you back there emotionally and cognitively and how one cannot live in the past. He spoke of incidents during deployments where one faces death again and doing what one can to survive. There were feelings of survival guilt in his story, which may explain the re-enactment of trauma as he continues to deploy frequently. He mentioned hypervigilance and emotional reactivity, which is frequently pointed out by his wife, which he dismissed, as though looking to me to collude with his defence. He then brushed it off as women always complaining and having a lot to say. I got the sense that he did not want to continue talking and that he felt he had said too much, as well as a discomfort in confiding in a young woman. In addition to his repression, avoidance and dissociation in defense against psychic pain, there was a willingness to forget what happened in the past at the cost of forgetting who he is or was. He spoke of what I interpreted as ‘psyche-soma negotiation’ rather than ‘psyche-soma integration’ as part of drinking before going to sleep to abate the unwelcome disturbing dreams which entailed negotiating with you mind and body.

Participant 3 was a 49-year-old, with the rank of a private. He was a former MK member and married with children. His wife and children lived in the Eastern Cape. He moved to Gauteng in the hope of being promoted. He rented a room outside the military base and preferred not to live with his family because he experienced the emotional demands from his wife in particular as rather emotionally draining. He shared that this drove him to drink more when he visited his family. This participant's score on the IES-R also indicated prominent intrusive and increased physiological arousal, avoidance and numbing symptoms, which were indicative of significantly functionally impairing symptoms of PTSD, even years after an impact event.

Despite intrusive memories, unpleasant dreams and avoidance of reminders of past traumas, participant 3 is in denial of the impact of trauma to the 'self'. His trauma symptoms are organised and perpetuated by chronic trauma, organisational stressors, including feelings of abandonment and loss of trust in authority figures. Psychic splitting and numbing characterise his defense structure. There are feelings of survival guilt defended against, as he quickly mentions friends lost and some permanently disabled during traumatic military experiences they had faced together. The troubling dreams are a hidden shame, also perceived as a form of punishment for acts committed and surviving. There is a denial of needing psychological help as he believes he has learned to help himself by bringing himself to a different mental space and coaching others to do the same. This continues the thread of the theme of misattunement to signs of psychic distress by the organsition, as well the continued concealment of distress for fear of being perceived as weak or declared psychologically unfit and thus PTSD remaining undiagnosed. He also finds that a few drinks help him feel and sleep better. There was a defensive cognitive rigidity with this participant, which he attributed to the need for having control over oneself and situations, with an undertone of trauma induced characterological change. He gave this poignant description of himself: "*You don't think much, you know you have to carry on surviving somehow. Your life does not seem real sometimes, it is like things in your mind are more real than the things you have been through you know. I don't know how to explain like living life but not always in the same world with others, like there is a world you escape to so you can be your old self*". He continued after a long pause: "*Ja, can't say more, you never open those wounds, it is like going to a grave site after people have died, there is no point, nothing will change it*". For this participant family seen as entity to be looked after financially void of emotional connection. He mentioned an aversion to relational conflict which he had no capacity to resolve but chooses to avoid and disconnect as he does with his psychic trauma. He explained that his wife expects him to be too involved, too caring, and that it was better if he sends money and is not there all the time. For him living away from family means he does not have to pretend to be what they want him to be. This he described as a happy person all the time, even without

a drink, and added that he actually drinks a little more when he is visiting home. The fact that he speaks of home as a place he visits is suggestive of the impaired relational capacity typical of long-term PTSD.

> **Participant 4** was a 54-year-old, former SADF member with a rank of a private. Although he was from KwaZulu-Natal, he had never been based in that province. His wife and three children lived in KwaZulu-Natal and he lived in Gauteng inside a military base. He preferred not living with his family so he could focus on his job and avoid stress. He shared that family could be an added stressor and that a military base was no place for children and wives. He added that family should not be exposed to the ways of military life to which soldiers had become accustomed. He was adamant that "work is work and family must be kept separate." Participant 4's score for intrusive symptom criteria was the second possible highest score with elevated avoidance and numbing symptoms indicating the presence of PTSD, with significantly functionally impairing implications even years after an impact event.

Despite this participant's trauma induced annihilation anxieties from his military experiences informing his perception of deployments as being suicide missions at times, he continues to deploy repeatedly and says that if he is to die that's where he has accepted it will be. This for him comes from having lost many a good object in the battlefield, as well as feelings of surivival guilt which fuels his reenactment of trauma. This is how he partly captures his lived experience of undiagnosed PTSD: "*memories you always buried come back up and attack you, they are like your own demons you know. All that confusion and fear is opened up that is why you are never the same person that is why you never talk about them after they have happened. You have to try to forget it all as soon as it has happened*". This participant copes by not thinking or talking about bad things and just keeps going. He shared: "*Even if sometimes there are dreams that keep you awake, you teach yourself to tolerate them and just suffer them on. Maybe it becomes your punishment on earth for having taken and seen lives taken and surviving. You go back to your family and those who lose their lives are gone forever and their families will see them no more*". He emphasised that when you start going to a psychologist it means that you are showing you have lost self-control or you have lost your fight with your demons and that means you lost your mind. I got the sense that he was trying to show me how well he is coping and that he does not see the value of psychological interventions. There was an aggressive undertone of I know myself and my problems well and there is nothing you can tell me that I don't already know and I would do it any differently. It was a stilted interview, mistrust that their wellbeing is of concern was palpably unsettling. He spoke about solving problems himself in his life. He had beaten up his wife and ended up at the social worker's office. His anger gets displaced onto her, he conceded to the consultation for fear of losing his children. There was a sense of disregard of and disconnection from others, with extra-marital affairs normalised. He empahsised that they were for purposes of physical satisfaction, also serving as

a distraction from 'emotional stress' and not emotional connection. His manner of being is driven by the need to be in control which was not any different during his interaction with me, void of any connection. There was also hurt around friendships and they were devalued as a defense against his feelings of isolation and abandonment. He perceived the world outside the safe confines of the system as malevolent and not belonging there. His internal world was deadened as though devoid of internal objects. This was captured as follows: "*There I can't say because I am one person who does not have time for nursing emotion*s". As the interview progressed, it emerged that he presents with symptoms of long-term impaired functional capacity, chronic symptoms of low mood and alcohol dependence as self-medication. As he says: "*I know when I drink, I feel relaxed and at ease you know, so that keeps me going when I am off duty, they say it is poison, but I say it is my medicine*".

> **Participant 5** was a 47-year-old, former SADF member with a rank of a private. He lived outside the military base because he wanted a little freedom from what he explained was the way of being a soldier. He spoke about how "one eats and breathes this thing of being a soldier." His wife and children lived in a village. He believed that was best because they were afraid of him. Furthermore, when he was at home, he had the sense that they just wanted him to leave. He accepted that they only communicated with him when they needed money for the provision of their material needs. He attributed this to his inability to change from being a soldier even when he was at home because "it is something that is in his blood." This participant's responses on the IES-R indicated elevated avoidance and numbing symptom criteria for PTSD.

This participant began by almost looking down on those who are not coping with their psychological distress and attributed this to their ill-discipline and poor training as soldiers from their former forces and the SANDF. He almost then blamed his psychic distress on having to 'handle' that of others with weak minds who turn to drugs to cope. Upon acknowledging the challenges, he voiced and reflecting on the need for support from the organisation. He switched to being part of the force and plight soldiers suffered at the hands of a disintegratingly "maddening" SANDF compounded with their complex and traumatic past military experiences. Avoidance of reminders, feelings of survival guilt and a deadened internal world underlie his tough exterior. Retraumatising flashbacks, chronic symptoms of low mood plagued him. He attributed the resolve to hide their symptoms to fear of being exploited for what will be deemed as weakness by management. He spoke about being demotivated and no longer taking pride in being a soldier, in contrast to how he began the interview, as a hero who loved and excelled in what he was trained to do and be as a soldier. He bemoaned not being able to leave the SADNF as he would not know how to survive outside the force. His words were: "*even if you feel you are drained you can't anymore, it is too much, but what can you do because outside it is an unknown environment actually to*

us. I would have to now integrate into society which I don't know how. I don't know the way of life outside of this. I'm a visitor to the outside. I don't have the surviving skills required outside". He spoke about ambushes during deployments and handling dead bodies to return them to camp and how they just don't talk about it but somehow just move on. He said it's become normal to just go on and live after an incident. He explained: "*Life goes on you see but maybe we are not the same, some get affected in one way and others in another, some will be strong and some will act as if they are strong only to find that they are affected in the long run. Honestly speaking after an incident there is nothing happening, like psychological help, if there is you see them once and nobody says that group let me go and check how they are since the incident for example. There are things whereby there are people I arrived with here they were good but as time goes on you see some changes to a person*". He attributed charectorological changes in people to the work environment, characterised by lack of support and many stressors some mentioned by other particpants, including discrimination.

When asked about how he copes with troubling thoughts and feelings he replied: "*You just tell yourself you have to be strong and carry on with your job. When you can still sleep, and the dreams don't come too much you will cope. It is like you must find ways to trick your mind by controlling it. Sometimes you can take sleeping tablets to help yourself. You must not find yourself allowing your feelings to be strong like take over, otherwise this thing will beat you. I can say it is an everyday battle with yourself to keep it away from other people*". This participant's heart dropped and there was a vulnerability about him when he spoke about how his wife and children are afraid of him as his 'personality' is that of a soldier and he does not have one of a father and husband which is something he cannot change about himself. He reflected on how when he tries to be social with them it feels forced on their behalf and how they cannot relate with him except as a financial provider. He felt this was a heavy price they have paid in choosing the path of being soldiers. He continued: "*It's like that, we find difficulties in relationships for sure that's why soldiers divorce a lot. You cannot balance, you cannot you are lying, you cannot*". He continued explaining their familial difficulties and that being the reason people become womanisers and not caring anymore, and also staying away from their family for a long time. He continued to explain: "*You are going to hide that pain you carry with certain substance abuse also, sometimes even if it's bad to abuse alcohol or drugs but sometimes there are situations where you find you are not strong that much and sometimes being strong is dangerous because you keep things inside, the day they explode what happens*"? He then shared a story of a friend who kept things inside until it got too much: "*I have a friend who shot his wife, shot himself without even leaving a note no one knows. The guy was my friend my best best friend. That thing leave us with the scars till today. So ja, he was working here then got a promotion to 2SAI. I'm sure just within the space of a year he did that*". Everyone of us carries his own trauma, no one knows until these things happen. This interview always

stirs up such sadness in me, leaves me teary each time I revisit it, which may speak to the pain of unresolved trauma this participant lives with.

> **Participant 6** was a 55-year-old man who joined the former SADF in 1987 when he was searching for employment. He related how he thought he would leave after a few years when he had saved enough money to start his own business. He explained that he did not want to study to be a teacher like his mother and siblings. His rank was a private and had always lived outside the base with his wife and children. He shared that when he came home, he went straight into the bedroom where he did not have to engage with his family. His youngest son who was nine at the time always followed him to the bedroom to check on him. He mentioned being close to retirement and looked forward to selling his house so he could buy a small apartment and car for himself and his wife. He had plans to travel to different places when he retired. He would not divulge these plans to the neighbours so they would never know where he was in case they had plans to harm him. Participant 6's intrusive symptom criteria was the second possible highest score, with elevated avoidance and numbing symptoms, which was indicative of the presence of PTSD, with significantly functionally impairing implications even years after an impact event.

For this participant current deployments despite being peace keeping missions were a reactivating factor of past traumas, when direct contact with rebel militias would go wrong as soldiers would not be mentally prepared and drop their guard. He decided to stop going on external deployments and only stick to internal ones. He explained: "*But after violence that started happening too much on these deployments but they say it is peacekeeping missions and you think there will be less bloodshed cause those things can bring back all those you experienced when you were still young that you buried far away to carry on with your life. Because they become like skeletons in your closet and when they come out you can become an animal living either in fear or anger that is too strong I've seen*". He also lambasted the system for not providing support and gave an example of soldiers getting so angry that they shoot others before taking their on lives. He explained: "*Now with the things that happen on the external deployments when the past ones come back to you it's like watching a horror movie of yourself in your mind. You start having trouble sleeping cause you see yourself in those situations in your dreams. I think it is our sickness us soldiers so it is better to avoid those situations and not deploy on such missions. It really gets tough to feel okay when those scars are open. You find yourself also feeling sick in your body but the sickbay they tell you they can't find anything wrong. That is why you drink to forget the pains*". There was a sadness stirred in me for this elderely man, but not out pain I felt he carried but a loss of a certain functional capacity in him, both emotional and cognitive. Perhaps because he related coming from a family of teachers and that he could have taken that route but got stuck in the

army. I started imagining the kind of person he could have been had he chosen a different path away from the long-term psychic trauma endured. I could think as actively as with other participants whilst interviewing him, as though there was a transferential attack on my thinking capacity.

He compared the 'good SADF' to the 'bad SANDF' and how their mental health was prioritised in comparison to the current lack of regular assessments and counselling. He spoke about the pattern of soldiers pretending to be mentally healthy during routine CHA assessments so they can deploy, with incidents then occuring in mission areas because psychologists don't know how members feel inside. In effect PTSD continues to plague members undiagnosed, which is the reason for the exploration of lived experiences of undiagnosed PTSD in the SANDF. Participant 6 was once hospitalised for months as he used to drink heavily. Again, the lack of structural and psychological holding from the organisation which perpetuates trauma induced psychic disintegration was pointed out. The members' experience is that of them against the system. He spends most of his time in his bedroom when he arrives home and just not join in on family activities. He had instituted a legal case against the organisation at the time of the interview, as he felt he was robbed of opportunities to further his career in the force. I wondered about his capacity for reality testing in this regard. He said this about how he plans to spend his years of retirement: "*You can travel and not stay in one place, so people know your routine. You play them so you are here one week and gone another two".* This is curious and touches on an element of cognitive inflexibility bordering on paranoia about threat of danger from years of chronic trauma.

> **Participant 7** was a 42-year-old former SADF member. He was ranked a lieutenant, a lowest ranking commissioned officer, following his demotion from the rank of captain. He experienced familial problems while on a deployment. After not receiving support from his commanders, he reportedly reacted aggressively and threatened violence against his fellow soldiers with an axe. He was returned to the unit and disciplinary action was instituted against him. He lived outside the military base with his girlfriend and daughter. He thus described life at home: "There are just ups and downs, we fight a lot and my family has to get involved. We were fighting a lot whilst I was on that deployment where I eventually had to be sent home. She doesn't know how to deal with a soldier like me and my family always says I must leave her but I think of my child, what if she takes my child and I never see her again. It is losing someone again, you understand, I have lost too much I can't. She is the only good thing I can say I have in my life." This participant's score for intrusive symptom criteria was the second possible highest score, suggestive of the presence of PTSD, with significantly functionally impairing implications even years after an impact event.

What was of interest was how this participant described the impact of undiagnosed PTSD in his military and home context, which seemed to be characterised by emotional reactivity with

decompensation into aggressive acting out. There seemed to be a split between good/functional and bad/damaged parts of himself. His experience was that his good parts which enable him to be good at executing his military duties are accepted in the organisation, which affirms his sense of self. It was his traumatised 'damaged' self that becomes emotionally overwhelmed and seems not to be coping as required, that is perceived as bad and thus rejected by a representation of his bad internal and external objects. He was actually charged for this perceived 'ill-discipline' and had his rank stripped away, which continues to be part of his lived exprerience of the SANDF as traumatising and perpetuating his PTSD syndrome. His experience is that of being misunderstood, mistreated and failed by his objects in empathic attunement, especially in the insensitive labelling and management of his stress reaction during a deployment mission. The participant felt unprotected and victimised by his commander and fellow soldiers that his anger escalated to threats of physical harm towards all at camp. He had this to say about that experience: "*no-one supported me they made me feel like I was going crazy like I told the social worker. Yes, I got so angry but I was not going to hurt anyone, ja they all turned against me and said I wanted to kill them with an axe because I couldn't be released to go home immediately*". This is in contrast to his reported good experiences in the SADF, whilst the SANDF is experienced as a persecutory (bad) internal and external object that is emotionally abusive to soldiers. He reflected: "*They just add on to the damage in people's mental wellbeing. We are a sick army and nobody cares*". His is a case of cognitive disturbance secondary to chronic trauma, as manifest in his inability to think clearly in the face of strong emotions, with paranoia and poor general reality testing, much like ones reported on by the other participants, with participant 1 having been a victim of. A more detailed summary of his transcript analysis forms part of Appendix8.

> **Participant 8** was a 48-year-old former SADF member with a rank of a staff sergeant. He rented a room outside the military base and his family lived in Limpopo. He liked focusing on his job, enjoyed his space and consequently, chose not to relocate his family. He stated if he were to live with his family, he would not be free to live life in the manner he preferred. He explained, "You must always think about other people first and I would not like them to see how I am at work just because I'm a different person. And the problems with sleep and sometimes erectile dysfunction I don't want stress from the wife having to explain what this and that tablet is for. No, I can't, it is better to be alone." This was supported by his elevated avoidance and numbing symptom criteria for PTSD as indicated in his responses on the IES-R.

Participant 8's description of his undiagnosed PTSD syndrome he mostly located in somatic manifestations. As he explained: "*No, generally I was a healthy person but just because of this deployments and stress you find yourself having some sicknesses like high-blood, sugar diabetes, sleeping problems, bad dreams, just not feeling good inside most of the time, it is the stress just because*

you don't know who to talk to, who to cry to". The following statement encapsulates the structurally and psychically disintegrating theme that other particpants also gave their experience of: "*These people of the new government they thought we were supporting the old regime, so the old regime also they were not trusting us...they were not trusting us that means we are abandoned. But now we don't trust our commanders they don't plan at the moment, they don't plan. The matter of going for deployment these days is just because people have got financial crisis that is the reason. A day is too much just because you know you go there without any orders; you don't know what you are going to do there*". He continued that ammunition is in short supply and poorly maintained. When they were attacked, they suffered and lost guys and others were injured, which makes him angry and how he can't move on from that because they sent them there to die, he believed. He continued that it is the pain and anger that depresses him and gives him sleepless nights to this day. He contrasted the 'good SADF' to the 'bad SANDF' in that with the 'old regime' they were well equipped and just had to carry out what they were tasked with, if lives were lost they accepted as part of what happens in the battlefield. He lamented: "*So before you even come in contact in the battlefield the organisation has already put stresses on you, it is like the inside is more torture than fighting out there. Unlike other soldiers we go out there already with injuries mentally you see".* He continued: "*It does not mean anything just because you are part of a system but at the same time you are alone, so you go through all these things and put your life at risk for what? Just extra money that's all now, but you know these incidents cause other scars to open from the past and you just carry on, that is why most of us can't sleep you end up having to rely on a drink. If you ask most guys, they'll tell you they sleep with the TV on they can't sleep like normal people because of the dreams we get. Aah, we have lost our lives to this system it's like we are dead men just soldiering on*".

He also spoke about people passing CHA but not being mentally ok, which speaks to missed diagnosis and treatment opportunities, thus the conceptualisation of their lived phenomenon of trauma as undiagnosed PTSD. He gave a glimpse of his family life and explained that when he is at home, he talks about things but when it comes to his job, he doesn't like to talk about it, as it is a part of him, he doesn't like to share because of the person it has made him into. He stated: "*I am ashamed of the damage it has done to me mentally and physically*. *A person is got funny sicknesses like your hypertension and those things, then there is a problem of sleep, always feeling like something bad will happen like you are in danger even if you are not on deployment area*". Providing for his children is important to him but he ackowledges years of being away from home for long periods have put a distance on the emotional relationship with his children. His wife was not made mention of, except for in the context of incidents of conflict. He described himself as in these words: "*Yes I can say I'm no longer the person I used to be so much has happened. You don't want people get close to people this thing of emotions you don't believe in just because you can't trust that they will be good to you and understand that you are*

sick when it comes to normal civilian life matters, it is like you don't operate the same. It is hard to talk about because in this uniform you must be this tough person but inside you know it is like a graveyard I can say. We don't talk about it all of us".

> **Participant 9** was a 46-year-old female private. She had been a member of the KwaZulu Self-Protection Force before integration. She was a single mother of three children who self-isolated because she was afraid of getting involved in a romantic relationship. She believed she could not trust others because she feared getting hurt. Her reason for living involved her children and she prided herself on being able to provide for their instrumental needs. This participant's responses on the IES-R indicated elevated avoidance and numbing symptom criteria for PTSD.

This was the only female participant who is a single mother. She described her experience of trauma symtoms as follows: "*You just have the stress after these happenings and you live with it but not like to go to 1 Military Hospital Psych Ward and now start taking medication because then if they say that it means your CHA is not green and you can't deploy or go on courses for promotion can you see*". She described an incident on deployment when she started having a lot of 'stress'. She spoke of being so stressed as though she was losing my mind. I understood by stress she meant truamatised. She continued: "*I couldn't function couldn't handle a weapon, everything all the blood from the past I would see in front of me and think I will hurt someone or myself. I don't think that fear really ever left me. I still have it I try to avoid the weapon mostly when I can. I love my children, I panicked because I didn't want their lives to become like mine, where you haveno parents and have lost all enjoyment in living and you are just surviving for the sake of being alive*". She talked about regrets about finding herself in the struggle and now being female soldiers and living with problems with trust, anger, sleep and all those sicknesses and memories that feel so real like it is all happening again every time she has a stressful life situation. This was an experience unique to her of all the participants: "*Especially for a woman because there are cases of rape when they find women soldiers, so it is only when you are in danger that you realise the risk of this job. I found myself just firing during this incident cause of all these thoughts in my head and always feel that I may have taken lives where it was unnecessary maybe we could have disarmed them because we were better equipped but I was just firing. I was not okay after that sometimes I still get dreams of it and when I think of it a lot of things come back"*. She continued tearfully: "*I look at myself and my life and it just makes me sad, it is not nice what I've been through. Thinking of that I still shake so I decided on my side I will never do external deployments again I won't make it, no I won't cope. But my section head and company commander don't know this they think I don't do external deployments because of my health. They won't understand I won't go on courses for promotion, it is like that, how can I put it...? eh, I will be punished cause they will think I am weak"*. With this participant like all

participants the fear of being declared weak and mentally unfit keeps them entrapped in the long-term impairing course of undiagnosed PTSD. She felt nothing was gained from her military career, as she now has to live with haunted memories. This was her experience leading to the integration process: "*The leaders we were following at the time just betrayed us handing us over to this so-called integration. There was no time to heal a person was young at the time. The sacrifice and for what were we sacrificing our lives so that we can feel like you are dead inside. I can say it means nothing. Some of us lost our innocence in this and you have to face it again being a woman means there are issues of rape so you must protect your life against it at all costs. And with the integration no one helped us with the old memories so that when we start as one Defence Force we are healed and start like people with new minds, no*"*!* When she had recovered herself emotionally, she stated that she was just there like a zombie sometimes and maybe it was age. I could not imagine how it must be for her to have her unique psychological traumas as a woman, whilst also carrying the psychic wounds endured by soldiers in general. She felt like one of the male participants in the room and it was just motherhood I felt we had in common as women. Something of her womanhood was lost to the system, to me and to her enduring undiagnosed PTSD. She had this to say in closing: "*I just live to work for my children. I am not the kind of person that likes to have a lot of friends, I am a single mother and I don't know if I can trust people, I meet and that's why I prefer to be alone. I am sometimes happy like everyone else, but it doesn't last then the sad and painful things I've been through come back to me and I find myself crying and feeling scared again. So yes, I live with a sick heart I can say*". She lives with a *soldier's heart,* which has walled off her feminine heart.

6.2 Master and superordinate themes

The identified master and superordinate themes across all nine participants are subsequently tabulated and thereafter, discussed. In this section, the themes generated from the data are displayed in Table 6.1 and subsequently discussed.

Table 6.1: Summary of Master and superordinate themes

Master theme	Superordinate theme
SANDF as a traumatising system perpetuating PTSD	Lack of a holding environment
	The SANDF cannot be trusted
	The SANDF as a bad object
	Lack of attunement and sensitivity to latent manifestation of undiagnosed trauma
	Colluding with defenses

Master theme	Superordinate theme
Undiagnosed PTSD symptoms	Underlying feelings of survival guilt
	Difficulties with falling and staying asleep
	Troubling dreams that become a hidden shame
	Disturbing memories of traumatic experiences
	Alcohol use assists with sleep and abates troubling symptoms and dreams
Failed psychic integration of trauma characterised by psychic splitting and numbing	Lack of psychological and cognitive integration into a unified SANDF
	Psychological splitting: self as soldier vs family member
Lived experience of trauma	Unresolved residual traumas
	Chronic symptoms of low mood
	Impairing self-destructive behaviour
	Feeling vulnerable and out of control
	Deadened internal world
Impoverished relational patterns	Feelings of isolation in relation to the external environment
	Feeling disempowered and disconnected from others
	Feelings of abandonment by former forces and current force
	Avoidance of intimacy in relationships
	Feelings of resentment
Impaired emotional connection with family	Relational ties associated with financial responsibilities
	Fear of losing relational connection with children compared to spouses
	SANDF disintegrates families
Employing psychic defenses to cope with symptoms of trauma	Experiencing primitive psychic anxieties
	Repression of traumatic emotive experiences
	Avoiding seeking psychological help
	Cognitive rigidity as a defense
	Disintegrated psyche-soma
	Splitting of SADF as a good object and SANDF as a bad object
Loss of overall well-being	Loss of self, loss of meaning in life and work as a soldier
	Loss of control and feeling helpless
Feelings of shame and fear about symptoms of trauma	Shame and fear of being declared psychologically unfit
	Seeking psychological help seen as a weakness

6.2.1 Theme 1: SANDF as a traumatising system perpetuating PTSD

In exploring what trauma meant to each participant, this theme provided insight into from where the perpetuation of trauma was understood to originate: its meaning, how it manifested and how each participant dealt with it in the SANDF. The following sub-themes comprise the theme: integrated members' experience of the SANDF's lack of a holding environment; the SANDF cannot be trusted; the SANDF as a bad object; lack of attunement and sensitivity to latent manifestation of undiagnosed trauma; and colluding with defenses.

6.2.1.1 Lack of a holding environment

The initial process of making sense of a traumatic experience was apparent in the form of locating it within and blaming it on the SANDF. Most of the participants expressed feelings of despair and hopelessness in response to their experiences of a lack of a holding environment. Participant 6 related, "This system is trauma because before you even deploy you see things here that mess with you mentally." This echoed these integrated members' sentiments of the organisation's failure to be the *environmental mother* to hold and lend structure to their manifest psychological and functional impairment as a result of undiagnosed trauma. Participant 7 thus expressed his grievances: "The commanders don't motivate people; it is like they are happy to see people walking around like there is something wrong in their heads. They are the first ones to leave the unit early you understand." The participants experienced the perceived lack of psychological holding as perpetuating PTSD and corrosion of the SANDF members' self. Participant 5 asserted that the SANDF had no capacity to contain the manifestation of undiagnosed trauma and members turned to substances with deleterious consequences. He thus explained this:

> "It looks as if the defence force they don't have a solution for this. I cannot put a finger in a situation whereby there is a child who is loitering around almost two years now with a drug problem and when on these drugs he loses his mind**,** his case is known but there is nothing happening."

The participants commended the SANDF for being a well-established organisation with proper structures and infrastructure to support its mandate of protecting and defending the South African territory through integration during peacetime negotiations. This motivated the integrated members not to demobilise. However, it appeared that after the integration process, the SANDF had stumbled into an administrative and psychological structural collapse, which was experienced as re-traumatising. Participant 7 asserted:

> "You see the leadership of today they are now playing a vital role on the abuse of soldiers on the ground because most of the time when I look at the soldiers the current leaders only care about their own pockets, ranks, career and going on promotional courses."

Promotion to a higher rank is equated to authority and salary progression in the military system. Therefore, lack of access to fair opportunities was perceived as a continued stressor that may have perpetuated the participants' undiagnosed PTSD. Participant 7 explained, "That's the reason why soldiers today are so stressed. I can give you one example, the courses, you find a soldier of more than 20 years, 30 years still a private." Participant 8 thus supported this assertion: "Like now I've got 13 years in a rank and there are other people who have been coming up, coming up from down upwards can you see cause a lot of things."

Perceived inadequate training, which was perceived as setting foot soldiers up for failure with catastrophic psychological and physical consequences where loss of life that could have been prevented becomes inevitable, was another traumatising practice the participants noted. Participant 8 reflected, "So before you even come in contact in the battlefield the organisation has already put stresses on you, unlike other soldiers we go out there already with injuries mentally you see." Participant 1 added, "Some people they hate the system, they go home after roll-call because no re-training happens, you just sit around here." This conduct, labelled as dysfunctional by those in authority, may not only point to the manifestation of functional impairment of the chronicity of undiagnosed PTSD, but also a response to a system experienced as traumatising and dysfunctional in its failure in psychically integrative holding. It appeared some 25 years after integration, the SANDF still failed at environmental provision as a result of a lack of restorative measures, thus perpetuating primitive anxieties with ego disintegrating defenses, as manifest in the participants' undiagnosed symptoms of PTSD. This perpetuated strong defensive feelings such as mistrust towards a national force that was experienced as psychically injurious and lacking in secure holding to ameliorate symptoms of trauma. This is related to the following sub-theme.

6.2.1.2 The SANDF cannot be trusted

The participants' responses reflected a deep sense of mistrust towards the SANDF. They did not experience the organisation as a secure base. Consequently, they experienced themselves detached and estranged from it. Participant 7 reflected, "You are not safe in terms of the army doesn't give a damn about us." The SANDF was perceived as an enemy that their members had to defend themselves against psychically. The soldiers' underlying feelings of distress had disarmed them of their internal resources. An element of partial adaptation could be detected from the manner in which participant 9 had resigned herself to this experiential reality; she shared, "It hurts really even if we can say this is our organisation deep down you know you are like a doormat and they don't really care about you." The participants did not trust the SANDF had their well-being at heart. Participant 7 reflected on how he was pushed to

breaking point when his commander handled the extent of his emotional difficulties callously; he recalled, “But I said I’ve stated the reason that I’m not emotionally okay, that word it says a lot there are a lot of things you understand then we fought for that.” Participant 2 supported this when he stated, “…it is better to cope with your life problems away from the system, they’ll think you are mad.”

The participants appeared to have accepted that any expression of their symptoms of trauma was intolerable and punishable. They felt as though the SANDF as a system was against them; they constantly activated elements of hyper-vigilance in defense. Participant 9 stated this succinctly: “It is us against this system.” Participant 8 thus described it: “…it is like the inside is more torture than fighting out there.” The organisation appeared to mirror the participants’ persecutory internal world that comprised disintegrating bad objects. It was also apparent that even when members took decisions related to their safety during combat exposure, they were reluctant to disclose fully what informed those decisions because they feared that they would not be taken under the system’s confidence and protection. The participants distorted and concealed certain truths from those in authority because they feared imagined persecution. This perpetuated failure to integrate traumatic experiences into their psyche with resultant PTSD syndrome, which remained undiagnosed. Participant 9 declared, “Even when we come across dangerous incidents the support is not really enough it is like you are blamed.”

It was apparent from the participants’ responses that feelings of mistrust were not only harboured towards those in positions of authority, but also among each other as serving members on the ground. This perpetuated an agonising psychological *phantasy* as members from each former force perceived that the organisational structure disadvantaged them. Participant 5 shared, “Your force number still speaks volumes when it comes to promotional opportunities.” Although the former MK formed part of the governing political party, its members experienced the system as equally injuring and dishonest because of the inherent SADF administrative procedures from which it operated and the trauma associated with SADF structures. It appeared that all the participants shared this collective psychological distress, which could be described as a shared trauma perpetuating factor outside of their conscious awareness. The participants appeared to be in perpetual disintegrating psychic pain. Participant 6 captured this succinctly: “On the ground here you fight amongst yourselves over promotions.” This experiential reality had left members with psychologically injurious repercussions, which participant 9 described as follows: “It’s all part of those things we have gone through with this system and a person can never forget, when you sit alone and think about it you cry.”

Perceived lack of transparency in managing administrative and operational issues led to internal psychological and organisational conflict. The participants’ sentiments echoed a sense of a trauma-induced psychic devastation, which eroded their sense of self. There was a sense of a cry for help, an unsaid save us, that they were not coping. This was more prevalent in the tone underlying most of what

was verbalised throughout the interviews rather than what was said directly. Much of this was interlaced in other themes. In failing to meet the participants' needs to be saved and healed, the SANDF was devalued and internalised as a persecutory bad object in defense against psychic distress.

6.2.1.3 The SANDF as a bad object

A theme of the SANDF being experienced as a bad and persecutory object was conveyed through the participants' responses. Participant 8 commented, "…that makes me angry and you can't move on from that because they send us there to die you can say. It is a pain and anger that depresses you and gives you sleepless nights to this day." This was consequent to the trauma-induced regressive psychic injury as they derived a sense of self and identity from the internalisation of their experience of the manner in which the system related to them. Participant 6 declared, "Yes communication cause as soldiers we experience these things alone and no one from management cares. They play mind games." The SANDF was introjected as a bad object and was identified with their bad traumatising introjected objects. Participant 5 reflected, "It's like part of our job, I don't know, it's normal to just go on and live after an incident. It's like that, they don't care."

The responses from the participants indicated that the SANDF comprised punitive authoritarian figures who left psychological scars in its wake. This was supported by participant 9's statement about not disclosing her troubling traumatic symptoms: "They won't understand I won't go on courses for promotion, it is like that, how can I put it...? Eh, I will be punished cause they will think I am weak." The participants did not experience the authorities within the SANDF as a benign superego. They felt disregarded and rejected by those in positions of authority. Participant 8 asserted, "The army will give a damn about you while you working, get injured or something happens to you it's up to you how you survive and cope." The system was experienced through projective identification, which was evident of a splitting defense and part-object relating.

While the SANDF was perceived as careless in relation to the members' well-being, the former SADF was experienced as more caring by the former SADF members. Participant 6 shared, "We knew that when you are sick the chaplain came to see you just to pray but and give support to say you'll get better soon." One of the participants even used the word *torture* to describe the severity of the perceived persecution. The SANDF's experience as a bad object had been internalised to mean that any trauma-related symptoms had to be concealed for fear of it being exploited as a weakness, which left the participants feeling alone and unsupported. Participant 9 related, "…and you must learn to survive without looking weak and tell yourself you are strong." This resulted in the organisation's misatttunement to latent clinical presentation of PTSD syndrome and it remaining undiagnosed. The next superordinate theme illuminates how the system perpetuated this.

6.2.1.4 Lack of attunement and sensitivity to latent manifectation of undiagnosed trauma

The participants' reflections conveyed overwhelmingly that their capacity to mentalise so as to make sense of their psychic distress adaptively was underdeveloped and impoverished. Therefore, psychic distress was expelled from their psyche and manifested behaviourally and psychically in its chronicity as complex trauma. This was formulated as dysfunctional conduct that stemmed from the participants' ill-discipline, especially those from infantry military bases. This could take the form of substance abuse, somatic complaints and neglect of military responsibilities. Participant 5 poignantly shared, "No one from management cares and these things affect us. That is why some drink, some so ill-disciplined and don't care about the system and don't want to work anymore and awol." The underlying traumatic emotions and anxieties at play were missed, similar to the connection with the person of a soldier, what informed his or her psychic makeup and the implications thereof on their functional capacity. Participant 7 explained, "Like by the time I went to see the social worker things had already happened on the deployment and I was sent there because I was seen as a problem, instead of having a problem that time." Despite the nature of military duties, the participants were not intuited with crippling empathic failures that were internalised as being disregarded, unvalued and thus, inherently bad. As a child who needed to hide his badness to obtain a parent's love, participant 4 reflected, "But I am proud of myself because I can really hide it well and no one knows how it is deep inside of me." The participants were aware that they were suffering, what the symptoms of trauma were and that these affected them differently. Participant 5 explained:

> "It's like that, they don't care. Life goes on you see but maybe we are not the same, some get affected in one way and others in another, some will be strong and some will act as if they are strong only to find that they are affected in the long run."

Participant 6 highlighted that even mental practitioners did not diagnose their trauma. He further stated that members disintegrate, threaten others' lives and take their own at times because of added deployment stressors. These constituted some of the traumatic experiences the participants endured and were expected to recover spontaneously from as traumatic stress responses were pathologised. He reflected:

> "I can pretend to be positive for CHA cause I want to deploy and then I'm green and go knowing how I feel inside. This system does not give you enough support. That is why on external deployments now with people who have passed away you hear that they had stress and shot people before shooting himself. "

6.2.1.5 Colluding with defenses

Light was shed on how through projective identification, the maladaptive defenses the participants employed were colluded with by the system to a point where they became normalised. They had become the norm and accepted as the psychic culture of the environment. A presentation with different or perhaps a more adaptively acceptable response to emotional traumas threatened the stability of the system, the consequences of which the participants believed soldiers bore the brunt. Those in positions to help within the system inadvertently assisted in maintaining the farce these functionally disabling defenses held. Participant 2 shared, "You must always put on this mask that you are coping normally for family and at work." They had conditioned themselves to hide their symptoms of trauma quite successfully. Participant 9 shared, "People can't see it only you know what is inside of you." It was apparent that sending members home as quietly and quickly as possible following deployments, without experiencing psychological restorative and integration interventions, was an indicator of an incident free deployment demobilisation. Participant 6 reflected, "There is nothing now when you come back you just take leave and go home."

Participant 5 expressed a similar sentiment:

> "And the ones in charge sitting on top they know all these problems and traumas very well, but because there are so many of us on the ground, whether you are sick or dead the work still gets done there is enough manpower. "

This may have communicated to members that they were alone in their traumatic distress, which perpetuated the development of PTSD that remained undiagnosed. This leads to the next main theme, which explicates how the participants experienced traumatic symptoms.

6.2.2 Theme 2: Undiagnosed PTSD symptoms

All the participants conveyed diagnostic features of PTSD and complex PTSD as their experience of traumatic responses. This theme comprises the following sub-themes: underlying feelings of survival guilt; difficulties with falling and staying asleep; troubling dreams that become a hidden shame; disturbing memories of traumatic experiences; and alcohol use assists with sleep and abates troubling symptoms and dreams. A number of studies have revealed that the response to traumatic experiences not only encompasses PTSD symptoms of hyper-arousal, intrusion, emotional constriction, and social isolation (Cloitre et al., 2009; Hagenaars, et al., 2011), but also leads to depression and substance abuse (Browne & Winkelman, 2007; Hathaway et al., 2010).

6.2.2.1 Underlying feelings of survival guilt

The participants' enactment of survival guilt was displayed when they re-exposed themselves to dangerous situations such as repeated deployments as a form of punishment and the possible acting out of death instinct drives. Participant 4 acknowledged that they did it for their fallen fellow soldiers: "When it is that time you do what you promised to do with your fallen brothers in arms." They alluded to thoughts of not deserving to be alive, accompanied by a conflicting need to understand why, with consequent deadening of good introjected objects with the death of perceived good self-objects in fallen soldiers. It transpired that the participants did not feel good enough or deserving of being spared. This is revealed in participant 5's questioning reflection:

> "A person can't talk a lot about it but in such situations, people die and you also end up handling dead bodies to get them back to your camp. Ja as a person you don't know how you survived it, you ask yourself why and that thing keeps coming back to you. "

The soldiers' guilt extended to fear in relation to combat exposure and the accompanying degree of danger because of the knowledge that precautionary measures were not in place to keep the soldiers as safe as possible. Participant 3 shared, "…and you are scared thinking maybe your luck has run out now, it is your time." A deep acknowledgement that military operations require one to save oneself no matter the cost in order to be able to save others appeared to exacerbate the participants' conflicting feelings of guilt. Participant 2 acknowledged, "When there have been incidents during deployments you again facing death and do what you can to survive." The participants who were commanders also experienced feelings of guilt, which they buried as deeply as possible because they were tasked with leadership roles on and off the battlefield. This indicated how normal combat stress response was pathologised from the top down. The culture of acceptance to the extent of denial of the psychological impact of combat trauma led to the participants becoming more susceptible to developing and living with undiagnosed PTSD. Participant 8 reflected, "…if lives are lost you accept as part of battlefield it's what happens. You feel guilty cause you were the one leading and motivating people on the ground." This conveyed that they felt they had failed to protect their fellow members and led people to the end of their lives despite efforts to accept this as part of their responsibilities on the battlefield.

The participants' traumatic responses were complicated by their lack of containment of their raw emotions and thoughts to facilitate healing, meaning making and integration because it was fuelled by self-attacking guilt. Following an incident of combat contact, participant 9 felt "…always feel that I may have taken lives where it was unnecessary maybe we could have disarmed them cause we were better equipped but I was just firing. I was not okay after that." The participants also internalised their feelings of guilt as punishment for surviving. This was compared to putting one's life before that of another. Participant 7 reflected, "It is like punishment always there you just ignore and move forward."

Participant 5 added, “Ja as a person you don’t know how you survived it, you ask yourself why and that thing keeps coming back to you.” The participants questioned the reason for their survival, which became another fixation around their pattern of traumatic suffering. This possibly beckoned to processes of resolution through meaning making. However, the belief that by avoiding thoughts and feelings associated with traumatic experiences and *moving forward* as well as not availing themselves to processes of intervention perpetuated undiagnosed PTSD. This is seen in the extent to which the participants suffered sleep difficulties as everything that was repressed and/or denied was relived and they struggled to quieten their minds.

6.2.2.1 Difficulties with falling and staying asleep

The participants expressed difficulties with their sleep patterns in that they struggled to fall asleep without resorting to alcohol or keeping the background noise from the television on. It was as though this was an attempt to drown the noises heard in the quiet of the night or ground themselves in the reality of not being back on the battlefield. Participant 8 explained, “…that is why most of us can’t sleep you end up having to rely on a drink. If you ask most guys they’ll tell you they sleep with the TV on they can’t sleep like normal people.” The participants did not experience sleep as restful, but a wrestle with the repressed traumatic content of their internal world, which sought to be integrated; this manifested as one of their symptoms of undiagnosed PTSD. The participants believed their difficulties with sleep stemmed from a fear of and attempts to avoid nightmares of traumatic experiences thought to be buried deep in the psyche. Participant 6 shared, “You start having trouble sleeping cause you see yourself in those situations in your dreams.” They experienced their problem with sleep as a sickness that had damaged them physiologically and psychologically. An element of shame was also associated with it. Participant 8 reflected:

> “Then when we are at home, we talk about things but when it comes to job, I don't like to talk about it, it is a part of me I don't like to share because of the person it has made me into. I am ashamed of the damage it has done to me mentally and physically. A person is got funny sicknesses like your hypertension and those things, then there is a problem of sleep.“

Sleep was distressful for the participants as it is supposed to be a quiet time between a person and their internal world, a self-relation dynamic, which underlay the participants’ core suffering in living with undiagnosed PTSD. Participant 9 described her experience of this symptom of undiagnosed PTSD as follows:

> “…and the sleeping becomes difficult and you feel like you have fallen into a deep grave and you come out and fall back in again. It is not easy sometimes I find myself crying when I go to sleep for a long time and sometimes, I don't even know why.”

The participants had no compassion for themselves for the pain they bore and were out of touch with the emotions associated with the trauma. The notion of a collective knowing among the participants of their psychological symptoms from the trauma they had suffered, which they had come to accept as a consequence of their military obligations, came up repeatedly. They did not seek help for these traumatic response symptoms but seemed to have pledged a silent collective code of being in it together. Participant 6 explained, "You start having trouble sleeping cause you see yourself in those situations in your dreams. I think it is our sickness us soldiers." Sleep became a psychic combat, which forced the participants to relive their traumatic experiences in the form of dreams. This was a terrain of their unconscious most resisted and an impairing symptom of undiagnosed PTSD syndrome. It is discussed under the next sub-theme.

6.2.2.3 Troubling dreams that become a hidden shame

The participants spoke unanimously about being sick with an ailment that manifested in repressed unconscious material and resurfaced in the form of dreams. Participant 6 elaborated, "…you see yourself in those situations in your dreams. I think it is our sickness us soldiers, so it is better to avoid those situations and not deploy on such missions." This intrusive symptom of undiagnosed PTSD experienced in the form of recurrent distressing dreams had intertwined itself in the fibre of the psychic wounds the participants bore. Participant 4 attested, "Even if sometimes there are dreams that keep you awake, you teach yourself to tolerate them and just suffer them on." This was also perceived as a form of punishment for acts committed in the battlefield and having one's life spared. The participants lived a life of flight from their internal world, but it appeared that they could not flee from their dreams. There to be an element of isolating shame in having these dreams, possibly because they symbolized a battle always lost. Consequently, the participants felt stripped of their tough soldier facades. Participant 2 thus described his experience:

> "As long as you know they are just dreams, it is not real anymore. You learn to negotiate with your mind and body. It's only your partner that knows that you sometimes have these dreams that is all, even if you try to keep it to yourself. "

The participants also shed light on how their symptoms of undiagnosed PTSD were reactivated when strong emotions were evoked in them. Participant 7 reflected, "When these things happen. They trigger those dreams we all don't like." Part of the core of the participants' traumatic suffering was found dwelling in their dreams, a part of their psychic reality that could not be defensively split off. Participant 2 thus demoralize his experience: "Sometimes you find you don't think but you have these dreams of things that happened in the past you forgot about." This alluded to the fact that even if they avoided thinking about past traumatic experiences, the dreams did not cease because part of their experiential reality that needed to be integrated into their psyche was reactivated. It was apparent from participant 2

that some traumatic experiences were better relived in the subconscious state in dreaming, rather than consciously in a state of awaking as though in fear of re-traumatisation. He explained, "Past traumas, like incidents when I was still with MK? Well, those ones a person must try hard to forget and only meet with them again in your dreams." The participants' lived experiences of undiagnosed PTSD revealed that one cannot remain in control and choose to have traumatic content only psychically active in the subconscious, but that it can also be involuntarily triggered in one's conscious state in the form of disturbing memories. These memories of traumatic experiences are discussed in the following sub-theme.

6.2.2.4 Disturbing memories of traumatic experiences

Most of the participants acknowledged the symptom of suffering with thoughts and/or memories that they experienced as though they were re-living the event. Participant 1 thus described his experience: "Yes, all these past things you try to forget about come back and you ask yourself why me when will this end." This inner conflict could not be controlled as rigid psychic defensive mechanisms that were duly employed throughout the years and had become maladaptive. Participant 4 reflected, "It always takes you back when these things happen, it is like those memories you always buried come back up and attack you, they are like your own demons you know." The memories and experiences of re-living past unresolved traumatic events appeared to be brought to light each time the participants encountered traumatic events or situations wherein intense emotions were aroused. Participant 7 thus described his experience of this symptom of long-term undiagnosed PTSD:

> "By now you would think you would be used to seeing a dead body but having someone just lying there gone just like that…haai…you just start feeling like it opens a storage inside of you of all these thoughts of the similar incidents you have seen."

What the participants described were flashback symptoms of PTSD, which they could not control. This brought them back to the traumatic experiences escaped in dreams and even during their waking state. Participant 5 stated, "Yes you start remembering those past things like they just happened and feel like you are there all over again." These were psychically and physically paralysing and impaired their capacity to carry out their military obligations, which they seemed to suffer undiagnosed. Participant 9 explained, "I couldn't function couldn't handle a weapon, everything all the blood from the past I would see in front of me." In order to try to cope with some of what was experienced as uncontrollable symptoms of PTSD, the participants turned to maladaptive forms of self-soothing or self-medication such as substance use.

6.2.2.5 Alcohol use assists with sleep and abates troubling symptons and dreams

Most of the participants indicated that they used alcohol for medicinal purposes and to escape. Alcohol was also used to promote sleep inttempt to escape troubling dreams. Participant 2 shared, "You get to know yourself and that it is better sometimes when you have had a few beers then you sleep better." Participant 7 added, "You see a lot of us have troubles with sleeping we always want something to relax the mind before you sleep." Alcohol not only enabled the participants to escape from their emotive reality, but also served as an emotion regulation agent. Participant 5 admitted:

> "You are going to hide that pain you carry with certain substance abuse also, sometimes even if it's bad to abuse alcohol or drugs but sometimes there are situations where you find you are not strong that much."

Substance use is often comorbid with other underlying psychiatric conditions and in this study, persistent low mood and (sub)-clinical criteria for complex PTSD. Participant 1 explained this coping mechanism clearly:

> "You know others drink because of stress, they have frustrations, others even bring beers to work. So when they go consult at the sickbay they can't be taken seriously cause you as a professional ask yourself how can this person come to consult drunk, not knowing it's the way in which a person heals himself. It's the way they have resolved to help themselves to be okay.**"**

The participants discussed their consumption and tolerance levels as though they were speaking about dosages for prescribed medication. Participant 3 explained, "…to bring myself to a different mind state, a few drinks help a person forget and feel better. You learn what your limits are as a person." There was also an element of ~~a I~~ of mastery after alcohol consumption that concealed a fragile self that was prone to vulnerability to traumatic syndrome and sensitivity to criticism and abandonment. The consumption of alcohol also seemed to help the participants to mask undiagnosed symptoms of PTSD so as fulfil certain military and familial obligations. One participant explained that his family's expectation that he had to be happy all the time made him consume more alcohol so as to be the person they wanted him to be: "The wife wants me to be a happy person all the time, even without a drink. I actually drink a little more when I am with the family." It was apparent that the participants felt that there was no safe space for them to be their authentic selves at home, within the force and and most importantly, not even with and within themselves. Participant 4 acknowledged, "I know when I drink, I feel relaxed and at ease you know, so that keeps me going when I am off duty, they say it is poison but I say it is my medicine (chuckles)." It became apparent that alcohol was used not only to numb emotional and physical pain, but also to experience a sense of happiness. Participant 6 reflected, "You find yourself also feeling sick in your body but the sickbay they tell you they can't find anything wrong. That is why you drink to

forget the pain." Moreover, it appeared that the participants turned their positive and negative emotional as well as physical experiences within because they were unable to rely on relational healing in their external environment wherein the psyche also found healing. This perpetuated their perceptions of others and the world as demoralized, which exacerbated the emotional impairment component of undiagnosed PTSD. Participant 7 shared:

> "…when I'm hurt, I'll arrive at home and change, sit with my liquor relax, watch movies, I'll tell myself I want to drink like nobody's business until I don't feel that hurt anymore. Uh now, I'm just a person with my ups and downs, I am demoralized and prefer to drink to feel happy and forget lots of things."

It was evident that the participants used alcohol to alleviate their psychological pain, rather than seek psychological support because they feared this would reflect poorly on their mental health status profile. The male participants' responses indicated that they consumed more alcohol than the female participant. This suggested possible comorbidity of alcohol use and PTSD. It was possible that the ease of accessibility with regards to close proximity of bars in military bases and low cost as an organisational culture could have resulted in internalised alcohol use. Thus, the general comorbidity and use of it as self medication was masked. Although the participants seemed to be aware of their excessive alcohol use, they continued with their lives without the necessary psychological intervention. Participant 5 expressed this poignantly: "You are going to hide that pain you carry with certain substance abuse." The participants were drawn to the momentary cognitive and emotional symptom alleviation they derived from alcohol use and the heroic or excessive tolerance in their consumption, which drove the dependency. Participant 3 shared, "…to bring myself to a different mind state, a few drinks help a person forget and feel better. You learn what your limits are as a person." Though a temporary relief, which led to further psychically and functionally impairing consequences, alcohol was preferred to the emotionally arduous work of psychic integration of their trauma, which could resolve their undiagnosed PTSD symptoms.

6.2.3 Theme 3: Failed psychic integration of trauma characterized by psychic splitting and numbing

Although the participants said they accepted their position and circumstances in relation to the SANDF, it did not stem from meaning making that had resulted from the integration of their traumatic experiences. The theme comprises two sub-themes: first, self as soldier versus family member and second, lack of psychological and cognitive integration into a unified SANDF. This was more of a partial adaptation as a result of failed integration of traumatic experiences characterised by a psychic split and psychic numbing for fear of loss of ego due to disintegration. This acceptance appeared to be a form of a giving up, intertwined with distressing underlying feelings, which fed a traumatic stress syndrome.

Any distress felt was internalised as something to gain mastery over, numbed in cognition but not integrated within the psychic function. Psychological integration was equated with matters of the heart, which is a sign of psychological defeat and weakness. The lack of integration of the trauma disintegrated the ego, which exacerbated the deleteriously impairing course of undiagnosed PTSD among these participants.

6.2.3.1 Psychological splitting: self as soldier vs family member

The participants' responses revealed that they tried to cope with undiagnosed PTSD through defensive splitting in psychological and structural function processes. These defenses became maladaptive to the point of psychic decompensation and consequently, an undiagnosed PTSD syndrome. Participant 5 observed:

> "So, but now if you are working here, staying here breathing this thing, haai. It's a little trauma even if you ignore it you see but it's traumatising. I won't lie to you I see my friends that still live in here you can see that Jesus, there's something wrong."

This participant's observation was that weakened ego strengths that result in unconscious denial/repression of distressful attacks from psychic and systemic organisation split off intolerable parts thereof. Participant's 2 response suggested that the splitting off of parts of one's psychic organisational units also happened on a conscious level as an inherent coping requirement by the system, especially after deployments:

> "…you can't talk about it you just have to carry on with the task at hand. But we survive and come back just fine, there is just one guy who didn't seem okay, but I see he doesn't wear uniform anymore, don't know what is happening with him but when I look at him he's not okay."

Similar to the process of stripping the R4 rifle down to its constituent parts to ensure it is operable, the participants had to do the same with their psychic parts in order to survive in their roles as soldiers and heads of families. Participant 3 commented, "…change into a different person not yourself that people at home know for example. It is like you camouflage you understand." The participants experienced the system as traumatising and thus, not conducive to psychological and operational integration. This perpetuated the splitting of the psyche of being either a soldier or a person who was part of a family system. This disintegrated the participants' ego function further. Participant 9 reflected, "…more sicknesses to yourself, more than the ones the army gave you of having two minds one of a soldier and one of a person when you are with other people and family." This impaired the participants' integrative capacity as they remained un-integrated psychically into families, the SANDF and society.

6.2.3.2 Lack of psychological and cognitive integration into a unified SANDF

The process of integration into a national force was experienced as having ushered in a disintegration of the organisation as well as of the members' internal and external experiential reality. Participant 1 stated, "…maybe in time with trust and better treatment we can start to heal because our minds and hearts have not been okay and it has been for so long." Once again, the participants conveyed a sense of having to split themselves into parts and function from part self-object, but never as a cohesive whole self-object functioning and relating being. Participant 4 shed light on how those who could not sacrifice being integrated into the system at the expense of disintegrating psychically and functionally, demobilised. They opted for integration into civilian life, which they believed was less of a cost to their psychological functioning than integration into a national defence force. One participant admitted, "It was like you have to change yourself and be someone else they said." The dynamic of part-object relating was palpable among the participants who experienced a strong driving divide between *them and us.* This fed into a psychotic organisational structure, thus making the participants more vulnerable to traumatic stress responses. It was noteworthy how the SANDF members in general and the organisational structures responded with incapacitating psychic disintegration in defense against integration, which may suggest that to integrate psychically into the SANDF also required psychic integration of past traumatic combat experiences. Differences not only in ethnicity and former force allegiance, but also in training within the SANDF had reinforced splits within the organisational structures that seemed to delude the integration process. Participant 8 thus explained this:

> "…these people of the new government they thought we were supporting the old regime, so the old regime also they were not trusting us… they were not trusting us. We welcomed the change but they had that hatred and anger at us. I think some they still do, there will always be mistrust. They still see us as the enemy cause we fought on their enemy's side."

Since its inception, the process of integration appeared to have had no meaning and therefore, no healing for the participants from their combat trauma. It represented a process of repression of their psychological scars of traumatic distress, rather than a process that would help with resolving trauma to be able to move towards an integrated sense of self and thus, a unified SANDF. The process was introjected as part of the participants' psychologically traumatic experiences, a reminder of who they were and where they came from as soldiers. Participant 4 noted, "Now with promotions you struggle because your force number indicates that you are former SADF." The process was experienced as having been instituted to perpetuate a fragmented sense of self and ill feelings among the integrated former armed forces, which prevented healing. This complicated the participants' trauma as they could not feel emotionally authentic and thus vulnerable which may have facilitated psychic healing, in an environment one could not trust. Participant 7 reported, "I don't even trust going into war with my platoon, you cannot go as a battalion I cannot go fight a serious war with these people because I've

never built that trust from the onset." It appeared as though the participants felt lost to the system and lost in the system, with a loss of connection among themselves as well as between themselves and the system. This situation maintained the symptom criteria of hyper-vigilance in PTSD, which perpetuated unresolved trauma in members of the SANDF.

6.2.4 Theme 4: Lived experience of trauma

The participants believed that chronic exposure to combat trauma as part of their military obligation was a contributory factor to the fuelling and igniting of past unresolved patterns of traumatic suffering. This is elaborated under the following sub-themes: unresolved residual traumas; chronic symptoms of low mood; impairing self-destructive behaviour; feeling vulnerable and out of control; and deadened internal world.

This necessitated the mobilisation of persistent rigid maladaptive coping mechanisms, which lived on and off the battlefield, making it part of their psychic functioning. In spite of the acceptance of the military environment as not being a normal one and constant vulnerability to repeated trauma, the participants seemed to have survived with undiagnosed PTSD for a long time. Therefore, their chronic symptoms became normalised. The traumatic stress syndrome was also hidden particularly in deployment areas, lest it was misunderstood as ill-discipline and met with stringent disciplinary measures.

On the contrary, the chronic trauma led to chronic cognitive and personality impairment, with underlying anxieties and hidden feelings that became a constant source of internal conflict. Continued organisational and interpersonal traumas over and above combat exposure during operations formed part of the participants' continued patterns of psychic suffering and gradually disarmed them of their internal resources. It appeared that when dangerous situations were encountered during operations, some of the participants internalised being placed in danger by those in leadership positions, which complicated their capacity to work through their traumatic experiences because it was linked to deep-seated feelings of mistrust of those in leadership positions. This exacerbated the participants' introjection of bad self-object relations, which they experienced in their internal and external world. Their exposure to long-term trauma, especially that which was perceived as being perpetuated by the SANDF and could have been avoided with due diligence, plunged them into depression because of unresolved residual traumas.

6.2.4.1 Unresolved residual traumas

Witnessing the loss of lives, be it in their arms or in the retaliatory return of fire, left permanent traumatic wounds in the participants' psyche. Participant 1 attested, "Yes, like things I used to see in

outside operations when people got killed, I never got help from a psychologist or anyone for that trauma." Participant 2 supported this: "Yes, we saw a lot of things, people lost their lives, I can say there was a lot of blood shed." Nothing in the participants' military training armed them with coping mechanisms to mourn death adaptively. Rather, it became an enemy that disarmed them of their built-in resilience. Participant 3 explained, "You see one or two people losing their lives and you can't talk about it you just have to carry on with the task at hand." It became pain that festered into a characterologically and functionally impairing undiagnosed traumatic syndrome. Participant 7 reflected, "I am one person who has deployed a lot and we have been ambushed, lost guys or some got injured." During a recent deployment, he was driven to breaking point and threatened to kill his fellow soldiers and commanders with an axe in a violent outbreak. He thus described his experience: "No one supported me they made me feel like I was going crazy like I told the social worker. Yes, I got so angry but I was not going to hurt anyone." Separating the person of a soldier from the role of a soldier threatened fragmentation of the self as it was the person of a soldier that was charged with mourning and adaptive negotiation of loss.

Traumatic losses remained unresolved and resulted in a root of deep pain and long-term undiagnosed traumatic syndrome for the participants. It affected how they reacted to death in their lives. Participant 5 related, "But when you get that side it's another story, you don't know how to adapt you tell yourself I'm fine, people die." Participant 8 recalled:

> "There was an operation where we were supposed to be training but we were attacked with real ammunition, which was not even supposed to be there by another country … we had to fight there even using our hands and we lost one guy."

Residual unresolved trauma of loss through long-term combat exposure became a source of chronic low mood among the participants.

6.2.4.2 Chronic symptoms of low mood

The participants alluded to a persistent low mood, which is typically co-morbid with symptoms of post-traumatic stress reactions and can be linked to emotional detachment. Participant 8 described this feeling as: "…just not feeling good inside most of the time, it is the stress just because you don't know who to talk to, who to cry to." Furthermore, the participants not only felt alone in their struggle with intense negative feelings associated with undiagnosed PTSD but preferred to isolate themselves when these feelings were evoked. Participant 5 explained, "When those memories and emotions come, they are so strong you don't want anything but just to be alone." There appeared to be an awareness of a consequent deterioration in quality of life and sense of self, which the participants mourned. Participant 9 elucidated, "And I love my children, I panicked because I didn't want their lives to become like mine,

where you have lost all enjoyment in living." Long-term undiagnosed PTSD may have resulted in the participants enduring traumatic experiential realities from which there could not be resultant meaning making, thus creating disquiet in their state of being. Participant 4 shared, "I get surprised when I laugh at something sometimes because it feels like the days are too long some days and I can't remember what makes me happy anymore or if happiness is real." This pervasive state of melancholy found expression through isolation and enduring psychic pain on the participants' psyche, with positive feelings only flickering briefly. Participant 9 related, "I am sometimes happy like everyone else, but it doesn't last then the sad and painful things I've been through come back to me. I find myself crying and feeling scared again." In an attempt to escape the distress from a disintegrated ego and self as a result of long-term undiagnosed PTSD, the participants resorted to self-destructive behaviour as though to counteract the internal annihilation over which they had no control.

6.2.4.3 Imparing self-destructive behaviourr

The participants' psychic defenses appeared to have become maladaptive in that they no longer served to buffer them from psychic distress and potentially debilitating annihilatory anxiety but perpetuated a long-term functionally incapacitating undiagnosed PTSD. The serving members' chronic untreated trauma correlated with enduring personality change due to combat trauma, which originated from their psychic organisational pattern of defenses that were mobilised to cope when the ego was overwhelmed. Participant 4 elucidated, "…that is why you are never the same person that is why you never talk about them after they have happened. You have to try to forget it all as soon as it has happened." The participants' manner of engaging and negotiating their roles in relationships lent itself to enduring maladaptive behavioural patterns, which impeded their ability to provide and receive nurturance in these relationships. Participant 4 added, "So to avoid fights even when I am on leave and go home, I spend time with my friends in the tavern it is better that way, when you get home, you just sleep." The maladaptive-ness of the defenses the participants operated through mirrored the perceived abnormality of their experience of the military environment. Participant 5 explained, "…even if you survive you make mistakes in your life that you have to live with, but I have learned to toughen up. Yes, I know always you cannot be like that but we have to because this environment is not a normal one."

Participant 7 endevoured to cope with his experience of a fragmented and self-destructive self in the following way: "I'll tell myself I want to drink like nobody's business until I don't feel that hurt anymore, especially if someone did something and I ignored it, it is better if I reacted with a fight back then it's over for me." The primary attempt was to protect the self and conceal distress even at a high cost to their psychic equilibrium or cohesive sense of self. Participant 6 shared his experience following a long hospital admission for health complications due to excessive alcohol use: "I wasn't able to eat solids, salt and hot spices too. And at that time, I was drinking a lot but after that I stopped drinking."

Participant 7 also painted a picture of how members arrived at work drunk, which was met with punitive disciplinary measures and exacerbated the distress from undiagnosed PTSD syndrome. He related, "They do see him drunk acting like this you can call him and speak to the member what you are doing is wrong why don't you do this and this." The SANDF's intolerance of the participants' insufferable traumatic psychic distress, which spiraled out of control in self-destructive behaviour, may have left them feeling vulnerable and at the mercy of attacks from their internal and external worlds.

6.2.4.4 Feeling vulnerable and out of control

The participants acknowledged feeling vulnerable and out of control in response to the raptures in environmental provision experienced in the SANDF. This mirrored their psychic ruptures from undiagnosed trauma. Integrated former statutory and non-statutory members found themselves in a system experienced as persecutory and that elicited paranoid anxieties. Participant 7 stated, "We knew that time why we wear this uniform but nowadays we find ourselves so stressed we become so vulnerable." The participants appeared to feel out of control in a system that was experienced as less than optimal and that persistently failed to respond empathically to their traumatic stress bind in its introjected capacity as a mirroring self-object. Participant 6 explained, "Now with the things that happen on the external deployments when the past ones come back to you it's like watching a horror movie of yourself in your mind." The organisation became a relational self-object as soldiers appeared to develop and experience their sense of being and sense of self as part of the organisation, for which the family unit had been given up. The SANDF, however, became a self-object that could not be internalised and merged with as an image of calm and cohesiveness. Participant 7 reflected, "…members get charged but a psychologist or social worker in the unit never gets called to come and assess the person." The participants conveyed a struggle to find safety, not only within the structure of the self but also within the organisation. This contributed to persistent traumatic self-object experiences and thus, a damaged self. This predisposed the participants to the subsequent development of a traumatic pathology of the psyche and self. Participant 6 asserted:

> "…now with a drug problem and when on these drugs he loses his mind, his case is known but there is nothing happening. So actually, how must I handle those people in having to do duty with them? I don't know how do you get what I mean?"

The participants' feelings of being vulnerable was not only felt during deployments, but also in response to the organisational structural processes, which had a traumatic impact on the cognitive, emotional and occupational aspects of their functioning. Participant 8 noted, "Last time when we went to Sudan, we went there, there was no sustainment planned … haai the weapon system in fact logistically we were at a disadvantage."

6.2.4.5 Deadened internal world

This sub-theme centers on how the participants deadened their internal world as they experienced emotions as malevolent threats, which elicited traumatic memories. Participant 9 explained the gain from killing their emotions: "So that we can feel like you are dead inside." The splitting and killing of bad traumatising objects and parts of themselves left the participants with a deadened internal world, void of emotional connections with themselves and their external environment. Participant 8 likened it to a graveyard: "It is hard to talk about because in this uniform you must be this tough person but inside you know it is like a graveyard I can say." The participants' long-term undiagnosed PTSD impoverished their internal world, which subsequently impaired their emotive and cognitive functioning. Participant 5 stated, "You must take your brain and use it to think and not your heart or you will be a mental case." When their emotions escaped them, they became intolerable and promptly acted out aggressively in order to be evacuated. Participant 6 explained, "Who will you fight, you won't find anyone to fight. Because if you carry it in your heart you will want to fight." The deadening of psychic reality may have been mobilised to protect the ego from disintegration and the self from unbearable emotional pain, which was inevitable. Participant 4 related, "I can't explain it, certain things change in you after living your life in that way, it is like something or part of you dies even if you are alive." His thoughts were collaborated by participant 8: "It's like we are dead men just soldiering on." The participants' deadened manner of relating to their external environment was not only restricted to the military aspect of their lives but got transferred to all their relationships. This is discussed in the following theme and its sub-themes.

6.2.5 Theme 5: Impoverished relational patterns

The participants' impoverished internal world and resultant impoverished relational patterns are further elaborated in the following sub-themes: feelings of isolation in relation to the external environment; a sense of disempowerment and disconnection from others; feelings of abandonment by former forces and current force; avoidance of intimacy in relationships; and feelings of resentment.

As noted previously, psychic rupture secondary to trauma exacerbated the propensity for repression, particularly of *bad* aspects of emotive and experiential reality, self-objects and the self. There was a lack of acceptance of good and bad parts of the self among the participants with resultant relational difficulties with the self and another. They seemed to struggle to forge secure, trusting and loving relationships, but rather held on to their internal bad objects in their psychic, ego defenses and organisation. It appeared that the participants' internalised representations of past relationships with significant others and the organisation dictated how they responded in their current intimate relationships.

An element of lack of tolerance of others when unable to control them cognitively and emotionally contributed to the participants' impoverished relationships. This may be attributed to the the fact they felt they had lost control of their internal reality in the battle against the distressing symptoms of undiagnosed PTSD. It appeared that the impoverished quality and pattern of relating within the system was repeated and displaced onto relationships outside the system, with the participants taking on the role of the traumatising aggressor. There was psychological conflict around loyalty, which translated into part-object relations, the perception of others as bad and intolerance of ambivalence. Consequently, the participants felt abandoned and isolated in relation to others.

6.2.5.1 Feelings of isolation in relation to the external environment

The participants appeared to attempt to deaden the self by isolating themselves from their internal world and external environment. Participant 9 reflected, "…just because you are part of a system but at the same time you are alone." The participants revealed how denial of the need for relatedness was employed as a sort of defensive protection of an extremely traumatised internal world: it was manifested in their propensity to withdraw literally from the external environment. Participant 9 painted the following picture:

> I just live to work for my children. I am not the kind of person that likes to have a lot of friends, I am a single mother and I don't know if I can trust people, I meet and that's why I prefer to be alone.

The participants also seemed to carry feelings of loneliness in relation to not being able to feel part of a family and how to be emotionally vulnerable in that space. However, these feelings were disavowed when they were with family because of the fear of feelings of distress this evoked. Participant 5 shared:

> They don't want to be that close to you. It's fine for them for you to just be the provider because there's that thing you see. Your child only knows to ask you to buy this and that but to go somewhere with them to spend time to get close to you does not happen.

The participants experienced this need for inter-relatedness as difficult because it was an acceptance of their own unmet dependency needs. Their capacity to relate to fulfil these needs appeared to be impaired by suffering from undiagnosed PTSD. This compounded core conflicting feelings of isolating loneliness, which were split off and kept out of conscious access of the self and others in defense against the pain of it only finding expression in the repressed company of the undiagnosed trauma. Participant 4 shared:

> I can say I don't have a lot of friends; my friends are some of my fellow soldiers and comrades, otherwise my life and movements are restricted. I am in the base most of the time cause I am a living-in.

It is noteworthy that the participants' failure to satisfy their core psychological needs invariably almost always seemed to be experienced as rooted in the SANDF as a traumatising system. Participant 1 reflected, "And then you find this guy isolated from his family and thinking I used to be close with my family, but this promotion has cost me that." This served as a defense against accepting that there was something inherently wrong with them in the form of the undiagnosed PTSD over which they endeavoured to gain mastery, which led to feelings of disempowerment.

6.2.5.2 Feeling disempowered and disconnected from others

Despite being married, several of the participants described a lived experience of emotional detachment and disconnection from their loved ones, which is also a symptom of undiagnosed PTSD. Participant 4 related, "Family I see them when I see them, I taught myself never to get too close." These feelings, coupled with a sense that they would never be understood or accepted, impeded the process of psychic and social integration, pushing the participants deeper into an empty internal world. Participant 1 thus described his experience: "That is why my ex-wife used to say I don't care about her, and that was always the fight." Participant 5 explained:

> It's like that, we find difficulties in relationships for sure that's why soldiers divorce a lot. You cannot put a finger on it or what but simple something is wrong with this. It is that thing of problems you face in relationships because I cannot be fine and show you who I am inside, I cannot because me here (tapping his chest) …haai I cannot.

The propensity of psychic flight away from the self and relational objects (family) forced the participants to escape through deployment missions in defense against the underlying persecutory pain and anxiety, exacerbated by trauma to the psyche. Participant 2 shared, "I just learned to avoid talking and just leave the house when they make me cross. And also deploying helps because you are away from it all." It became *safer* to rationalise the disconnection as the result of the distance imposed by periods of deployment rather than emotional distress linked to unresolved traumatic experiences. Participant 2 admitted, "You lose touch with people as you deploy." This profound sense of disconnection, which manifested as internal conflict in the participants' capacity to negotiate their relational needs, also appeared to be functionally disempowering as they internalised that they could not function outside of the SANDF. Participant 5 wondered, "Now imagine getting out of the system where will you get hired." It is possible the trauma may have been accepted as permanently continuous because the participants may have felt maladaptively entrapped in the SANDF. However, the SANDF was experienced as safer and more familiar and thus, associated with a quasi-psychological equilibrium of a normalised state of living and consequently, with undiagnosed PTSD. At times, the internal pressure or conflict resulted in members removing and disconnecting themselves physically through divorce.

Participant 5 attested, "… that's why soldiers divorce a lot. You cannot balance, you cannot you are lying, you cannot … It's hard actually (cynical laugh) you see." Feelings of rejection also underlay some of the participants' sense of relational detachment and disempowerment when efforts to connect with family were thwarted. This came at the risk of allowing themselves to be emotionally vulnerable, which activated primitive injuries at a slight detection of rejection. Participant 5 explained, "I wanted them to feel the difference of having me around when I'm home so we all have a good time, but you can see even if you want to socialise with them, it's as if you are forcing them."

6.2.5.3 Feelings of abandonment by former forces and current force

The participants displayed an element of negative distortion of cognition, a diagnostic feature of undiagnosed PTSD, in their resolute and exaggerated negative beliefs of others. This was also evident in their reference to former and current force commanders as their collective conviction that "no one can be trusted" seemed to fuel their sense of being cast aside and abandoned. It appeared that this experiential reality felt like a self-imposed psychological exile, far removed from the reality shared with others. Participant 7 shared poignantly, "I've never built that love from the onset, we've never built that mutual relationship amongst ourselves you understand. Soldiers have lost hope and trust in leaders because of what they are doing that affects them everyday in their workplace." This seemed to indicate an impaired psychological capacity to share a lived reality with others, compounded by the deleterious course of long-term PTSD the participants had endured. The impaired relational capacity to share others' reality and allow others to share in on theirs, for fear of having their *sickness* of traumatic syndrome exposed, exacerbated feelings of abandonment by former and current authority figures.

Participant 7 recalled, "Soldiers used to be counselled on their problems but nowadays you can't talk to your commanders because they go spread your problems to everyone. Soldiers have lost trust in the commanders." This may suggest a psychic defense against the fear that their superiors would fail them in regulating their internal working models because they believed they had failed, which may have led to them losing all hope of healing. This masked their disavowed regressive dependence, perpetuated by ego disintegration secondary to psychic trauma. The participants may also have been intimating a need to be regarded positively by their commanders to ward off abandonment depression. Participant 6 shared, "Even when you are sick … I got sick with ulcer and was admitted for three months, recently, four, five or six years ago no one came to see me, no one you see." Participant 7 added, "…us soldiers we are being neglected career wise, promotions and social welfare." These perceived emotional failures may have resulted in a maladaptive self-reliance among participants, making them avoidant of relational intimacy with underlying abandonment and rejection anxieties.

6.2.5.4 Avoidance of intimacy in relationships

The participants seemed to share a relational pattern of avoidance in their defense against the need for intimacy for fear of possible further disintegration of the self by risking being emotionally vulnerable. Participant 1 acknowledged, "No, I'm scared of that part, I'm afraid because you can never know what the other person's intentions are for you. Cause I told myself let me focus on my child." There also appeared to be an element of feeling that they damaged relationships and anyone they loved. Therefore, they cut themselves off as a defense against damaging and being damaged. Participant 4 thus reflected how he approached relationships: "I taught myself never to get too close at least if you keep that distance they'll say we are free now he is gone, he was too strict and so on." The anxiety of not being accepted also underlay the participants' avoidance of intimacy in relationships. Participant 2 related, "…sometimes really prefer being alone, to avoid getting told you are soldier and that is why you are the way you are, serious, short-tempered, angry and those things. I just see myself as any person." This may have been a manifestation of past relational traumas in their lives, influenced by their earlier object-relational patterns and resultant emotional and thus psychological development and function. This primitive relational trauma resulted in the participants' psychic organisation being susceptible to developing PTSD when exposed to traumatic events. Participant 8 acknowledged:

> You don't want people get close to people this thing of emotions you don't believe in just because you can't trust that they will be good to you and understand that you are sick when it comes to normal civilian life matters, it is like you don't operate the same.

Participant 3 added, "…no outside people. It takes too much energy to invest in friendships." The participants' responses also conveyed a fear of intimacy, which was associated with intense feelings. Furthermore, they mostly avoided feelings. Any possible intense feelings that may have been evoked were associated with feelings repressed from past traumas and were responded to destructively. Participant 5 stated, "Yes that's why people start being womanisers and not care anymore, and also stay away from their family for a long time." This statement encapsulated the participants' shared anxiety about being vulnerable enough to establish and maintain romantic relationships.

6.2.5.5 Feelings of resentment

The participants appeared to have a sense of resentment as they felt that the physical and psychological sacrifices they had made were not appreciated or acknowledged by their families and the SANDF. Participant 3 asserted, "… just know that you must look after yourself to survive, no one cares at the end of the day. It is just that sacrifice you make peace with." This appeared to make the participants resent the course they had followed, which had come to dictate the person they had become and essentially, they felt impaired because of it. Participant 8 shared, "…so you go through all these things

and put your life at risk for what? Just extra money that's all now." The participants' feelings also suggested they felt burdened being alone. However, once they had shared their feelings, it appeared as though they understood what it meant to become a burden on others. Because the members' pride had been replaced with shame, it became a load they did not seem able to shed no matter the cost. The resentment of the self-sacrifice led to members choosing the system over their family systems despite it not being optimal. Participant 5 observed:

> Because there are guys I've worked with before, you find he is more happy at work than with his family, so obvious there is a problem there. You pick it up that when a person is at work or during deployment he puts on weight and looks good and healthy. One month at home you see a person losing weight. You look and say, oh okay something is not alright here.

At times, they defended their resentment by directing the self-sacrifice towards the family's benefit, by equating their death not with loss but monetary gain for the family. This may imply they had deep-seated feelings of being a burden rather than a valuable part of the family. Participant 8 shared, "… but what will happen if my life ends? Okay if I die the rest will get the money, you don't care about your life, you care about your dependents of the money." It appeared as though the participants believed their value in relationships was equated to monetary currency over emotional currency; this is linked to the next theme.

6.2.6 Theme 6: Impaired emotional connection with family

The participants collectively presented with defenses against the distress of not being able fulfil the emotional demands of their roles in their families. It appeared as though they felt too internally depleted and could thus only sustain a connection with family through financial provisions. This theme comprises the following sub-themes: relational ties associated with financial responsibilities; fear of losing relational connection with children compared to spouses; and SANDF disintegrates families.

6.2.6.1 Relational ties associated with financial responsibilities

The family unit was a source of great pain for all the participants who battled with core psychic conflicts and thus, evoked their trauma-induced underlying anxieties and hidden feelings. This involved a constant state of living through an ego defense state. Participant 4 conveyed this as follows: "Family I see them when I see them, I taught myself never to get too close because anything can happen to you and you have these people left behind with pain." Distancing from the emotional connection from family and a replacement of that with a monetary connection in the form of provision occurred. Participant 3 asserted, "… it is better if you send money and you are not there all the time." This was thus collaborated by participant 5: "Your child only knows to ask you to buy this and that but to go somewhere with them

to spend time to get close to you does not happen." Identity and role within family also appeared to be narcissistically entwined as money was a currency in the participants' relational functioning in their perceived roles as providers only. Participant 3 attested, "For me what can you do, providing for my family is important and that is what has kept me going."

The participants appeared to experience pain as it evoked unresolved emotions from their family as well as the former and current military force. It had been hoped that the military force would fill voids from primary familial object-relations traumas, but through combat exposure became the very source of trauma. Deployments became a form of extra income and escape from family, which was a manifestation of physical distance and conscious emotional distancing. Participant 4 complained, "They (women) are never satisfied, they don't see you work so you can take care of them and the children." The importance of social support, which could have played a protective or healing factor for these members, was negated. Rather, financial transactions replaced emotional transactions. The participants were notably aware of the dangers of deployment and thus, possible re-traumatisation, which seemed to be almost laced with a death wish. They spoke of ensuring there was money for funeral arrangements as though unconsciously wising to escape re-traumatisation and not death. Participant 4 acknowledged:

> You start thinking if you left everything in place back home so when I do not come back there is money for the funeral and to take care of the family. Yes, if I am going to die that is where it'll have to be then. And the extra money helps a lot when it comes to taking care of your responsibilities.

This connected with their descriptions of themselves as *dead men walking* and possibly touched on death as the only way through which they could finally be rid of the internal torment of undiagnosed PTSD. With this wish unfulfilled, upon returning from deployments to a continued survival of life with undiagnosed PTSD, these participants' children appeared to be a source of consolation.

6.2.6.2 Fear of losing relational connection with children compared to spouses

The participants appeared to prefer a close relationship with their children than with their spouses. Participant 4 shared, "Even going to the social worker I went because I needed to please my wife because I had beaten her up when I went home and she made threats that she will leave with my children if I don't get help." Most of the participants appeared to value a parental relationship. It was apparent that they feared losing this relationship and went to great lengths to protect it, even if it meant availing themselves to psychosocial intervention. Participant 7 related, "She doesn't not know how to deal with a soldier like me and my family always says I must leave her, but I think of my child, what if she takes my child and I never see her again. It is losing someone again, you understand, I have lost too much I can't. She is the only good thing I can say I have in my life."

Although their relationship with their children was based on monetary and not emotional currency, their children were evidently important to them and they seemed to find safety in the parent-child dyad. Their preoccupation with being providers (instrumental needs) and identifying with being a father or mother was possibly experienced as easier as it did not make emotional demands and they could remain in control of its process. This suggested an element of impairment in sustaining intimate relationships, which fed into their impoverished internal resources. Participant 1 stated, "Haai no, I can say I've moved on which I can attribute to my daughter, I won custody of my first born and she came back to me, she is 21. That at least heals me that she came back to me." Furthermore, a split between acceptance of the reality of the quality or manner of relating with their children and a phantasy that all was well was apparent. This conflictual splitting was apparent when participant 5 shared, "… now imagine getting out of the system where will you get hired. It's just self-motivation that helps you survive and thinking of your children." The participants' children had the privilege of experiencing the good parts of their ego, possibly because they mirrored such to the participants, which made their suffering with undiagnosed PTSD less painful, even though momentarily.

The split-off bad parts got projected onto spouses, which activated anger that was displaced on to them. An element of devaluing them was apparent. Participant 7 acknowledged, "And my girlfriend knows to stay out of my way when I come back angry, I just want to be alone". This was associated with their traumatic experiences and they responded from a fight mode given their undiagnosed PTSD when strong emotions were aroused. This may have explained why disagreements with their spouses escalated into physical aggression. Participant 6 admitted remorsefully, "…there are times when you don't expect it and they see you angry especially with their mother. That is where you can lose your temper and fights have happened." Participant 7 related, "…we were fighting a lot whilst I was on that deployment where I eventually had to be sent home. She doesn't not know how to deal with a soldier like me." Despite the participants' preference for distance between their families and them, there appeared to be underlying feelings of it being yet another part that had got taken away from them by the SANDF. They had no control over this due to their military obligations.

6.2.6.3 Sub-theme: SANDF disintegrates families

The nature of military life entails not being geographically bound. Although many of the participants did not live with their families, this seemed to be a preference embedded in their psychic defenses rather than one the system imposed. Participant 5 explained, "It's like that, we find difficulties in relationships for sure that's why soldiers divorce a lot. You cannot balance, you cannot you are lying, you cannot. … It's hard actually (cynical laugh) you see." It was apparent that those soldiers who remained married had always lived away from their family. Although those who were divorced had been living with their families, participant 5 poignantly explained that they had struggled in their roles as husbands/wives and

fathers/mothers. Being away from family led to disconnections that the members' ego function could neither restore nor repair. Due to undiagnosed PTSD and related psychic disintegration, the participants also struggled to integrate into their family systems. The situation was then defensively accepted as an expectation in the military. Participant 4 explained, "To be able to focus on my job and have no stresses, family can stress you out. And it is also no place for children and wives." The role transition was one that also left the soldiers feeling disempowered both at home and at work. Participant 1 noted, "…and that was always the fight when I travel for work you leave the family behind for some time and the woman ends up having to take on the role of the man when you are not there, which causes problems and breaks marriages apart." The emotionally impairing symptom of PTSD in the form of emotional detachment and disengagement may also have contributed to the participants' familial difficulties. Distancing from their family was part of a psychic process of defending against their symptoms of undiagnosed PTSD being exposed. Their internalisation thereof reflected a weakness in them, of which they were shameful. It may also have been an unconscious defensive effort to protect their family from the perceived bad parts of themselves, which they experienced as impaired by the PTSD from which they suffered.

6.2.7 Theme 7: Employing psychic defenses to cope with symptoms of trauma

The participants' psychic organisation from chronic undiagnosed trauma and the rigid defenses mobilised in an attempt to cope with traumatic distress was experienced as a change in the self. This appeared to manifest in irreversible damage to character and perceived loss of the ego. It was as though the participants felt like shells of themselves at the mercy of paranoid-schizoid and persecutory anxieties that had to be defended against in order to survive. Some of the participants also appeared to display an element of defensive lack of self-awareness, which impeded their ability to integrate socially and form meaningful relationships. The different psychic defenses employed are further explained under the following sub-themes: experiencing primitive psychic anxieties; repression of traumatic emotive experiences; avoiding seeking psychological help; cognitive rigidity as a defense; disintegrated psyche-soma; and splitting of SADF as a good object and SANDF as a bad object.

6.2.7.1 Experiencing primitive psychic anxieties

The participants' enduring symptoms of unresolved trauma culminated into what appeared to be a psychic organisation centered around annihilation anxieties and inherent ego defence patterns. Participant 2 shared, "… and you live with that fear what if it is me next." They appeared to have developed a persistent pattern of psychological suffering grounded in concerns about survival, self-preservation and safety. This entailed fears of being overwhelmed, merged, disorganised, death, dying, objective and phantasised bodily and psychological harm or serious injury. Participant 3 expressed his

fears as follows: “These were guys who were good combats and they were killed so what will stop you from also being killed at some point.” The participants had an enduring trauma-perpetuating fear that they would not be protected or saved, which may have led to their untimely deaths. Although they were expected to be brave in their role as soldiers, there seemed to be an element of fear and a need to be protected with which the participants lived. Participant 6 solved this internal conflict by no longer availing himself for deployments: “They said they needed drivers and I said no, I won’t go there and you find there is no medic.” Participant 9 explained her fear of annihilation as a woman as follows: “…you have to face it again being a woman means there are issues of rape so you must protect your life against it at all costs. I can say now I will never deploy externally I am afraid.” Participant 3 thus described a traumatic experience:

> Our base was ambushed and there was shooting, some people got hurt and there were threats of more ambushes if we don’t leave that country. And we know they have better weapons than us, you don’t know if you stand a chance of surviving.

Lack of control and certainty during deployments and accompanying misperception as dictated by the psychological armour of their defenses drove members deeper into their annihilation anxieties. Participant 8 stated:

> …those weapons that were there previously 15 or 20 years ago and they are not tested if they are shooting or not, we are going to find out when we are attacked, when we are in a hell hole then we are going to find out. So, if ever I was not so vigilant at the time, I was supposed to be dead.

These anxieties may have exacerbated the participants’ symptoms of undiagnosed PTSD. This implies that they were always functioning from their psychic defenses, which fed into their hyper-arousal state of being. This resulted in participants living in a persistently vigilant state because they felt as though they were in constant danger, even when not on deployments.

6.2.7.2 Repression of traumatic emotive experiences

The participants’ inherent manner of employing psychological defenses served to drive them away maladaptively from their emotive reality, which became an enduring source of internal conflict in cases of complex trauma. Participant 2 related:

> …so you do what needs to be done without thinking too much. Otherwise, you find yourself getting too emotional, you don’t want to keep getting angry or sad. Involving feelings doesn’t change anything I tell you.

This was driven by the conscious and unconscious underlying distressing feelings and anxieties that the participants had to defend against for fear of being completely overwhelmed by the symptoms of

undiagnosed PTSD. Participant 5 shared, "For me it's like a history that I was part of but that is buried somewhere inside me." All the participants became adept at repressing painful emotive experiences despite the cost to their psychic and physical well-being. Participant 1 added, "…if you going to dwell on a lot of thoughts we harbour, it's like … eish, you try not to think about it. It's like this guy who collapsed on Friday just here, he passed away." This illustrated an over-reliance on psychic defenses. Avoidance was employed to such an extent that it was no longer effective. The participants began to accept that pain not worked through could not be avoided into non-existence. Participant 4 explained, "When things happen you are reminded of where you come from and who you are and that as a soldier these memories will take over your mind if you don't try to avoid them by all means." Unbeknown to the participants was the manner in which they defended against psychic pain and trauma, which resulted in further psychological and physical deterioration. Participant 4 attested, "… it is like those memories you always buried come back up and attack you, they are like your own demons."

Because the nature of military occupation requires that traumatic incidents be repressed as a sign of mental and emotional fitness so as to move on with other operations, the participants' capacity for resolution and integration of trauma was complicated and thus, they experienced PTSD symptoms. Participant 7 explained, "We have seen and done a lot it's just a person is not trained to go back there you know once something has happened, we recover and move on." It became evident from the participants' enduring symptoms of undiagnosed PTSD that repression and avoidance of their traumatic experiences and thus, integration thereof had deleterious effects on their psyche. This necessitated that when one defense no longer served the desired function, different defenses were subsequently employed maladaptively. These defenses resulted in an emotional disengagement from the self and others, the emotional devastation of which became repressed.

6.2.7.3 Avoiding seeking psychological help

This sub-theme centers on how the participants were resolute on self-managing their undiagnosed PTSD symptoms and not seeking psychological rehabilitation. Participant 1 explained, "Sometimes you see a psychologist or social worker as young and feel they will not be able to help me, and you don't go for help forgetting that they are trained in what they are doing, but you tell yourself let me keep my problems to myself, we are afraid to go." This may have been suggestive of defensive aggression towards mental processes that implied an attack on thinking and making meaning of intolerably distressing emotions. An attack on the psyche pointed to a psychotic psychic organisational structure, which may have perpetuated the participants' annihilatory dread. Participant 4 asserted:

> It is a waste of time, it is something that can't be fixed. So, I don't entertain or show emotions. When you start going to a psychologist it means you are showing you have lost

self-control, or you have lost your fight with your demons and that means you lost your mind.

There appeared to be an interplay between a fear that their feelings would cease their *being* yet at the same time choosing to live as ceased beings by not feeling. The control the participants were constantly at pains to exercise over their emotive state illustrated an impaired capacity to tolerate and make sense of their feelings. Participant 5 elucidated, "No. You learn to deal with these things. We were trained not to say anything. It just becomes too much to bottle it all in because you are trying to show discipline. You just have to cope."

When asked how he had tried to cope with troubling thoughts and feelings, participant 3 replied, "I don't pay attention to them any more, I have learnt to help myself to bring myself to a different mind state." The deployment of this psychic defense was also compounded by the reality of conflicted misgivings about the protection of confidentiality within the system and the manner in which one could be disadvantaged should their psychological difficulties be disclosed. Participant 3 shared, "I have not consulted a psychologist, no, confidentiality is a big problem, you don't know if your problems will get to your seniors and how it will be used to your disadvantage." This mode of survival was deemed a *victory* over the psychological warfare between self, threatening internal conflict and the organisational psychological and physical health stipulations. Participant 9 explained, "I have never spoken to a psychologist except for when we do CHA but to say to myself okay, I have this problem now, and maybe it needs a psychologist no I have never." Help was sought in the form of medical help because psychological distress became located in the participants' bodies, which were displaced from the psyche as a manner of coping. Participant 6 attested, "It really gets tough to feel okay when those scars are open. You find yourself also feeling sick in your body but the sickbay they tell you they can't find anything wrong." It appeared to have become normalised for these participants to feel physically sick, rather than psychologically sick. This was because physical wounds were *hero-ed* as part of being a solider, while psychological wounds were shamefully dissociated and denied, which perpetuated long-term undiagnosed PTSD.

6.2.7.4 Cognitive rigidity as a defense

An element of an unyielding cognitive pattern among the participants manifested in a restricted manner in which they engaged with their external world. The lenses through which they perceived their reality served as a defense against pain from past traumas. Participant 3 shared, "I prefer to plan my things and have targets and goals. I don't like being unsure of things." The perceived malevolent emotions in which their cognitions were embedded informed their psychological organisation and accordingly, who they had become. Participant 2 declared, "I am strict person is what I can say, I don't

know if that has to do with the military." Moreover, through cognitive distortion they were able to feel a semblance of control over their thoughts (memories), evoked emotions and behaviour. Participant 6 conveyed this as follows: "Once you take things and put them in your heart you will not make it, that I can bet you." This was not pleasant for them or others, but alleviated a certain level of persecutory and paranoid anxieties, which exacerbated the severity of undiagnosed PTSD syndrome. Participant 3 related, "You learn self-control and not to let things make you angry. You exercise the discipline mental and physical you have been trained in and follow instructions." This implied that the trauma to the psyche remained unintegrated to form part of the ego and the self.

6.2.7.5 Disintegrated psyche-soma

The memory of the trauma was not integrated and accepted as a part of the participants' personal past. Rather, it came to exist independently in a pathologically split-off dissociated form as though part of another lifetime and not the self. Participant 4 stated, "We all have our own history and what happens to you become a part of your history not you as a person, is what I think." The participant's psychic organisation became such that the psychic distress from any traumatic experience was discarded dissociatively and denied any room within the psyche and thus, the self. This resulted in psychic and bodily disintegration and thus, a non-cohesive self, which underlay the participants' undiagnosed PTSD syndrome. Participant 9 thus described her experience of a disintegrated psyche-soma:

> It just makes you feel like as we all live this life some people are going that way while you are going in another direction. Ah, but in life you make choices and this is the one I made. It is like there are different pieces of you to keep it all separate.

An experience of not only escaping their external world, but also their internal world, which resulted in a disintegrating and weakening war on their ego function capacity and further driving the psyche and the body apart, was shared. Participant 3 shared, "I don't know how to explain like living life but not always in the same world with others, like there is a world you escape to so you can be your old self." As the participants lost the internal war of keeping their psychic pain out of the body and thus, the self, they learned to doctor the body so that it felt like it is had been ridded of all threatening psychic elements. Participant 5 related, "It is like you must find ways to trick your mind by controlling it. Sometimes you can take sleeping tablets to help yourself." The participants conveyed a development of psychic developmental arrest and thus, fixation in trauma as the body was denied its capacity of carrying out its integrative soma function in relation to the psyche. Physiological signs of distress appeared to be denied to the point of pushing them further from reality. Participant 6 acknowledged, "When you feel pain, don't feel it with your heart, put your heart on neutral like it is not there." The participants also used to split unconsciously and consciously as another coping psychic defense.

6.2.7.6 Splitting of SADF as a good object and SANDF as a bad object

There was a defensive splitting of the SADF as a good object and the SANDF as a bad object among the former statutory force participants. This was despite old psychic traumas or wounds that were sustained during combat exposure under the SADF. The SANDF's inability to provide a secure base for the participants in which their psychic wounds could be examined may have been one of the many reasons. Moreover, they may have also been protecting the SADF from their destructive anger and wanting to preserve it as a good object on which to hold. Participant 7 related, "We used to enjoy soldering even if we did not earn a lot, so whatever you experience you knew you would be okay." The inability to introject both good and bad parts of an object manifested in intensely negative feelings about the SADF being displaced, split off and projected onto the system of the SANDF. Participant 8 explained, "With the old regime you were well-equipped and just had to carry out what you are tasked with, if lives are lost you accept as part of battlefield it's what happens." When asked if he would allow his son to join the SANDF, participant 2 stated, "It is not how things used to work, it is not what we did. Things have changed, I won't allow him to come work here seeing how it is, he will also change into a different person." It appears the participants' perceived bad parts related to certain inadequacies were disavowed and deposited onto the SANDF leadership system. This may also have explained their inability to integrate psychologically into the system. Participant 6 related, "Well the training was thorough and you were trained how to handle your weapon and instructions were always clear. So now with these ones that are peacekeeping missions they say but become dangerous because leaders relax and when ambushes happen people get hurt because leadership is poor." Accordingly, some of the participants defended against abandonment depression by the SADF by maintaining their loyalty to this non-existent object so as to not betray it by psychically integrating into the SANDF even though they felt betrayed by the SADF on an unconscious level. Moreover, giving up this object would have been another loss and exacerbated the participants' enactment as fed into by undiagnosed PTSD. Participant 8 reflected:

> Previously everything was open to us, uh … there was this thing of trustworthy and truth in the events. But previously not to say I'm favouring the old regime, but the planning was appropriate, it was very good it was excellent.

6.2.8 Theme 8: Loss of overall well-being

The participants'years of military service had culminated in deterioration in their overall well-being. When the presenting complaints were of a somatic nature, it was apparent that prognosis was guarded when there were always underlying causal traumatic psychological syndrome. The participants seemed to experience secondary trauma after witnessing loss of well-being amongst their fellow soldiers. This further exacerbated annihilatory anxieties in varying degrees, which further perpetuated their enduring

PTSD. It appeared that being physically sick, whether from battle wounds or biological aetiology, which the participants often linked to military service, was as traumatising as being psychologically sick. The participants appeared to have mastered concealing their ill mental health to the extent of denying it, which reinforced impairing maladaptive psychic defenses. Feelings of shame and weakness were associated with this loss of functional vigour and possibly linked to feeling damaged. The participants seemed to mourn the loss of the self verbally, secondary to overall damage to their soma and psyche. This is further elaborated in the following two sub-themes: first, loss of self, loss of meaning in life and work as a soldier and second, loss of control and feeling helplessness.

6.2.8.1 Sub-theme: Loss of self, loss of meaning in life and work as a soldier

All the participants felt that they had lost themselves to the harrowing course of undiagnosed PTSD. What remained were versions of what may have been their former selves. Participant 5 asserted, "Exactly, and that part of yourself is gone forever. And when this system is done with you, it is done with you forever, it just leaves you like that." The loss of meaning in the work as a soldier may have also been embedded in a perceived loss in the fight to strive for a meaningful life and existence. This experiential reality encapsulated all the aspects that made up a cohesive self that the participants felt they had lost to the system. Participant 6 reflected poignantly, "Haai, no I can say you just work there is no meaning anymore. It is all gone. We lost our years here it means nothing to them." When being a soldier became the means for providing for their families, it impeded the healing from traumas in their line of work, which occurred through a process of meaning making. Participant 2 acknowledged, "Ehh..h… you have to work otherwise what else do you do at home, and there are people dependent on you." This may also have driven the chronicity of the undiagnosed PTSD from which they suffered. Because the participants were not in their roles as soldiers, which had to come to represent the self to them, this also meant a loss of a part of self. Thus, the self was further removed or lost to them when not in active routine or duty. Participant 3 shared, "We are currently inactive, no routine, no re-training programmes in place. We are only active in operations where you have a rifle in your hand at all times and you are in your positions, you know doing your job." The participants appeared to have lost motivation in their work as soldiers, which was enacted and thus, perceived as ill-discipline. Participant 5 stated:

> Yes, communication cause as soldiers we experience these things alone and no one from management cares and these things affect us. That is why some drink, some so ill-discipline and don't care about the system and don't want to work anymore and awol. I am just working…even me my motivation is gone honestly speaking, I am just working that pride of being a soldier is out now. Haai motivation is gone.

The participants were unaware that it was the undiagnosed PTSD and not really the system that had taken so much of them and from them. The positive feelings they could no longer feel about themselves or work were part of a manifestation of an emotionally impairing feature of PTSD. Participant 9 reflected, "I can say nothing was gained from it, I now have to live with haunted memories. I can say it means nothing."

The perceived lack of acknowledgement for the loss of the self to an imago with the system was a pain that gnawed at the participants' psyche. Participant 9 reflected, "The sacrifice and for what were we sacrificing our lives so that we can feel like you are dead inside. Some of us lost our innocence in this." The sacrifice of giving themselves to the system that was unable to hold their psychic split off bits in the form of psychological interventions had left the participants feeling lost in and to the system. Participant 5 acknowledged, "Part of my life you see, 80% of my life is here…and that part of yourself is gone forever. And when this system is done with you, it is done with you forever, it just leaves you like that." The participants seemed to make a distinction between a loss of the self and of life. They did not appear to be distressed with possibly losing their lives in the line of duty in comparison to the pain of sacrificing their families as relational self-objects. Participant 4 explained, "It is part of your job, you sacrifice your life to protect others." Although they still had immediate families, they had sacrificed their emotional role in the family unit and that of their family members within their internal self-object representation. This implied they had lost not only themselves and a place in and with their families, but also importantly meaning in life. This was a factor over which they had no control and that perpetuated the participants' undiagnosed PTSD. Participant 5 reflected:

> That one honestly is like that, if you are a soldier, you can't change it. I know they are afraid of me and I hate that part of it. When I'm there I know it and it stresses me. They don't want to be that close to you. And you feel bad, haai, we are paying the price when it comes to that.

6.2.8.2 Sub-theme: Loss of control and feeling helplessness

The participants experienced a deep sense of feeling disregarded and unprotected, and thus, at the mercy of the system. Participant 5 explained, "Here you are just expected to be on time, be fine, fully fit do your job, after doing your job it's done, you'll see to yourself." These evoked feelings of vulnerability and left them feeling they had lost control of their minds in their inability to integrate their defense mechanisms so as to adjust adaptively to psychological and military demands. This had implications for the participants' loss of psychological stability, meaning in life and future. This drove the splitting off and projection of perceived undesirable discarded parts of themselves, which were perceived as undesirable and discarded by the system, onto others in exaggerated negative mood extremities, especially anger. Participant 5 reflected, "You find yourself working hard but you are left behind in advantages, they are being given to some people, but you don't know how and that is painful."

The negative mood extremities were also turned inwards as manifest in the participants' negative expectations in relation to important aspects of their life including themselves, others and the future. Participant 3 shared poignantly, "…you are just sacrificing yourself, like a lamb to the slaughter which is what most of us have done. No one cares, no one thinks to help us in a way that will make a difference." The participants accompanying persistent inability to feel positive emotions such as happiness, joy and satisfaction was a typical diagnostic feature of PTSD. The participants experienced their basic needs to health as also being disregarded, which rendered them vulnerably out of control of the failings of systemic processes in relation to their needs. Participant 3 acknowledged, "…even if here at work a person is never sure what will happen." This continuous loss of control perpetuated their undiagnosed PTSD syndrome. Participant 6 shared, "You go to the sickbay there are no tablets, you must go ask from another unit and they tell you we can't give you all we are just giving you a little bit to help. Then I keep quiet and say what is going on in this system." Participant 9 thus captured the experience of loss of control linked to a traumatic stress response poignantly:

> They are unhappy and stressed at home all these years of not knowing what will happen. I can say the people on top are careless with the people on the ground, they don't know how to take care of us. So, it is all these stresses really that cause us pain and trauma.

6.2.9 Theme 9: Feelings of shame and fear about symptoms of trauma

Shame coupled with a sense of being a burden when asking for professional help for distressing undiagnosed PTSD symptoms were internalised as being a nuisance to others. This informed the tendency towards inadequate and defended self-reliance and thus, turning away from others. This may have also been attributed to the participants not feeling that they deserved help as a result of an internalised bad object and accordingly, the belief that they, in turn, were inherently bad. This is discussed further in the following two sub-themes: first, shame and fear of being declared psychologically unfit and second, seeking psychological help seen as a weakness.

6.2.9.1 Sub-theme: Shame and fea of being declared psychologically unfit

The participants expressed that they were afraid of admitting to or showing broken or fragile parts of themselves to those within their reporting lines or the mental care practitioners who were charged with dealing with these vulnerabilities. Participant 9 related, "For me maybe seeing a psychologist means my mind is no longer okay, I must be sent to ward 7, I can't risk that." Participant 6 concurred, "I am ashamed of the damage it has done to me mentally and physically." Being in tune with their emotional vulnerabilities as a means to fortify their psychological resolve for the mental and physical fitness required of a soldier, this possible trauma protective factor had become equated with shameful weakness. Participant 4 explained:

> You know, as a person you don't have to reveal your weaknesses especially in this job. So, you can't and once you go there to consult when it is time for CHA they'll say you are not green and then you don't deploy. No, a person does not need that kind of stress.

Therefore, the participants repressed their emotional vulnerabilities maladaptively and thus, forewent the possibility of psychological resolution of their trauma because they feared being declared psychologically unfit and thus, excluded from deployment and promotional opportunities. Participant 2 asserted, "Those sessions will get recorded and your section leaders will know, then you can't deploy or go on courses because it means you are not strong mentally." The participants mirrored the system's inability to look within unashamedly for reparative work to occur regarding integration, which led to a cognitive distortion regarding the importance of psychological well-being, which is the foundational weapon a soldier needs to be armed with. Participant 9 stated, "For me maybe seeing a psychologist means my mind is no longer okay, I must be sent to ward 7, I can't risk that." *Mental fitness* cannot be void of emotional well-being in the same way a *soldier* cannot be separated from the *self*, the ideal being an integrated cohesive self. Participant 5 stated, "It's not a normal way of living, it's like a little torture. So you must keep it in because the way we were taught you don't talk about your feelings." The soldier in the participants was ashamed of the self, which they were instructed to split-off. It appeared that by splitting, the self was wherein the undiagnosed PTSD got located and not in the soldier in the participants. Participant 5 asserted, "We were trained not to say anything, like in interviews and so on. But also no one can know about your stresses because you learn to hide it well with discipline." The defenses of splitting, repression and denial employed by the system and the participants in relation to emotional vulnerability contributed to psychological trauma. Participant 3 acknowledged, "So a person must always put on this mask that you are coping normally for family and at work." It was important for these soldiers to put on a brave facade that masked all signs of psychological weakness, namely, undiagnosed PTSD, which had become a weakness of which to be ashamed.

6.2.9.2 Seeking psychological help seen as a weakness

Seeking psychological help was equated with weakness rather than a phase during which the ego was weakened. The role of psychological intervention was to strengthen it. Participant 9 declared, "No, like stress no, you just have the stress after these happenings and you live with it but not like to go to 1Mil Psych and now start taking medication." This conveyed a propensity to cope in the form of flight from self as explained by Kleinian depressive and manic defenses. The participants' psychic wounds remained hidden from psychological support officers, leaving them to rely on themselves and their impoverished internal resources. Participant 5 explained, "…don't talk about your feelings, it's like exposing my inner weakness actually. You just know like that as a soldier … otherwise this thing will beat you. I can say it is an everyday battle with yourself to keep it away from other people." The negative

emotions that arose from this not only got turned inwards in a self-attacking manner, but also towards the system in its perceived failure as a source of psychic relief or health. This may have manifested in patterns of behaviour, which was interpreted as ill-discipline within the system, which psychological distress and traumatic syndrome have come to be labelled.

It appeared that even those in senior positions avoided enlisting psychological support for their members because they were afraid of being perceived as inadequate, weak and unable to manage their subordinates. Participant 7 noted, "When the problems started no one cared and no one invited a psychologist to come from the beginning, they always want to hide things and look like they are coping with the members but they are not that's the problem." Participant 5 thus explained this from the members' experience: "That is why you find if with management it shows weaknesses they exploit those weaknesses too much, and that makes discipline deteriorate in some other people." This behavioural modelling seemed to perpetuate a cycle of a system with members who functioned at an impaired psychological level, secondary to undiagnosed PTSD. This evidently re-enforced a perception that psychological distress is a weakness that would not go unpunished. The participants, in turn, punished themselves for suffering from it. Participant 8 explained, "It is hard to talk about because in this uniform you must be this tough person but inside you know it is like a graveyard I can say. We don't talk about it all of us." It appeared as though the participants found strength in silently and collectively carrying this perceived weakness, namely, undiagnosed PTSD from traumatic combat exposure from former forces and the SANDF.

6.3 Researcher's reflection

My reflections on the influence of my subjectivity on the data analysis are discussed in this section. This entails a discussion of my interaction with the participants as well as a consideration of how my personal experience may have influenced the data analysis and presentation of information.

6.3.1 Researcher-participant relationship

It is imperative for me to consider how my own interaction with the participants affected the data and its analysis. My interview questions alluded to my position as a clinical psychologist and psychodynamic therapist. Therefore, a patient-therapist alliance was formed with the participants to discuss their experiences of traumatisation and manifest long-term undiagnosed PTSD. My questions may have suggested that the consequence of undiagnosed psychic trauma was functionally impairing in various degrees and that participants needed ways of managing and coping with their PTSD symptom experiences in order to continue with their military obligations. My questions may have allowed the participants to accept the notion of trauma as a lived phenomenon with deleterious consequences on

their overall functioning and consequently, something worth acknowledging and normalising, and not patholigising the self for. Moreover, given that I am a clinical psychologist and understand their position, it could have increased their desire to over-report their experiences with me as I was someone who could understand their position and experiences and possibly help them. My questions and understanding may have drawn the inference that the participants may have suffered from untreated PTSD, from which the second theme, symptoms of traumatic response, emerged.

6.3.2 Impact of my personal experience on the data analysis

It is also important that I highlight that my interaction with the participants as well as my subjectivity may have influenced the data analysis. I was aware of my precarious position as a researcher, given that I was a psychologist in the SANDF at the time, and their resistance to psychological help for their traumatic stress syndrome and consequently, it remaining undiagnosed. I feared that would make them resistant to share their experiences of combat trauma. Accordingly, I may have formed an alliance with them because they possibly did not perceive me as part of the system but invested in helping them. However, the data analysis does adhere to the requirements of IPA and the study highlights the participants' shared diagnostic PTSD features, internal and external conflicts secondary to trauma, struggles in connecting with themselves and others, sense of being damaged, and experiences of the SANDF and deployments were evident in the data. In addition, I explored the data sets for inconsistencies and obscurities in relation to my interpretations and identified themes. This ensured the themes were grounded in the participants' experiences and allowed my personal experiences to add interpretative depth to the analysis (Larkin et al., 2006).

6.4 Summary

In this chapter, the nine participants in this study and the case material from the data analysis of the semi-structured interviews conducted with them were presented. The material uncovered the meaning of the experience of traumatisation and long-term undiagnosed PTSD, as well as various ways in which the underlying and overt symptoms affected these participants' lives and the subsequent way they related to their internal and external world. Nine master themes and related superordinate themes formed the basis of the findings and were presented in conjunction with direct quotations from the participants, which reflected how they made sense of their world. The participants' lived experiences from where they projectively located the perceived perpetuating cause of their unresolved trauma, their lived symptoms thereof, the psychic defenses against distress and functional paralysis therefrom, and the consequent effects on their relational capacity and relationships were presented. In the next chapter, these themes are discussed and integrated with the relevant literature.

CHAPTER 7: DISCUSSION OF FINDINGS AND CONCLUSIONS

7.1 Introduction

In the current study, the subjective lived experience of how Black SANDF members understood and made sense of long-term undiagnosed PTSD from combat exposure from an object relations perspective was examined. The primary objective of the study was to explore SANDF members' experience of consequences of undiagnosed PTSD and the resultant relational, functional and characterological impairment. A secondary aim was to shed light on how the SANDF members made sense of their experiences of trauma and how it had shaped the person they had become. This entailed determining how serving members, with varying of experience, understood and experienced their symptoms of undiagnosed PTSD and what they did to cope with the unresolved trauma. Accordingly, semi-structured interviews with nine integrated Black SANDF members were conducted to generate data for the study. Data were analysed by employing interpretative phenomenological analysis (IPA) so as to acquire an in-depth understanding of integrated members' experience of long-term undiagnosed PTSD secondary to combat trauma.

In this chapter, the master and superordinate themes presented in Chapter 6 are discussed in relation to the literature, which was reviewed in Chapters 2 and 3. However, the active interaction of the researcher in the entire research process and particularly in the interpretation thereof is imperative in IPA. Consequently, it is important to reflect on the impact of the research process on the researcher. Finally, recommendations for future research as well as the limitations and strengths of the present study are outlined.

An integration of master and superordinate themes that emerged from the interviews with the participants is provided in this chapter. As the aim was to examine and reflect on Black SANDF members' lived experience of undiagnosed PTSD secondary to truamatisation, the discussion in this chapter is substantiated by quotations that captured these experiences. An attempt is made to integrate participants' experiences, my own interpretation and reflections, and theory in order to provide an all-encompassing discussion.

7.2 Reflections on the impact of the research process on the researcher

The researcher was part of and not divorced from the phenomenon under study, particularly because I took the position of the primary research tool. I considered my personal feelings and experiences that might influence the study and integrated this understanding into the study to promote objectivity **(**Burns & Grove, 2003). The exploration of my experience made me aware of possible biases and preconceived ideas. Throughout each phase of the study, I applied bracketing to suspend what is known and intuiting,

which involves examining the phenomenon, to avoid bias and approach the phenomenon with an open mind.

In line with the notion of reflexivity, which is recommended in qualitative research, it is imperative for researchers to indicate how their personal involvement in the phenomenon may have coloured the manner in which they collected and analysed the data (Terre Blanche et al., 2006). The awareness that a researcher's beliefs and prejudices play a role in the interpretation of data were taken into consideration. When this inquiry was first initiated, as a researcher, I was influenced immensely by my experiences in the SANDF because I assumed that I was part of the permanent force because at the time I worked in the force as a clinical psychologist. My limited experience of working with infantry soldiers and my elementary understanding of a soldier's psyche in relation to trauma were altered significantly through the course of the research process.

When I started collecting data, I had assumptions that because the topic under study has not been explored within the SANDF despite observations of its manifestation, there would be an element of poor insight and reflective capacity when talking to the members about their experiences. However, my assumptions were shattered because I soon realised that the members could articulate their experiences and conscious psychic defenses employed to cope. The data collection process was emotionally laden and evoked a lot of difficult feelings for the participants as well as for me. In the beginning there was a sense that the participants feared being vulnerable and having their core psychic conflicts exposed. These transference dynamics were partly evident in my tendency not to explore deeper than the superficial in my first two interviews. On some level, I was colluding with the participants' wish to avoid and keep any painful details repressed. However, after reflecting on this, I understood what was happening between the participants and myself. Consequently, I was able to adapt my interviewing technique in order to allay the participants' fear of feeling emotionally vulnerable to create good rapport. In hindsight, I realised that I had initially responded from the part of me that perceived they were fragile and needed protection.

Kvale (1996) argued that a researcher in phenomenology should have a thorough understanding beforehand of information the research intends to elicit. Smith and Osborn (2003) concurred that a researcher ought to be able to structure and plan the process of research in accordance with the information the research aims to extract. Smith and Osborn further explained that interviewing becomes a skill wherein care is taken not to compromise validity while participants are guided skillfully to keep them focused on the scope of the research. Kvale recommended that the researcher compile a set idea for what material is aimed and steer the conversation through skilled but subtle questioning towards these goals.

To elicit rich material from the interviews, I compiled a set of concepts to acquire the psychological meaning from the SANDF members' lived experience of traumatisation and undiagnosed PTSD from an object-relations perspective.

These questions included:

- Can you tell me about event/s in your line of work under former forces where you feared for your life or when something happened that really threatened your sense of safety in returning home safely?
- How have these past traumas been reactivated during deployments and military activities under the SANDF?
- What disturbing thoughts or feelings do you think are responses to these traumatic events that you have been left with?
- How have you tried to cope with these troubling thoughts and feelings?
- What meaning have you assigned to these traumatic experiences?
- In general, how do you cope with other stressors/traumas in your life? Have you ever consulted a psychologist within the SANDF? If so, concerning what? If not, why not?
- Do you think these events have changed or affected your life? If so, please explain.
- Tell me how it has affected you mentally? How do you see or perceive things?
- How has it affected your behaviour or how you do things?
- Has it affected you emotionally?
- Briefly describe yourself after these traumatic events?

During each interview, I listened for this information. If I needed information that was more specific or for clarification, I probed and asked direct questions about the concept being explored. Aspects that were not volunteered spontaneously were probed during the interactive process of engagement. The impact of the interpretative paradigm of constructed reality became prominent in my experience of and during these narratives. I experienced difficulty during the study, but similar to the participants, I executed my responsibilities even though, unknown to others, I was suffering under the most challenging personal circumstances. After engaging with these service men and woman, I experienced the study as exhausting because I shouldered their traumatic distress as well as my own life's difficulties.

My resilience in my capacity as both a researcher and human being was enhanced during the study. My urgency to develop psychologically integrating and healing programmes in the SANDF was highlighted as part of my journey of service to our country and to these brave men and women. As much as I conducted the study to make meaning of our Black soldiers' traumatic experiential reality, the

process mirrored my traumatic experiences back to me, which I had to process in an integrated manner. This process was both an academic and personal undertaking. The emotional distress these service men and woman carried still echoes deeply in my being. I believe that if this research contributes to the body of literature on undiagnosed combat trauma and facilitates the development of programmes to help serving members shift to a more integrated sense of self, I will perceive it as a cathartically meaningful contribution.

7.3 The experience of long-term undiagnosed PTSD from an object-relations perspective

In this study, the participants were asked to share their experience of traumatisation and long-term undiagnosed PTSD syndrome, secondary to combat exposure from statutory and non-statutory warring armed forces as well as during service within the SANDF. This was extended to their lived experience of the syndrome physically, cognitively, functionally, emotionally and relationally as well as on their sense of self from an object-relations perspective. Themes that emerged from the interviews conducted were presented as findings in the previous chapter. The interpretative nature of IPA, particularly the critical and empathetic hermeneutics employed during the analytic process, afforded the researcher the opportunity to explore a group of Black SANDF members' experience of the system as traumatising and perpetuating the psychically disintegrating impact of their undiagnosed PTSD in detail (Finlay, 2008). The symptoms of PTSD appeared to be exacerbated by continued traumatisation from the perceived lack of holding and misattunement within the SANDF, which reinforced maladaptive repression and denial of symptoms and thus, the ego was further disintegrated. This may underlie a psychic organisational structure erected around a perceived impoverished bad self and self-object relations, and a deployment of maladaptive defenses to protect a fragmented self as manifest in functional impairment. Kashania et al. (2014) and Vaillant (1976) noted that immature defenses characteristic of character disorders include fantasy, hypochondriasis, acting out and passive aggressive behaviour; this concurred with the behaviours observed among the participants in this study.

Although each theme is discussed separately, it is noteworthy that the nine master themes are interrelated. The central theme *ego disintegration* is discussed first because it served as a golden thread that was not only constructed by the participants, but was also an overarching link between several themes as a disintegrative core conflict underlying PTSD syndrome.

7.3.1 Ego disintegration as a central theme

The experience of ego disintegration emerged as a dominant and powerful unconscious psychodynamic conflict perpetuated by long-term undiagnosed PTSD. In constructing this account, the participants narrated the experience of the process of integration as a camouflage for the psychic wounds

from warring activities of former armed forces. This seemed to perpetuate the participants' pattern of suffering as manifest in the raging internal conflict with the self and within the system. A disintegrated, weakened or deadened ego is suggestive of stunted psychological development and therefore, a cohesive self. This thrust the participants into a defeating shell of loneliness that robbed them of the emotional and cognitive capacity to connect and thus, form part of any system. Purcell (1996) expanded on this with an account of the dual wish to protect and be protected. However, when these protections fail, the soldiers developed a sense of primitive abandonment, guilt and loss. This irreversibly split them into the person they were before who believed in relatedness as well as the people they became after the trauma who were inconsolable and totally alone.

Most of the participants alluded to feelings of helplessness and hopelessness in relation to not being integrated in the SANDF, family and society. This was also extended to not having an integrated or cohesive sense of self as a civilian and a soldier, with implications on how they defined themselves. The *person* who they were, the self, became devalued. The was in line with the notion of being trained to be a *soldier first and a person behind* and possibly the inability to deploy adaptive mental processes to protect and conserve an integrated sense of self in the face of trauma. This was underpinned by the identification of principles such as diffusion in the sense of being *split* into a soldier and a victim, chronic unmet needs for mirroring and idealising, and vulnerability to self-fragmentation experiences (Kernberg, 1980).

The notion of an ego conflict (*Ich-konflikt*) between the peace ego and the new war ego was developed by Freud (1981) and further expanded by Simmel (1994) who underscored the importance of the type of traumatic situation and made a distinction between traumatic neurosis in peacetime and wartime. A notable difference was bound to the fact that the soldiers developed a *military ego* as a consequence of functioning in a military unit. This dictated a change in their civilian superego and the development of a type of child-parent relationship with their superiors, which implied regression. Their superiors would assure them of protection and guidance in a situation that was both unknown and dangerous. If this was accompanied by disappointment, soldiers experience abandonment in the same manner as children when abandoned by their parents. According to Simmel, this subsequently becomes a precipitating cause for a traumatic response due to loss of an inner protective agent. The outer, dangerous situation becomes overwhelming. Simmel also placed emphasis on the other in the traumatising process and foreshadowed modern object-relational perspectives on traumatisation (Laub & Podell, 1995).

Wolf (1998) suggested that during adolescence and young adulthood, de-idealisation of parental self objects occurs. Adolescents and young people tend to turn to subcultures and heroes of cultural history for the much-needed self object sustenance. This resonates with some of the various reasons and

meanings for which Black SANDF members, in the early stages of their lives at the time, may have taken up arms under their different non-statutory and statutory forces. Wolf further explained that military and combat life disturb this developmental requirement consequent to failure to provide healthy cultural values and heroes for idealisation in relation to the need to reintegrate back into broader society. Participant 5 explained, "I would have to now integrate into society which I don't know how. I don't know the way of life outside of this. I'm a visitor to the outside. I don't have the surviving skills required outside."

In this study, it was apparent that the conscious disintegrative splitting of the self and the participants' internal conflict in response to trauma was experienced as a psychological triumph of their survival with undiagnosed trauma. The literature has revealed that the ability to regulate internal states and behavioural responses to external stress defines both people's core sense of self and their attitude towards their environment (Van der Kolk et al., 1996). When difficulties in obtaining and sustaining good object-relations are too pronounced, human relations are approached with great anxiety and conflict. Therefore, desperate attempts are made to deny this basic need as evidenced in the participants' relational patterns (Guntrip, 1968). The maladaptive psychic defenses employed to defend against intolerable underlying anxieties and feelings disintegrates the ego, which thwarts working through past and current traumatic experiences. The findings of the study demonstrated that the more unyielding and neurotic the participants' character traits were, the more they revealed that a past pathogenic internalised object-relation had become fixated into a character pattern and thus, its defenses (Kernberg, 2004). Honing et al. (1999) noted that the most crucial long-term impact of trauma often takes the form of persistent character traits that may have originated as coping responses to trauma. It appeared that the participants' disintegrated ego secondary to trauma impaired their ability to resolve trauma through adaptive ego defenses, thereby fixing long-term patterns of psychic suffering into distressing character traits. The themes generated from the interviews with the nine participants are subsequently discussed.

7.3.2 Discussion of main themes

The themes are discussed in relation to the object relations theoretical framework and existing literature on PTSD. The master themes were: SANDF as a traumatising system perpetuating PTSD; undiagnosed PTSD symptoms; failed psyhchic integration of trauma characterised by psychic splitting and numbing; impoverished relational patterns; impaired emotional connection with family; employing psychic defenses to cope with symptoms of trauma; loss of overall well-being; and feelings of shame and fear about symptoms of trauma.

7.3.2.1 The SANDF as a traumatising system perpetuating PTSD

The first theme is related to what trauma means to the participants. One of the research aims was to understand how they made sense of their experiences of trauma. All the participants acknowledged their experiences within the SANDF were retraumatising, thus evoking past traumatic experiences and in essence, perpetuating symptoms of PTSD. The participants blamed the SANDF for their trauma in defense against attacking the self for having developed PTSD and the associated shame thereof. This may also be linked to the preceding discussion on internalising superiors' failure to protect and guide those under their command in dangerous military activities. On the contrary, Gabriel and Neal (2002) suggested that although combat may be a factor in the development of psychological distress, the experience of noncombat trauma may play a more salient role in the development of PTSD in this population. For the participants, the non-combat trauma formed part of collective traumatic experiences, which rendered the SANDF a traumatising system.

It appeared the unresolved and thus, chronic traumatic stress syndrome had regressive implications on their psychic organisational structure. This may have possibly hindered their process of psychological development towards organisational and psychological integration, and thus the experience of the SANDF as *lacking in organisational structure and thus, environmental holding*. The findings suggested that the military as an object had been introjected as traumatising rather than integrative possibly due to the participants' transference of unresolved past traumatic experiences onto the SANDF. The participants' expectations of a fulfilment of unmet maternal needs on the SANDF is suggestive of arrested self-object psychic development. This may also be interpreted as a lack of introjected good objects to strengthen internal resources against impairing traumatic syndrome.

Jacobson's (1959) contribution to the theory of trauma illustrates the process of regression as a result of a traumatic experience as well as the effect of trauma on the sense of self. Jacobson posited that due to the experience of trauma and the resultant narcissistic regression, the patient's initial self-representations, organised in accordance with a healthy sense of self-respect, are altered to form new self-representations based on a painful sense of self as worthless and humiliated. This was evident in the participants' experience of not being nurtured and thus, held by the organisation. Participant 1's statement "…but still I haven't received a promotion, my things are just stuck" was indicative of feelings of worthlessness and narcissistic injury. It was apparent that certain expectations that stemmed from assumed progression from former force activities had not been fulfilled by SANDF. The following assertion from participant 1 is suggestive of not only occupational, but also psychological frustrations transferred onto the SANDF that were inherent in the process of integration: "Then they tell you we've come to inform you that the general says this and that, when we must ask about matters such as our ranks from APLA (outside experience) which were held back, it is not open for discussion." This may

be interpreted as a cry of distress that was not only unheard, but also not met with soothing psychical and structural holding.

Winnicott (1958) coined the term *ego-relatedness,* which is a positive state that is derived from trusting that the world is safe and reliable. This study revealed that not only did the participants not trust their former forces, but did not trust the SANDF either. This led to decompensation into ego disintegration as a result of the SANDF's internalised continued trauma. As gleaned from participant 3's experience, "It's a little trauma even if you ignore it, you see but it's traumatising. They play mind games. Haai we are paying the price when it comes to that." These systemic *traumas* were experienced as not only perpetuating undiagnosed PTSD symptoms, but as risk factors of compounded traumatic stress from combat exposure while in deployments.

The literature has suggested the split non-assimilated parts comprise large fragments of experience and fragments of object relationships directly related to trauma in those who have survived extreme traumatic experiences, similar to the participants in this study. This encompasses basic trust, a sense of belonging and a re-examination of the meaning and value of institutions. Therefore, externalisation through re-enactment of traumatic events serves a function of gaining control over the traumatic experience and traumatising bad internal objects (Fenichel, 1941). There appeared to be an element of dependence and expectation on the system to repair past traumatic psychological impingements from the previous armed forces, which reinforced a part-relating experience of the organisation. The literature has found that part-relating of the infant toward the breast of the mother as a primary object entails splitting it into two distinct parts that are either good and satisfying or bad, frustrating and persecutory (Duckham, 2011; Kavaler-Adler, 2014; Potik, 2018; Summers, 2014). Unable to deal with its own innate destructive and aggressive drives into annihilation or integrate the good and bad parts of an object as a whole due to an immature ego, an infant resort to primitive defense mechanisms, as evidenced by the participants in this study. This could explain why the participants' understanding of trauma was located in the SANDF and primitive injuries experienced from the failure of perceived environmental and psychic holding of their disintegrated psyche as a result of undiagnosed PTSD.

Most of the participants perceived being discriminated against based on their former force allegiance prior to integration. This perception was exacerbated by the fact that they believed that the former MK members were promoted to higher ranks while those in the other former forces were overlooked. The participants also felt abandoned by their former forces to a system they could not trust despite the sacrifice of laying down arms for national unity. Feelings of abandonment coupled with mistrust left all the participants feeling disillusioned, demoralised and resentful towards integration into a unified defence force. As reported by participants 3: "Now with promotions you struggle because your force number indicates that you are former SADF, so it is like the system is against you and your fellow

members on the ground too." In a potent description of the debilitating effects of trauma on service men, Kardiner and Spiegel (1947) posited that new adjustment is erected on the ruins of what was once a rich reciprocal relation to the outer world. The ego is left impoverished, which results in a detrimental effect on the ability to work, disorganisation, emotion and impulse dysregulation, lack of confidence and paranoia, because the external world becomes a hostile place and the subject feels in constant threat of being overwhelmed by it. This was manifested in the collapse of the participants' capacity to negotiate their relationship with themselves, the world and in essence, the SANDF. The SANDF lent itself to an organisational integration of ruins of psychic structures secondary to past military traumas and adjustment, which involved a constant reminder of past traumas and thus, a perpetuation of PTSD symptoms. It was not only a psychic reactivation of unresolved trauma that elicited feelings of mistrust, paranoia and victimisation for the participants, but also a painfully undeniable reminder that the SANDF was formed from the organisational ruins of SADF, a source of traumatic combat exposure.

Most of the participants were of the view that military proficiency had been sacrificed in an act of political expediency. Ironically, this was at the core of the reactivation of the former forces' psychological distress as all the participants experienced the organisation as being victimising. The former SADF members and those of former forces experienced feelings of despair, hopelessness and helplessness, which perpetuated mistrust towards the organisation. However, due to the mistrust not only of the organisational structures, but also of each other, the integrated members did not know that they harboured common underlying fears and feelings. These underlying anxieties and hidden feelings necessitated psychic defenses, which made the course of the PTSD syndrome more deleterious. Participant 5, a former SADF member, reflected, "So it's easy to discriminate because of our force numbers when it comes to courses and promotions. It's just a mess." The participants' shared feelings of mistrust of the organisation may have suggested that what unconsciously integrated them was the pain they perceived the SANDF inflicted.

The same manner, in which the participants felt under attack from their traumatising internal objects, the *SANDF too, cannot be trusted* as distressed and unintegrated parts of themselves felt attacked. In essence, they could not trust the system with vulnerable parts of themselves, which reinforced the need to conceal their PTSD symptoms. As indicated in participant 7's statement: "That is what I said, then the Colonel refused to sign and made a comment that no I have to state all the reasons. But I said I've stated the reason that I'm not emotionally okay, that word it says a lot there are a lot of things you understand then we fought for that."

This was also extended to transparency about decisions involving the use of force participants may have used to save their lives when in the line of danger during deployments. This exacerbated their undiagnosed PTSD symptoms, as these became traumatic experiences that could not be integrated and

therefore, not made sense or meaning of. This concurs with the literature in that impairment in a soldier results not only from the loss of transitional objects, but also the loss of faith in traditional authority figures, which the SANDF as an organisation may be internalised as. This results in vulnerability to regression and/or seduction by archaic internalised superego role models (Haley, 1993). In this study, the participants' regression may have been linked to former force structures towards whom feelings of abandonment and repressed anger were harboured as they found themselves in a system that was blaming and rejecting and therefore, could not be trusted with the integrity of the self. However, these feelings had to be repressed and defended against because the possible acceptance that former force authorities should not be trusted would have left the participants void of any internalised objects and superego role models.

Fairbairn (1943/1986) asserted that separation-anxiety is intensified by the separation of dependent individuals from their objects while in the military, a condition that is reduced in totalitarian regimes that exploit infantile dependence and make individuals dependent on the regime. However, in democratic societies, soldiers are less able to transfer dependency onto a regime or military organisation and suffer more during separation. The participants' suffering of separation from their former forces was not afforded an honest psychological space/experience and thus, possibly the projection of dishonesty about everything related to the SANDF. Van der Kolk et al. (1995) found that the effects of a traumatic experience on people's perception of themselves and the world around them should be unpacked to restructure trauma-related schemes of internal and external reality. It was apparent that there needed to be a deconstruction of the process of integration and the SADF administrative structures under which it would incorporate the non-statutory forces. This failure in transparency meant that members of forces who felt their own political structures were dishonest and psychically injurious in leading them into the integration process were absorbed into the SANDF, thus transferring this experiential reality onto the integrated force. This possibly meant that it was difficult for all former force members to be honest about possible psychic traumatic syndrome from former force military activities. Members may have felt thrust into a structural defense against a perceived bad object with a foundation of perceived dishonesty, which may also have translated into a psychological dishonesty with themselves about their symptoms of trauma. This was evident in members feigning good mental health status and suffering silently from undiagnosed PTSD for fear of persecution and perceived devastation to their military careers. Because of the perceived inherent dishonesty of the system, the participants experienced difficulty operating in a structural and psychological space of mistrust, which perpetuated underlying enduring undiagnosed PTSD syndrome. As reflected in participant 4's statement: "Because they become like skeletons in your closet and when they come out you can become an animal living either in fear or anger that is too strong I've seen."

The participants' residual symptoms of PTSD, which were undiagnosed prior to the integration process, were pertinent in colouring their experience of being in the SANDF. Therefore, the organisation was introjected as a bad object and identified with their bad introjected objects. As noted previously, the paranoid-schizoid position postulated within a Kleinian framework of object relations is characterised by part-relating of the infant toward the breast of the mother as a primary object, thus splitting it into two distinct parts that are either good and satisfying or bad, frustrating and persecutory (Duckham, 2011; Kavaler-Adler, 2014; Potik, 2018; Summers, 2014). The mechanism of projection is employed as a defense in an attempt to assuage the anxiety that the infant experiences internally. Feelings of aggression are projected onto the object; this projection leads to a phantasy of the bad object (Quinodoz, 1993). The distorted image of the object or the phantasy is experienced by the infant as real. The object is perceived as dangerous with the ability to retaliate and harm the infant. The SANDF was related to as a persecutory primary object with real or phantasised harm being exacerbated by the participants' unresolved symptoms of trauma. Past traumatic injuries appeared to get re-activated by perceived frustrations within the SANDF as the distress therefrom became interwoven with those from cumulative traumatic experiences. The external persecutor is also internalised by means of introjection and becomes the internalised bad object (Quinodoz, 1993). Thus, simultaneously through the mechanisms of projection and introjection, the persecutory object becomes threatening from both within and without. However, because of this unconscious defense, *the SANDF becomes the persecutory bad object* to whom all psychic trauma was defensively attributed. The organisation was experienced as more brutal on the psyche than being on the battlefield. This experience was captured by participant 7: "They just add on to the damage in people's mental wellbeing. We are a sick army and nobody cares." A sentiment echoed by participant 8: "So, before you even come in contact in the battlefield the organisation has already put stresses on you. It is like the inside is more torture than fighting out there. Unlike other soldiers we go out there already with injuries mentally you see."

According to Duckham (2011), the subsequent defenses drive the cycle of projection and introjection, which serves to defend the ego against irreconcilable trauma as manifest in persecutory anxiety stemming from the persecutory bad object. The participants' anxieties were projected onto the SANDF as the organisation perceived to be responsible for them. There appeared to be unmet primitive needs that could not be reconciled with the militant regime that informed the structure of a statutory force. However, the participants were not aware that they would be unable to feel structurally and psychically safe within the SANDF if past psychological ruptures resulting from their previous forces were not healed. The literature has revealed that individuals who have been traumatised and carry much shame often form a split between the idealised projected self, namely, the strong and proud survivor and the essentially deficient or shameful authentic self, which is believed to underlie an inauthentic projected persona (Herman, 1997). The masked authentic self that is so bad, so shamed deserves being meted out

with punishment. This may explain the participants' feelings of persecution in response to every action taken by the SANDF from an organisational perspective.

Constantly feeling under psychic attack in the SANDF led to many participants feeling extremely hyper-aroused, which exacerbated this symptom of undiagnosed PTSD, which meant that they never realised stillness or *going-on-being*. This feeling may be described as "a profound sense of belonging, a being at one with his world which is not intellectually thought out, but is the persisting atmosphere of security in which one exists within himself" (Guntrip, 1995, p. 240). This is particularly evident with hypervigilant traumatised individuals whose brains and nervous systems pick up signals of threat unconsciously to which most people are oblivious (Tarter et al., 2009). The participants may have located their psychological distress in frustrated promotional and monetary incremental needs despite the fact that they were aware that they concealed their traumatic stress syndrome as manifest in their mood, physiological and behavioural disturbances. This split-off perceived badness in the self was projected onto the system as the bad breast incapable of gratifying their needs. The SANDF may have inherited members with existing frustrated needs, which had been transferred as promotional frustrations and feelings of being discriminated against, which became re-introjected as a bad self-object relational experience. This, in turn, may have resulted in the apportioning of blame and responsibility, which subsequently often became the central issue rather than the trauma itself. McFarlane and Van der Kolk (1996) found the issue of blame to be extraordinarily convoluted. Trauma evokes emotional reactions and one way of dealing with these intense emotions is to look for scapegoats who may be held responsible for the tragic event; in this case the SANDF.The participants' experience of the SANDF as a bad breast highlighted an unconscious need for emotional feeding so as to heal psychologically. The lack of promotional advancement may also partly have been perceived as persecution on the SANDF's part. The participants may not have been able to perceive and thus, introject any good from the SANDF due to underlying persecutory anxieties that may have stemmed from a bad persecutory breast experience from former force structures. Klein (1946a) and Anderson (1992) posited that the infant's phantasised attacks on the external object, coupled with fears that the object is retaliating in return, are experienced as violent and bad in their entirety. This internal conflict may have further complicated the presenting clinical picture of PTSD symptoms among the participants.

When the psychological distress became overwhelming and manifested behaviourally in symptomatology consistent with complex PTSD, the participants were understood to be ill-disciplined and treated accordingly. This concurs with findings that the amount of traumatising combat exposure is indicative of exacerbated PTSD, which could be linked to poor social and occupational functioning (Tanielian & Jaycox, 2008). This may also explain why members from the infantry bases were reportedly cognitively, emotionally and functionally impaired, which was exacerbated by their chronic

substance dependence. According to Young (1995), the behavioural pattern of PTSD sufferers becomes increasingly detached or estranged and is frequently aggravated by related disorders such as depression, substance abuse and problems of memory and cognition. The disorder often results in impairment in the capacity to function in social or family life, which more often than not results in occupational instability. Van der Kolk (1987) made reference to the direct association between trauma and poor affect regulation, inclusive of modulation of aggression and impulse control. Trauma survivors often overreact to slight stressors and have difficulty calming themselves in stressful situations. As they are easily overwhelmed by their affective responses, they are likely to manifest with external aggression (Luxenberg et al., 2001).

The participants hinted at a lack of clinical rigour, which was experienced as a *lack of attunement* in connecting manifest symptoms at any given time with feasible underlying post-traumatic stress syndrome despite awareness of their combat history. They experienced empathetic failure by those who were supposed to look after their psychological well-being as they did not appear to be attuned to the psychological pain they bore, despite the defenses they employed. Anderson and Winer (2003) noted that Winnicott posited that the false self develops when the child is attuned to the caregivers, rather than the caregivers being attuned to the child. Furthermore, the manifestation of the false self is an act of compliance and an intimation of a wish to be loved. The mother's capacity to understand her infant through attunement is imperative because interference in the process will affect the infant's ability to symbolise (Charles, 2006; Hinshelwood, 1994; Krueger, 2001; Lane, 2002; Ritvo, 1984; Schwartz, 1986). The process needed for symbolisation permits the infant to create a transitional object, an object of psychological comfort (Winnicott, 1974) from the illusion of good mothering (Hinshelwood, 1994). Accordingly, when an adult experiences psychic trauma, the incapacity for symbolism can result in global dissociative difficulties across areas of cognitive, affective, somatic and behavioural functions.

It was apparent that when psychological programmes were implemented, they were not in attunement with the core traumatic pattern of suffering the members had to endure and were thus, resented as being conducted for departmental statistics and not for the members' well-being. This perpetuated lack of trust in one's objects (Winnicott, 1965) as manifest in the PTSD symptom of emotional detachment. The participants perceived that the very people who were supposed to be trusted to map the terrain for them in relation to their psychological pain let them down and were viewed as possible gatekeepers to their deployment opportunities. Participant 6 articulated this unequivocally: "There is nothing now when you come back you just take leave and go home. Before you go the CHA also does not prepare you for what you gonna find there. I can pretend to be positive for CHA cause I want to deploy, and then I'm green and go knowing how I feel inside." In accordance with previous studies, the findings revealed that despite exposure to highly stressful or traumatic events as well as significant distress and impairment

resulting from PTSD, the majority of military personnel do not seek help. Fears of disadvantageous career consequences, somatisation of psychiatric symptoms and stigmas associated with mental illness in servicemen and unit leaders alike may delay the presentation of PTSD in clinical settings (Gabriel & Neal, 2002). The danger is that although members are deployed, they are not psychologically fit to be there and therefore, they collapse psychically under added stressors while on deployments. One of the participants reported breaking down psychically during a deployment and received no support from his commanders, which led to him threatening to harm them if they did not allow him to return home. Solomon and Horn (1986) found that the more support an officer was afforded from fellow officers, supervisors and administration, the less post-shooting trauma occurred. Despite incidents of psychological disintegration in deployment areas, the responsibility was left to the members to acknowledge that they were suffering from traumatic stress syndrome and thus, request psychological help. As these individuals continue to get deployed, studies have shown diminished mental or physical health status before combat deployment is strongly correlated with an increased risk of new onset of PTSD symptoms after deployment (LeardMann et al., 2009).

Colluding with the participants' conscious and unconscious defenses was experienced as inadvertently perpetuating living with undiagnosed PTSD, which had almost become a norm. It is possible that colluding became a way of coping for those in positions of authority as accepting participants' distress from symptoms of unresolved trauma required commanders to examine their own internal world and their own trauma too. Therefore, it may also have been in the service of the commanders' psychic defences to dismiss the participants' traumatic experiential reality. Acknowledging the participants' psychic trauma would have entailed them to acknowledge that they too may have had certain traumatic syndromes even though they may have been less affected than the participants. The participants may have been perceived as weak and a liability. Consequently, after an initial period of compassion, they became vulnerable and were singled out as "parasites and carriers of social misery" (McFarlane & Van der Kolk, 1996, p.35). In this study, the participants carried the collective misery of trauma of the armed struggle involved in the political history of South Africa. It became somewhat of a coping mechanism to dismiss the participants' psychic wounds to which they responded with the maladaptive employment of psychic defenses such as repression, splitting and denial to assuage intolerable distress.

Given the political undertones that underlay the participants' post-traumatic stress response, there was an inclination amongst mental health practitioners not to bring up any political sentiments within the system. This further perpetuated colluding with the maladaptive defenses employed and compounded the difficulty in diagnosing the PTSD syndrome with which the participants presented. Shay (1994) highlighted the subtle phenomenology of PTSD symptoms and posited that PTSD

symptoms were easily confused with those of other disorders, resulting in misdiagnoses historically. According to Van der Kolk (1987), there is a predilection to miss the diagnosis of delayed PTSD syndrome. This was revealed within the SANDF as participants' lived experiences were a clinical description of PTSD diagnostic criteria. The impairing effects of which the participants began to admit to themselves that they had a problem remained within and with them. The participants may have increasingly begun to realise that their internal resources were depleted and may have been in need of psychological support, but the system's collusion with their defenses exacerbated their trauma. It appeared that the participants may have become receptive to help if they were intuited and thus, felt seen and met at their point of emotional distress. This would have helped them to begin to trust in the safety of the presence of another, thereby creating a facilitative space wherein to resolve and heal from the psychic wounds of long-term PTSD.

The literature has revealed the occurrence of later life stressors or traumatic events has been shown to increase the likelihood of military personnel developing PTSD in response to a prior traumatic event (Andrews et al., 2009; Frueh et al.,2009). Therefore, even though the participants' traumatic experiences were in the past, they always responded to current stressors or trauma with the intensity of psychic traumatic stress responses from past trauma as these were the source of original trauma that never found expression or resolution. According to Freud (1926), there are numerous paradigmatic traumatic situations that are inherent to the development of each person. These situations give rise to overpowering helplessness, which is the basic traumatic situation to which all other traumatic situations relate. As a result of the lack of treatment of trauma from previous political military experiences, current traumas activate past traumas thus ensuring their course of PTSD is chronic. In addition SANDF members present with a proclivity toward violent behaviour, as shown in other studies in Africa (Jones, 2012). According to Klostermann et al. (2012), these enhanced violent reactions can be particularly associated with the hypervigilance symptom cluster of (combat-related) PTSD. In accord with this, in a study conducted in the DRC by Hecker et al. (2013), results indicated a relation between war-related trauma exposure and current (reactive) aggressive behavior as mediated by PTSD symptom severity and appetitive aggression.

The following theme, namely, undiagnosed PTSD symptoms provides an answer to the following research question: *What kinds of traumatic responses do members experience as a result of past and current traumatic combat exposure?* When asked about their understanding and experience of traumatic responses, the participants provided lived diagnostic features of PTSD, along with the defenses they employed to alleviate the disturbing thoughts and feelings.

7.3.2.2 Undiagnosed PTSD symptoms

The participants' experience of disturbing thoughts and feelings in response to traumatic combat exposure revealed clinical presenting complaints of PTSD symptoms. These symptoms were not residual despite some of the traumatic experiences having occurred during past former force activities. The trauma became continuous and thereby chronic, possibly because of the nature of the participants' military duties. Surviving to live with undiagnosed PTSD not only exacerbated the symptoms, but also stirred up conflicting feelings about having survived at all. Participant 5 shared the following:

"A person can't talk a lot about it but in such situations, people die and you also end up handling dead bodies to get them back to your camp. Ja, as a person you don't know how you survived it, you ask yourself why and that thing keeps coming back to you. You prepare yourself to do whatever it takes to survive. You don't want reminders after that because they bring everything back like you are experiencing it again."

It appeared that the participants found themselves in a double-bind in relation to *guilt of having survived* as well as doing what was necessary in order to survive. There may have been an element of a death wish in the re-enactment of trauma in repeated combat exposure opportunities, almost as though they had not wanted to survive. Fairbairn (1943/1986) asserted that the ongoing guilt that many soldiers may present with attests to the difficulty of removing the conflict between internalised good and bad objects as well as the incapacity of this defense to resolve the conflict between the internalised killer and the good soldier ideal. One may ask whether they possibly felt that physical death would have been preferable to a psychic death with which they lived and that was erected on a deadened internal world and ego. Purcell (1996) expanded on the double wish to protect and be protected, and how when these protections fail, soldiers develop a sense of primary guilt and loss. Freud (1957) stated that in addition to the impact of the traumatic event is the task of mourning, for others and for the self: for the person's own lost world, pre-trauma life and identity, and guilt feelings. Freud also compared the fear of losing one's own life to the fear of taking someone else's life.

This suggests that participants may also have been traumatised by the violence meted on others and bore the conflict of being both the victim and perpetrator of traumatic violence. Consequently, the participants' psychic pain comprised traumatic guilt and traumatic fear. Van der Kolk et al. (1996) noted the compulsive re-exposure of some traumatised individuals to situations similar to previous trauma. Taylor (1998) explained that premorbid motivations clearly influence the rate of self-exposure to traumatic events and vulnerability to PTSD. Freud (1920/1955b) posited this repetition compulsion may have been linked to mastering the anxiety produced by exposure to the traumatising experience. The participants' re-exposure through continuous deployments may have been an attempt at mastering their

perceived *weak* response to trauma in the hope of no longer suffering a traumatic stress response to traumatic combat exposure.

It may be interpreted that the participants may have felt that upon re-exposure to a traumatic event, they may have mastered their traumatic stress response and therefore, restructured their psychic organisational structure. This was in the hope of ridding them of their PTSD symptoms and accompanying intolerable distressing emotions, which afflicted them during their waking and sleeping states. Freud (1955b) posited that anxiety dreams are rooted in the patient's compulsion to repeat or the unconscious urge to return to the experience in which the pathogenic trauma occurred. He stated that dream anxiety is paramount as it attempts to anticipate, be it retrospectively, the danger that precipitated the trauma. However, these dreams ironically were experienced as re-traumatising and thus, were avoided by the participants, making sleep an unconscious battlefield for them.

During the participants' sleep, they relived traumatic events when their psychic defenses collapsed. Sleep became terrifying as the participants were thrust back into the depths of traumatic despair of unresolved traumas from pre- and post-integration. The participants fought this resurfacing of traumatic events, unaware that it was an unconscious process of psychic integration. This became yet another shame that had to be dealt with in isolation through maladaptive mechanisms of avoiding sleep or overstimulating the mind with the hope of falling asleep. Participant 7 thus conveyed this: "You see a lot of us have troubles with sleeping we always want something to relax the mind before you sleep." It was apparent that there was no escape from their psychic distress. While they escaped during the day, they were reacquainted with their unintegrated traumatic experiences and the rawness of their emotions at night. Young (1995) observed that persons with PTSD oftentimes relive the experience through nightmares and flashbacks. They report *difficulty in sleeping,* as was apparent with the participants in this study.

The participants described their disturbed sleep patterns as a sleep sickness clustered with other sicknesses, they reported they were suffering from as a result of military experience. It appeared that the participants were able to acknowledge their traumatic response syndrome in this symptom as the traumatic fear it evoked could neither be abated nor denied. Although there was a collective awareness of persisting PTSD symptoms in relation to military service prior and post integration, having to serve and survive carrying out their military duties as though asymptomatic seemed to have been internalised. This manifests in soldiers being deprived of recognising and defining their own inner experiences and the self thus becomes vulnerable, fragile and phenomenologically empty (Le`na`rd & Te`nyi, 2003). These inner experiences cannot be repressed forever because this would mean permanent emptying of the psyche. It is possibly in the stillness of the mind and collapsed defenses during sleep that the psyche attempts to refill itself, which cannot be done without reconciling the traumatic psychic content. These

deficits and thus depletion in the structure of the self may be a predisposition to a decompensation into a traumatic stress response trajectory that soldiers endure.

Trauma is usually linked with intense feelings of humiliation: to feel threatened, helpless and out of control is an incisive injury on the capacity to be able to rely on oneself. Shame is the emotion that is consistent with having let oneself down (Van der Kolk, et al., 1996). *These dreams,* more specifically nightmares are kept from fellow soldiers and partners where possible as the terrifying emotions they elicit may *evoke humiliation and shame.* The participants may have perceived the failure to gain mastery or obtain psychic triumph over traumatic distress in their dreams as suggestive of being inadequate and damaged. Freud (1955a) conceded that those experiencing traumatic neurosis have almost no control over the experiences of their memories. Consequently, memories are given expression during the unconscious dream state. Therefore, unlike anxieties or fears, trauma cannot be directly addressed by the individual. For those suffering from traumatic neurosis, such fright, as referred to by Freud, occurs most often through the repetition of dreams that return the individual to the moment of trauma. As participant 3 explained: "Sometimes you find you don't think but you have these dreams of things that happened in the past you forgot about and you ask yourself why do they not go away for ever?" Young (1995) reiterated those suffering from PTSD oftentimes relive the experience through nightmares and flashbacks.

The participants' difficulties with sleep were experienced as a sickness linked not to an inability to sleep, but an avoidance of emotional engagement with their traumatic experiences in the dream state. Bion (1967) explained that dreaming as unconscious emotional thinking is required to transform the primitive emotional experience into something that can be thought, known, felt, suffered and eventually repressed. Bion (1970) added that an inability to dream an emotional experience places the psyche in an intolerable emotional disturbance that has to be acted out and expelled through defenses of projective identification, somatic disorders, addictions and perversions. These defenses and especially attempts to alter mind states through substances before sleep so as to escape their dream state and thus psychic digestion of their trauma were evident amongst the participants. Bion's (1962) theory of thought explains how sensory experience is transformed by a certain function of thinking (alpha function) into mental contents, which comes to be the furniture of dreams and is suitable for further mental digestion. An individual's inability to think about an event and during which thinking about the event becomes the event itself is a feature of post-traumatic conditions. Sufferers usually do not dream; if they do, their dreams are a reliving of real events, unchanged by the work of the dream, as evidenced in the participants' experiences. According to Bion (1962), what is referred to as an attack on the mind's linking function is the mind's attempt at survival when threatened by an overwhelming emotional experience in the inability to dream; this too was revealed in the attempts of the participants' psychic

defenses. However, when the traumatic material is denied expression and thus, resolved in the unconscious state, it is propelled into the conscious state through disturbing memories over which the participants expressed not having control.

A common anxiety among participants was related to *intrusive memories* or thoughts, which were indicative of the presence of undiagnosed PTSD, a distressing experiential reality even years after the traumatic events. Laufer, Frey-Wouters, and Gallops (1985) revealed a relationship between experiential aspects of war stress and PTSD symptoms. They found that combat exposure results in higher rates of intrusive imagery, hyper-arousal symptoms and re-experiencing effects. The imagery surrounding the experience often preyed on these men for years in dreams and memory. These memories were a persistent affliction for the participants because they experienced the same psychic reality and pain as when they occurred during military service under the former and current force. This compounded their internal conflict as PTSD symptoms also include a multitude of understated qualities that are difficult to articulate, for example, loss of effortless and confident control over perception, memory and thought, which is an essential part of feeling sane (Shay, 1994). According to Ellenberger (1993), the traumatic memory takes on the form of a pathogenic secret. Moreover, such memories are pathogenic because they are reputed to be the genesis of psychiatric disorders and thus, for the participants secrets that had to be concealed. Ellenberger stated that two kinds of concealment are feasible: while the participants wanted to conceal the contents of their recollection from other people, they did not want to recall the memory themselves. The inevitable failure resulted in pathogenic defenses that pushed it to the edges of awareness, thereby further perpetuating undiagnosed PTSD syndrome among the participants.

Old psychic traumas were pushed to the fore each time the participants experienced a traumatic response as it elicited the same raw and thus, undigested emotions from previously archived unresolved traumas. The more the participants endeavoured to repress memories of these traumatic experiences, whose overwhelming distress rendered them *un-integratable*, the more they escaped to the conscious level. The participants in this study conveyed an enduring state of feeling at war with their psyche, which appeared to have been a pathogenic psychic pattern of survival before the formation of an integrated national force. Ulman and Brothers (1988) suggested that the trauma takes on an unconscious meaning, which challenges and compromises the person's sense of self and is subsequently symbolically represented in the symptoms of PTSD.

A war waged against the psyche is a war against the self and thus, self-objects; in this case, the SANDF and thus, its inability to be introjected as a good object. The reason thereof was because the SANDF had become a symbolic reminder of psychic wounds that were resistant to healing. Van der Kolk et al. (1996) explained that when people develop PTSD, the replaying of the trauma results in

sensitisation; with each replay of the trauma, the level of distress escalates. Accordingly, the traumatic event, which started out as a military and interpersonal process for the participants, had secondary biological sequelae that were difficult to reverse once they became entrenched. This is reflected in participant 7's statement: "Yes you start remembering those past things like they just happened and feel like you are there all over again." As the participants had never learned to regulate their arousal response physiologically, emotionally and cognitively, the intrusive thoughts and memories felt annihilatory. This possibly deteriorated further into comorbid mood and affective and behavioural symptoms common in the force. One of the participants recalled not being able to handle a weapon because of debilitating intrusive memories of past traumas. Military personnel have been found more likely to develop PTSD if they discharged a weapon or witnessed an injury or death during their deployment (Solomon & Horn, 1986). Discharging a weapon is likely to generate a traumatic memory directly associated with the negative event, which is considered a significant precursor to combat-related PTSD. It is probable that military service members who have witnessed someone being injured or killed during deployment experienced intense fear at that time, which remained psychically unintegrated, as in the case of that particular participant (Engekhard, et al., 2007). When the participants' psychic defenses failed them in managing this intrusive symptom of PTSD, they turned to alcohol for medicinal purposes to help them with these distressing thoughts and memories. This is supported by participant 3's statement: "I have learnt to help myself to bring myself to a different mind state, a few drinks help a person forget and feel better. You learn what your limits are as a person."

In this study, the participants experienced alcohol as a self-prescription measure to manage and abate physical and psychological pain secondary to undiagnosed PTSD. There is an element of *a culture of alcohol* within the military. There are bars in the bases for recreational purposes and possibly to enable soldiers to socialise or connect and attenuate potential traumatic responses. It appears the system, however, was unable to remedy this as a manifest symptom of psychological distress amongst the participants. Alcohol had become a form of medicine for emotion and self-regulation in the participants' lives. It is as though by turning to alcohol for medicinal purposes instead of mental healthcare practitioners, they felt that they were managing a psychological maladjustment rather than a psychiatric disorder, which may have implications for their future in the military.

Van der Kolk (1987) revealed that many trauma victims who show a semblance of normal functioning are in fact suffering from profound constriction in their involvement with others and a reduced capacity to modulate feelings. Therefore, alcohol use may indicate a defense against certain underlying anxieties and constriction as internal resources were believed to be depleted. Almost all the participants turned to alcohol to numb any pain they may have experienced. This was possibly easier

for them than accepting the extent of their presenting psychological distress. There was also an element of entrenched self-destructive behaviour in this defense pattern, which is typical of PTSD sufferers.

Kulka et al. (1990) found that male veterans with PTSD are two to six times more likely to abuse alcohol in comparison to those without PTSD. Likewise, the male participants in this study expressed patterns of alcohol dependence. Kulka et al. added that men with lifetime substance abuse are four to five times more likely to present with current or lifetime diagnoses with depressive disorders, manic episodes, panic disorders, generalised anxiety disorders and antisocial personality disorders, which supports the view that substance abuse may be a self-medicating attempt to cope with psychiatric symptoms. They further demonstrated that veterans with a PTSD or substance abuse diagnosis also presented with more current and chronic physical health problems. This concurs with the findings in this study: serving SANDF members exhibited chronic PTSD related mood, emotional, physical and behavioural symptoms.

Alcohol was also used as a distraction from reaching out to the external world. It helped the participants withdraw from themselves and therefore, a relation to self and self-objects. This is supported by literature that has revealed the psyche's typical reaction to a traumatic experience is to withdraw from the scene of trauma. If withdrawal is not physically possible, then a part of the self must be withdrawn, thus requiring the otherwise integrated ego to split into fragments or dissociates (Van der Merwe & Swartz 2015). Ego integration of the traumatic event was impossible among the participants.

7.3.2.3 Failed psychic integration of trauma characterised by psychic splitting and numbing

Psychic splitting is a post-traumatic response that often co-occurs with shame, which are both pivotal to complex PTSD and DESNOS. Both syndromes are a response to continuous or chronic trauma (Ford & Courtois, 2009; Ginzburg et al., 2009; Uji et al., 2007). A psychic defense of giving in, which is in contrast to integrative acceptance, was necessary for survival among the participants in this study. This was due to the nature of their military obligations and the resultant impairing psychological and physical impact on the self. Perceived trauma to the psyche, be it from past and continued traumatic operational experiences or organisational frustrations, leads to mental conditioning; internal material for partial adaptation rather than psychological combat wounds to be healed. This is similar to Kohut's (1971) reference to a state of disintegration characterised by a *depleted self* This is when the self is in dysregulated parasympathetic hypo-arousal, dissociation and excessive energy conservation. The participants experienced this subjectively as an implosion of the self wherein there was not enough energy in the brain/mind/body system to form the interconnections responsible for coherence (Weinberg, 2000). Many of the participants experienced the excruciating pain of the trauma as feeling forsaken and betrayed by their fellow human beings as well as their former military structures, who

robbed them of the capacity to hold the self, other and trauma integratively. Often suffering does not bring an increased sense of love and meaning; it more often results in isolation and disintegration of belief (McFarlane & Van der Kolk, 1996). In this partial adaptive acceptance, the participants took the position of being victims of the system and the reality of the nature of their military duties.

Non-integrated traumatic experience impinges itself through re-experiencing and is suppressed or split again. Depending on the complexity of the psychic defenses, that is, the maturity of personality, it has three recourses: to move into the body, the sensory sphere or enactment. These are manifest in psychosomatic dysfunction, perceptual hallucination and symptomatic action (Britton, 1998). As discussed previously, past traumas experienced in the former force structures coloured the manner in which experiences evoking the same intense emotions were located within the psyche. This very nature of acceptance was counter adaptive to psychological integration into the SANDF, the self and society. An examination of participant 5's statement revealed that for a psychologically integrated SANDF to have been realised, healing was imperative: "Well you have to accept what instructions come your way is how we were trained. It took a mental change because these are people you were instructed to fight against before now you have to be part of the same team and no longer see each other as enemies." This was apparent in the participants' resoluteness to deal only with the entry to their psychic wounds [as though a bullet entry], never to be revisited for *redressing* as though for fear of a mental breakdown from the emotional distress it entailed. The cyclical psychodynamics for the participants meant that to heal was to hurt and to defend against healing was to hurt. This appeared to lead to a figurative *ripping off of the heart* so as to escape pain that would, in essence, entail an escape from the self, which the complex dynamics of the human psyche do not permit. Enduring this unimpeded, infinite psychic realm, which is often experienced as meaningless, is painful as evidenced in the experience of the participants in this study. The individual may then be impelled to become mentally non-existent so as to survive the experience of this terrifying depleted and form-less abyss (Bion, 1970). This forms part of the personality where thought is gravely fragmentary and the aptitude for mental change is deficient. Thus, experience remains a non-mental overwhelming hysteria of stimuli inside the mind and body. However, when an emotional experience is encountered that is more intensely charged than the mind can tolerate, not only the experience, but the very capacity to experience, is attacked in the interest of survival (Bion, 1970).

It appears that partial acceptance is two-fold, the participants' acceptance of the organisational and operational traumatic experiences, and the organisation's acceptance of the participants with their psychological wounds and secondary somatic illnesses. The traumatised participants were surrounded by damaged objects, which were beyond repair and could not be integrated into the personality; their life had become a theatre in which the traumatic scene was constantly playing (Jovic, 2018). In fact, the

process of integrating traumatic experience could be comprehended as the impairment of ordinary processes for translating external experiences into internal contents: introjection, identification and assimilation.

The perceived psychological triumph in soldiering on daily with the psychologically disintegrating undiagnosed PTSD syndrome that the participants bore may have been experienced as neither acknowledged nor heralded by family and the system. Participant 3 elucidated, "… just know that you must look after yourself to survive, no one cares at the end of the day. It is just that sacrifice you make peace with." The literature has revealed that in the absence of validation and support, traumatic memories are more likely to prey on the victims' minds persistently and manifest as anger, withdrawal and/or otherwise disrupted and disrupting behaviour (McFarlane & Van der Kolk, 1996). The continued demands made on participants emotionally, cognitively and occupationally were experienced as a burden that placed added strain on their already fragmentary defenses. All the participants felt *split into different people: the person of a soldier and that of a head of a family* as these roles were not integrated into the self.

They operated as different entities of the psyche as the person of the soldier could not be brought into the family space in an attempt to conceal the traumatised part of the self. The self was split into a person known at home and that known in the force. Participant 2 reflected his experience as follows: "I saw that if you think with your heart you will call more sicknesses to yourself, more than the ones the army gave you, of having two minds one of a soldier and one of a person when you are with other people and family. It's like you are more than one person and you keep changing." The true traumatised self never found expression. The participants experienced life as a continuous trauma because they found no safe space to be and be seen in all areas of their functioning, which propelled them, deeper into psychic disintegration. Guntrip (1995) described a feeling of a profound sense of belonging as being at one with one's world, which is not intellectually thought out, but is the persisting atmosphere of security in which one exists within oneself. Feeling extremely over-aroused by external and internal experiences meant that the participants never achieved such stillness or *going-on-being*, with only the perceived good parts of themselves brought into their roles as a soldier or head of family. This appeared to disturb the participants psychically, further exacerbating their undiagnosed PTSD symptoms.

This is possibly the reason they felt their experiential reality was that of a life of self-sacrifice. They may have had underlying feelings of resentment regarding the sacrifice they believed they had made for the liberation of the country and the consequence thereof on their psychological and physical well-being. The family also did not appear to be a source of good self-object relations, but a system to be sacrificed for by staying in the force during which they endured further traumatic exposure in order to provide for them financially. Participants had underlying feelings of anger for having to live through compensatory

splitting defenses to compensate for the psychic wounds that family and the SANDF had possibly failed to allow time to heal. As reflected in the participants' accounts, individuals who have been traumatised carry a lot of shame and often a split is formed between the idealised projected self, the strong and proud survivor, and the essentially deficient or shameful authentic self, which is believed to underlie an inauthentic projected persona (Herman, 1997). Winnicott (1965) posited that the true self is who we are in the truest sense; it is when we feel alive, invigorated and spontaneous. Furthermore, only the true self can be creative and authentic. When they exist from the false self, individuals feel they are denying themselves. This may be related to the participants' feelings of self-sacrifice. They felt empty, void and/or non-existent in their compliance to what was expected or necessary in their roles as soldiers and head of families, rather than what was personally meaningful and psychically integrating (Anderson & Winer, 2003).

The integration of former statutory, non-statutory forces and the SADF was a political compromise to lay down arms and integrate through military experience for the greater good of South Africa. This implied that the participants' military identity and psychological allegiance may have remained with their former force structures. This identity was linked to a self that comprised core traumatic patterns of suffering linked to combat exposure under these forces. It is possible that the participants were unable to break away psychologically and remained fixated on the identity of the former force due to unresolved trauma therefrom. It thus appeared as though the participants employed an ego defense in identifying themselves by their former forces rather than the SANDF, while placing the blame for this on the administrative system of the SANDF.

The dissolving of former armed forces was mirrored in the psychic dis-integration of their members, with those who stayed to form an integrated SANDF seemingly finding safety for their disintegrated selves within a system rather than society. It is possible that the members who integrated could not change their mentality as a result of cognitive and emotional distortions/deficits secondary to unresolved trauma. The is substantiated by the following quotation: "Now what happened after integration we start identifying ourselves as former what- what -what- what accusing one another and say you were working for the white regime, you killed us by then you were against us you understand." It was apparent that with arms laid down psychic defenses were more rigidly erected to defend against psychic wounds or being found out to have these emotional scars. The participants appeared to suggest that psychical integration, as the integration into the SANDF, may have been experienced more as a demobilisation of arms and a mobilisation of psychic defenses against trauma that remained undiagnosed. The lack of a cohesive sense of self may have prevented the psychological and cognitive integration required to form part of a unified SANDF. Despite the ability to work together as disparate former force members within the SANDF to execute military tasks, a united force appeared to be limited to an operational level. From

what the participants shared, it appeared that there was a vested interest in identifying differences amongst themselves, perhaps because similarities would have forced the members to face certain truths about themselves including the traumatic stress syndrome from the beginning of their military service prior to integration.

The lack of psychological preparation of these former force members did not match the expectation of psychological and cognitive integration into the SANDF. The task of military, cognitive and psychological integration seems to have been left to the members on the ground to negotiate under the guard of former SADF, while those in leadership positions focused on the administrative processes and the political climate in the country. What may not have been taken into cognisance is that these members may have been suffering from traumatic stress syndrome from previous military activities. Disintegration is inevitable where psychic trauma has been experienced. Consequently, any task at functional integration was met with rigid psychic defenses and further deterioration when untreated. This may have been likened to a scene of patients welcoming new patients to an institution. Van der Kolk et al. (1996) compared the compulsive re-exposure of some traumatised individuals to situations similar to previous trauma. It may be one of the reasons that kept these serving members in the force.

Blizard & Bluhm (1994), proponents of object-relations theory, posited that although defenses employed may be maladaptive, they allow the survivor to avoid being overwhelmed by memories of trauma and maintain a brittle internal structure of self and object representations in order to avoid abandonment depression. This was possibly how an integrated force served the participants. Cognitive and psychological integration would entail a process of working through their trauma, which would require sitting with the raw emotional pain that underlay the participants' PTSD symptoms.

The nature of the military environment did not afford the participants the structural or psychological space to facilitate meaning making and thus, healing from previous traumas, which were activated by current trauma within the SANDF. According to the literature, traumatised individuals' emotional reactions are viewed as consequent to conflict between internal and external information (Horowitz, 1986; Horowitz & Kaltreider, 1980; Schwartz, 1990; Widom, 1989). The participants could not experience integration psychologically as meaningful because it may have been experienced as rendering their armed efforts meaningless activities to be repressed and denied space in their psyche and society. Signal anxiety alerts one to an impending situation of helplessness. According to Garland (1998), once the threat of annihilation has been encountered face to face, something is altered: once the ego has been traumatised or ruptured), it "can no longer afford to believe in signal anxiety in any situation resembling the life-threatening trauma: It behaves as if it were flooded with automatic anxiety" (p.17). She referred to this as a crucial factor in the loss of symbolic thinking in the area of the trauma, which is a marked feature of the behaviour of survivors. This may be related to the necessary psychic

defenses employed by the participants to protect themselves from disintegration anxieties if removed from their core pattern of suffering.

The process of integration could have benefitted from allowing the processing of unresolved combat traumas and not negating the organisation as experienced as a relational object by the members. This may have helped integrate members as a meaningful entity in national service under the SANDF. However, feelings of redundancy were evident, which made the participants feel as though they were absorbed into the SANDF to be checked on, rather than to enhance their military potential/strengths and instil a sense of purpose. The vision of the integration process could not be internalised as a good object because like the trauma, it became associated with introjected and projected bad internal objects through which relating and interaction with the external world stemmed. Years after the participants had formed a traumatic memory, it remained unintegrated, a self-perpetuating presence, perpetually reliving the moment of its origin through intrusive symptoms of undiagnosed PTSD (Horowitz, 1976). Because of the enduring and unintegrated nature of traumatic memories, victims remained embedded in the trauma as a present experience instead of being able to accept it as something belonging to the past (Horowitz & Kaltreider, 1980; Van der Kolk et al., 1996). Not only did this exacerbate the participants' undiagnosed PTSD but compounded it as a long-term continuous trauma as it was neither pre nor post their military service.

The next theme, lived experience of trauma, provides the answer to the research question: How do SANDF members cope with feelings associated with the experience of these trauma-related responses in their daily functioning?

7.3.2.4 Lived experience of trauma

The re-activation of past unresolved traumas the participants took with them into the integrated SANDF developed into chronic and thus complex traumatic stress syndrome, with military and personal trauma suffered. This can be likened to Continuous Traumatic Stress (CTS), a construct that refers to the condition of or response to being compelled to live in a context characterised by current and future danger in which traumatic stress is not past or post (Eagle & Kaminer, 2013; Stevens et al., 2013). It is of interest that CTS was introduced by those providing psychological services to activists during the repressive apartheid years in South Africa (Straker, 2013) against which participants fought through the armed struggle.

Several authors (Andrews et al., 2009; Frueh et al., 2009) revealed that the occurrence of later life stressors or traumatic events increases the likelihood of military personnel developing PTSD in response to a prior traumatic event. This explains the participants' vulnerability as they may have been integrated

into the SANDF with underlying post-traumatic syndrome. Distressing emotions from PTSD symptoms appeared to get displaced on to the SANDF, which may have been a cry for the organisation to acknowledge the members' psychic pain. This would have meant the normalisation of a traumatic combat response, with support from the leadership. Failure may have been what unconsciously drove the participants to continue deploying and repeatedly exposing themselves to danger.

Van der Kolk et al. (1996) attested to the compulsive re-exposure of some traumatised individuals to situations similar to previous trauma. This is reflected in one of the participant's assertions: "Deployments get very dangerous there are lots of people who are getting hurt then after that there is no support, we witness all that also." Taylor (1998) stated that premorbid motivations clearly influence the rate of self-exposure to traumatic events and vulnerability to PTSD. The complexity and chronicity of the traumatic response syndrome seems to lie in the fact that continuous psychological stressors cannot be processed and thus, become unresolved traumas thrust into the depths of the psyche with previous unresolved traumas. This keeps past traumas raw. However, for current or recurring traumatic responses to be processed and thereby integrated, past traumas have to be re-visited first. This would have enabled participants to learn to make sense of the self in relation to trauma and thus, the self in relation to self-objects. Shay (1994) examined the subtle phenomenology of PTSD symptoms and posited those symptoms of unresolved residual traumas are easily confused with those of other disorders resulting in historical misdiagnoses. This may explain why members based in infantry bases tend to be dismissed as dysfunctional. An oversight may be that as Africans, the onset and presentation of symptomatology of these service men and woman may have been somewhat different. There is no clinical conceptualisation of trauma within the African culture and therefore, no traditional models could have been employed to guide the participants in resolving their trauma.

The participants felt as though their emotions, in particular, their feelings of grief were buried along with fallen soldiers, thus inhibiting their process of mourning, which would allow a working through of their loss. An inability to grieve perpetuates a traumatic stress response trajectory and consequently, may have exacerbated the participants' undiagnosed PTSD syndrome. This robbed life from the participants as it robbed them of making meaning and mourning their losses. It became a process of killing off of those elements of their experiential and emotive reality, which further disintegrated their already fragile ego. Klein (1940) proposed the manic defense by which the infant minimises loss through phantasies of omnipotence. This process enables denial of the significance of the good object through devaluation. Burch (1988) argued that the sense of omnipotence that the infant may experience is maladaptive because denial of the external world impairs reality testing, prevents mourning and hinders internalisation of the good object. Therefore, loss of lives as witnessed in military combat was a significant source of trauma for many of the participants, which they experienced prior to and during

SANDF operations. In order for a dispensation that could form an army in the form of an integrated SANDF, blood was shed. However, this traumatic part of the participants' experiential reality was defensively split off psychologically as though it could also be buried. This was conveyed in participant 9's experiential reality: "The sacrifice and for what were we sacrificing our lives so that we can feel like you are dead inside. I can say it means nothing." She continued: "People can't see it only you know what is inside of you. Sometimes you don't want to live anymore and think those who have departed are lucky."

Burch (1988) explained that losses in adulthood might bring back to consciousness the primary mourning process; good objects feel lost again and paranoid fears are restored with a sense of persecution. Klein (1946) this collapse and deterioration of the inner world as a state of mental illness. Bion (1970) posited that the personality or psyche appears to oscillate between an inadequate capacity to tolerate pain or frustration, and intolerable pain or frustration. Consequently, those who cannot mentally resolve, think and fill their pain with meaning become trapped in a nightmare where they can only repeat their distress continuously; like the participants. The psychological repetition of harrowing experiences left residual trauma in these participants and formed trenches of psychic wounds of persistent low mood and emotional constriction.

It appeared that the participants presented with persistent mood disturbance associated with feelings of sadness, which is a manifestation of a sense of a traumatising internal life. This is suggestive of giving up hope for a joy-deserving self. Therefore, the participants went through life as though they were observers far removed by the incapacity to engage connectedly with self and internal and external self-objects. There was a depressive turning away from the self and from others, including the integrated SANDF wherein collective support and connection may have been forged, which could have facilitated a healing environment. This may have stemmed from a perceived turning away and thus, abandonment by former armed force structures to which they may have been connected by the armed struggle course that connected them. This experiential reality may have been perceived as punishment, which subsequently translated into self-punishment and a conviction of being punished by the SANDF as an organisation. There appeared to be a mourning of a self, buried deep within as a defense against psychic anguish too overwhelming to bring to consciousness. Freud (1957) captured this experience aptly in his assertion that in addition to the impact of the traumatic event is the task of mourning, for others and for the self, in particular, for the person's own lost world, pre-trauma life and identity.

Young (1995) posited that the behavioural pattern of PTSD sufferers becomes increasingly detached or estranged and is frequently aggravated by related disorders such as depression, substance abuse and problems of memory and cognition. The disorder often results in impairment in the capacity to function in social and/or family life, which more often than not leads to occupational instability, marital problems

and divorces, family discord and difficulties in parenting. This captures the functional, emotional and relational difficulties the participants presented with secondary to undiagnosed PTSD. The literature has revealed traumatised individuals present with comorbid mood and personality disorders (Herman, 1992; Herman and van der Kolk, 1987; Kulka et al., 1990; Reich, 1990; Shay, 1994) including extensive disturbances in affect regulation, dissociation, somatisation and disturbed beliefs concerning self and relationships (Ford, 1999) that impair characterological stability. This may have been misinterpreted as members being ill-disciplined and functionally impaired and possibly the reluctance or inability to advance them promotionally. Tull et al. (2007) also found that trauma-exposed individuals with severe post-traumatic stress symptoms had difficulties with impulse control and were less able to use adaptive emotion regulation strategies. It may be deduced that this not only perpetuated undiagnosed PTSD symptoms, but also maladaptive coping skills in the form of self-destructive behaviour.

The participants' coping mechanisms were maladaptive and self-destructive, which is inevitable as they stemmed from primitive psychic defenses. It was apparent from the participants that coping mechanisms are deployed maladaptively to maintain the equilibrium of psychic disintegration in defense against the pain of repressed unintegrated traumas. The participants self-destructed in an attempt to retaliate and attack the traumatising internal objects by which they feel attacked. Honing et al. (1999) noted that the most significant long-term impact of trauma often takes the form of persistent character traits that may have developed as coping responses to the trauma. For all the participants, self-persecutory cognitive and behavioural patterns underpinned enduring character changes secondary to trauma. The destructive psychic defenses the participants employed consciously or unconsciously informed patterns of psychic/personality organisation, which had implications for their internal resources and object-relational dynamics. Kohut & Wolf (1978) presented different types of pathological states of the self, which arose as a result of developmental failures. The fragmenting self is the consequence of an absence of integrating responses to the nascent self in its totality from the self-objects in childhood, predisposing the individual to states of partial fragmentation. Accordingly, these individuals lack the ability to reflect on their difficulties without destructive or self-destructive acting out and to soothe themselves in non-addictive ways, resulting from the exposure to massive mirroring failure in infancy (Swartz, 2009). They are susceptible to chronic states in which they lose a sense of continuity of self in time and cohesiveness in space; a psychic condition that produces profound anxiety (Kohut & Wolf, 1978).

The participants' manner of being was premised/modelled on splitting off their experiential reality as though it did not happen or belong to them, especially through the excessive use of alcohol. This study revealed that the participants' psychic distress was not elevated by *self-destructive behaviour,* but possibly exacerbated the impairing course of chronic undiagnosed PTSD from which they suffered.

Figley (1978b) argued that in the 1970s, research began to indicate that combat was a factor in postwar psychological maladjustment because veterans tended to have poorer coping skills, higher unemployment, more stressful family relationships, higher rates of drug and alcohol abuse, hostility, guilt, depression, sleep difficulties and nightmares. The participants in this study presented with most of these symptoms to the point of self-destruction, which placed them in a unique psychically conflicting position. Parson (1984) revealed that soldiers with PTSD engage in self-destructive behaviours that undermine self-cohesion, which stem from developmentally arrested self and object-representations in primitively organised individuals. These self-destructive defenses serve to defend the ego against irreconcilable trauma as manifest in persecutory anxiety stemming from perceived attacks from persecutory bad objects (Duckham, 2011). This indicated that the participants felt vulnerable and at the mercy of destructive internal objects as well as their self-destructive impulses.

Environmental impingements from former force structures and currently experienced within the SANDF evoked feelings of physical and emotional vulnerability, which may have explained the participants' susceptibility to post-traumatic stress syndrome in response to traumatic experiences. The participants felt out of control within the current system and with the demobilisation of their former forces. Even challenges that could be addressed administratively as grievances were internalised as abandonment, disregard and persecution, which exacerbated primitive injuries. It appeared as though failures in organisational structural processes were internalised as own failures, which pointed to a psychological vulnerability of fused identification with the former and current force structure. According to Ulman & Brothers (1988), the unconscious meaning of exposure to the trauma of combat is understood in terms of the individual's sense of having failed to live up to an idealised sense of self and thus, the individual's sense of uniqueness and strength is shifted to one of vulnerability, worthlessness and dependency.

This may imply a self-awareness that they did not possess the physical and psychological resources expected of them as force members due to the undiagnosed PTSD syndrome they suffered from traumatisation. In response, the participants would rather risk physical vulnerability and risk their lives, rather than risk the emotional vulnerability required to process their unresolved trauma therapeutically. This is reflective of divergence of psychological vulnerability to physical vulnerability, which seems to be an adaptive response to the system. Solomon & Horn (1986) found that the more support an officer was afforded from fellow officers, supervisors and administration, the less post-shooting trauma occurred. Kaplan and Sadock (1991) stated that the availability of social support may determine the development, severity and duration of PTSD. It is this very form of support that eluded the participants in this study, either in their inability to access the system integratively psychologically or make themselves accessible to the integrated system. This would require a healthy internalisation of emotional

vulnerability, which did not have to entail perceived exploitation over which they had no control. There appeared to be an experience of neglect of psychological services along with the participants' psychological needs within the system, which further perpetuated psychological decompensation into PTSD syndrome that remained undiagnosed.

Van der Kolk, Weisaeth, and Van der Hart (1996) posited that vulnerability is a significant factor in the development of trauma as well as in the long-term adjustment of living with the legacy of traumatic stress. The socio-political climate of the country at the time may have rendered integrated members politically, physically and psychologically vulnerable. McFarlane and Van der Kolk (1996) stated that victims of trauma are vulnerable to being used for a variety of political and social ends, for both good and evil. Victims are often perceived as members of the society whose presenting difficulties represent memories of suffering, rage and pain in a world that longs to forget: "Repression, dissociation and denial are phenomena of a social as well as individual consciousness" (Herman, 1992, p.8).

When people lose faith that their world is a safe, structured and just place in which to live, it colours their relation to it and mobilises defenses against it. Therefore, individuals experience a loss of effectual control over their environment and increasingly experience the world as an unsafe place (Van der Kolk et al., 1996). The participants expressed their pain about the lack of control over what pertained to their overall welfare within the SANDF, which may have disarmed them in relation to a sense of agency. This may have unconsciously evoked feelings of traumatic experiences during which the participants may have felt vulnerable, which drove their symptoms of PTSD and accompanying psychic defenses deeper. This concurs with Kardiner (1959) who stated that traumatic events create levels of psychic stimulation that the individual is inept to master and a severe blow is dealt to the total ego organisation. The individual experiences this as a sudden loss of effectual control over his environment, which results in an altered conception of the self in relation to the world (Kardiner, 1959). Their psychic organisation /core conflict centered on the perceived traumatic pain they had been caused by the SANDF as a system. It appeared as though the cost of holding on to their defenses meant holding on to psychic trauma as the person they once were was embedded therein. This perpetuated the cycle of vulnerability and giving up control of their internal and external world to military force structures. This may have led to the participants' passivity in their integration into the SANDF despite their misgivings about the process and psychological ramifications thereof. The lack of psychic feeding and thus, healing of the participants' internal world led to its impoverishment, which made their course of undiagnosed PTSD chronic. As expressed by partipant 5:

> "Being tough mentally everyday it kills you slowly at the same time. It's not a normal way of living, it's like a little torture. So, you must keep it in because the way we were taught

you don't talk about your feelings, it's like exposing my inner weakness actually. You just know like that as a soldier."

Having disengaged from their internal and external self-objects, it was as though the participants had taken themselves off life-support machines and surrendered to their annihilatory anxieties. They narrated what appeared to be their bodies carrying dead men through the motions of living. There appeared to be nothing in their external world that fed their *internal world and it had been deadened* as a result. Davies & Frawley (1994) explained dissociation as surrendering and resigning oneself to the inevitability of overwhelming, even psychically deadening danger. The psychological defense of dissociation against the experience of intolerable pain carries a great internal hardship as the psychological sequelae of the trauma continue haunting the inner world (Kalsched, 1996). All that was buried alive of their internal world had died because of a lack of healthy processing as though in complicated bereavement and thus, the former forces were unable to grow towards healing of the transition to an integrated force and self. Their impoverished internal world was experienced as a psychic internal suicide. It is possible that suicides in the SANDF were the result of the desperation to escape *the graveyard* they called their emotive reality.

In line with object relations theory, Kardiner & Spiegel (1947) described the result of war trauma as a contraction of the ego, with consequent inhibition of the action system, which encompasses the way in which activity in relation to the outer world is integrated. In a potent description of the debilitating effects of trauma on service men, Kardiner and Spiegel wrote, "The new adjustment is erected on the ruins of what was once a rich reciprocal relation to the outer world. The ego is now impoverished" (p. 324). This has an adverse effect on the ability to work and further results in disorganisation, emotion and impulse dysregulation, lack of confidence and paranoia as the outer world becomes a hostile place and the subject feels in persistent danger of being overwhelmed by it. This manifests in the collapse of individuals' capacity to negotiate their relationship with the world. I was also interested in the participants' experience of relationships given their psychic trauma, which I could explore through the research question: How do members describe their relational patterns in response to trauma? This is subsequently discussed under the next theme.

7.3.2.5 Impoverished relational patterns

It may be deduced from the participants' experiential reality that the manifest disengagement from the self, other and the SANDF as a system may have originated from their archaic introjected self-object relations. Kernberg (1997) noted that positive early experience results in libidinal object relationships and negative experience results in aggressive object relationships, which demonstrates the affective link between object relation units of the self and the object image. The participants did not appear to find

rooting in self: in relation to the self, others, the SANDF and society. According to object relations theory, when there is failure in emotional experiences with parents, the children transfer the problem to themselves by taking the burden of badness upon themselves (Fairbairn, 1943). The badness of the undesirable characteristics of the parents are now within them and become bad objects with whom the ego identifies through primary identification. In this manner, environmental (external) security is acquired at the expense of sacrificing emotional (internal) security. Another feature of this internalisation process involves the preservation of the phantasy of omnipotent control. If the badness remains inside children, they maintain hope they will acquire omnipotent control over it (Fairbairn, 1943).

Relating involves having the self mirrored back to one, specifically every aspect of the self, namely, anxieties, hidden emotions and defenses, which may have proved too much for the participants as they evoked emotions that they feared would exacerbate psychic wounds. This would entail the participants allowing themselves to trust and be seen by the other by showing them their psychic scars and not hiding parts of themselves by hiding their psychic trauma. However, the participants were unable to do so because emotional disengagement and detachment are relationally impairing symptoms of PTSD. It appeared that within and outside the force, the participants were defensively dependent on internalised bad objects as a map to navigate emotional terrain. This may be connected to object relations theories, which provide a conceptual understanding of the psychic developmental role of interpersonal relating in affect regulation, which is pivotal in the face of trauma (Schore, 1994). The participants appeared to experience relational difficulties with forging connections with spouses and a struggle to engage emotionally with their children. This awareness caused them distress, as indicated by participant 1: “It’s like that, we find difficulties in relationships for sure that’s why soldiers divorce a lot. You cannot balance, you cannot you are lying.”

The force came to represent a primary object for the participants. Furthermore, they internalised the demobilisation of their previous forces as an environmental failure and thus, abandonment. The underlying negative feelings therefrom got displaced or transferred onto the experience of the SANDF. The defenses including the perceived resistance towards an integrated force were employed to protect the fragile ego. Van der Kolk (1996) noted the importance of seeking and making use of interpersonal connection in order to negate the effects of trauma. It was apparent that the participants turned away from self and others as a defense against intolerable distress. Fairbairn (1943) made reference to the incorporation of the object as a process engaged in by the individual in an attempt to deal with frustrations in oral relationships. If individuals experience later complexities in their relations with others, they return to these early incorporated objects and regressively reactivate their relations with them in which they become further isolated from others.

McFarlane & Van der Kolk (1996) found that only a minority of victims appear to escape the belief that their pain, betrayal and loss are meaningless after they have been victimised. For many, this realisation is one of the most excruciating lessons that the trauma brings and they often feel godforsaken and betrayed by their fellow human beings. McFarlane and Van der Kolk further argued that often suffering does not bring an increased sense of love and meaning, but frequently results in isolation and disintegration of belief. The participants' accounts of their emotive reality highlighted a deep sense of loneliness in perceiving that they were not seen and therefore, not valued. The distress from being isolated compounded their trauma response as it translated into being isolated and thus, they had to deal with their trauma in isolation. The isolated and overburdened self was not afforded an opportunity to merge with the calmness of an omnipotent self-object. It had endured the trauma of unshared emotionality and therefore, they lacked the self-soothing structure that protected them from being traumatised by the escalation of their emotions, especially that of anxiety. A world absent of such soothing self-objects is experienced as hostile and dangerous (Kohut & Wolf, 1978). There was an element of internalisation of this experience as being outcasts among the participants as they were not wanted within the SANDF as a system or their family systems. There was a collective gravitational shift away from integration into a unified force (SANDF) as the isolation manifested in isolated identification with respective former forces. The inability to form part of nurturing self-objects may be part of a disintegrated ego as one of the manifest symptoms of long-term trauma to the psyche. When internal resources are depleted, the unconscious psychological isolation from others tends to be enacted through physical distancing by choosing to live away from family or deploying repeatedly. In keeping with symptoms of PTSD of cognitive and emotive distortion, the participants seemed to experience difficulty feeling positive emotions. Even when promotional opportunities were made available, which form much of the negative experience of the SANDF, there was no joy therefrom, but instead blame for further isolation from the family was evoked. This was captured by Le`na`rd & Te`nyi (2003) as the solitary, isolated, deprived, detached, exiled life of a soldier who lost the physical and psychological war.

The participants' emotive and experiential reality was that of a disempowering disconnection in and outside of the SANDF. This study revealed that intimacy with spouses is avoided or defended against. This was supported by Van der Kolk et al. (1996) in their postulation that many people with PTSD not only actively avoid emotional arousal, but undergo a progressive decline and withdrawal in which any potentially pleasurable and aversive stimulation provokes further detachment. To feel nothing is preferable to feeling irritable and upset. There also appears to be an avoidance of feeling positive emotions as any emotional arousal may be connected to the annihilatory physiological arousal signals associated with post-traumatic reaction syndrome.

The participants' defense against allowing others close emotional proximity may be linked to a fear of having their true self being exposed and possibly rejected. Moreover, relational objects are approached with reference to introjected bad internal objects. According to Kernberg, psychological development is rooted in the continued cycle of "internalisations of object relations units and defenses against them" (Christopher et al., 2001, p.690). Furthermore, through the process of internalisation, these units end up characterising "representations of the self, representations of the object and the drive motivational system" (Christopher et al., 2001, p.691). As revealed in the current study, Kernberg (2004) explained that the more unyielding and neurotic character traits are, the more they reveal that a past pathogenic internalised object-relation has become fixated into a character pattern and thus, its defenses. Krystal and Niederland (1968) found that this translates into a loss of all benign introjects including those that allow survivors to engage in consistent benign relationships or nurturing behaviours. To defend against abandonment depression, the participants abandoned their objects before allowing themselves to feel abandoned, which plunged them further into the psychic disintegration of their undiagnosed PTSD syndrome.

The findings from this study suggest that the participants may have internalised the process of integration as abandonment by their former force structures. This may have been entwined with their underlying feelings of betrayal and anger, which exacerbated their persecutory anxieties and the maladaptive defenses against them. However, former force structures as relational objects were protected from the destructive impulses and emotions, which subsequently got displaced and projected onto the SANDF. As the participants lost trust in their former leaders to protect them and their course of the armed struggle, so the SANDF as an integrated system was expected to mete the same psychological attack. The possible abrupt ending of the armed struggle and transition to an integrated force appeared to cause the participants, who already bore unresolved traumas, psychological distress. The process of demobilisation may have been internalised, relaying that their armed struggle was not meaningful, which raised questions about their core beliefs and sense of selves. This may explain why the integration process could not be internalised as meaningful with disparate former forces being a meaningful part of the SANDF, rather than mere victims absorbed into a system.

The participants collectively voiced complaints about poor leadership and lack of planning with dire operational consequences at times. This may have elicited feelings of distress around the plans towards integration between their former leaders and would be (current) authority figures from which they felt excluded. This was to determine the course of their military service and psychological developmental trajectory for the worst they might feel. The participants held on to their bad internal objects despite the internal conflict they endured in protecting them from their destructive impulses (bad parts), which may have complicated their ability to tolerate the distress of managing their PTSD syndrome. Fairbairn

(1943/1986) proposed that soldiers have both a strong attachment to their bad objects in their repressed state as well as an acutely repugnant reaction to the release of the bad objects and the consequent breakdown of defenses. Accordingly, the SANDF and other relational objects were experienced as bad objects. Fairbairn noted that, therefore, when a traumatic experience triggers the release of bad objects for the soldier, the following failures of defenses and coping strategies occur: The occurrence of psychopathological symptoms is directed by a return of bad objects, which have been repressed. In Fairbairn's view, these overwhelming experiences are all attached to bad objects.

The participants found relationships a difficult terrain to navigate as they placed a demand on the self to trust and be vulnerable with the other. This was frightening as it meant relinquishing control of their vulnerable parts and risking the potential to be accepted or rejected with their psychic wounds. These participants' psychic organisational structure was erected around the defense against the pain of their unresolved traumas, which had impairing implications for their self-object relational capacity. Therein lies the belief that when you trust the other with the self, abandonment, rejection, persecution and emotional distress ensue. The avoidance of relating extended to family relations and it was apparent that the protection of oneself and others from feared internal bad objects compounded the participants' internal conflict. Guntrip (1968) asserted that when difficulties in obtaining and sustaining good object-relations are too pronounced, human relations are approached with great anxiety and conflict. Accordingly, desperate attempts are made to deny this basic need.

The participants' experiential reality reflected a lack of feeling "a profound sense of belonging, a being at one with their world which is not intellectually thought out, but is the persisting atmosphere of security in which they exist within themselves" (Guntrip, 1995, p. 240). Feeling extremely over-aroused by external and internal experiences meant that most of the participants never attained such stillness or *going-on-being*. This is particularly evident with hypervigilant traumatised patients whose brains and nervous systems pick up signals of threat that most people are oblivious to unconsciously (Tarter et al., 2009). The participants experienced these as not only physical signals of threat, but also emotional signals, which coloured their relational reality. They may have perceived a sense of belonging within their respective former armed force structures. However, the demobilisation thereof led to the participants fearing the risk of self-object relational vulnerability within and outside of the integrated SANDF.

There are *feelings of resentment* and pain in the experience of feeling the system has not met the needs it was phantasised it would as an idealised object for which the self was sacrificed. This affected the participants deeply because these needs were left unfulfilled by former force structures to which the participants belonged. Purcell (1996) explained a soldier's double wish to protect and be protected: and when these protections fail, a sense of primary abandonment, guilt and loss ensue. This can irreversibly

split soldiers into people they previously were who believed in relatedness and the people they became after the trauma who were inconsolable and totally alone. The sacrifice of life, not only in the line of military obligations as understood as part of the work of a soldier, but that of the self also exacerbated the participants' traumatic stress syndrome. There appeared to be an expectation of an exchange with the system expected to give life in the form of a sense of identity, wholeness and healing. Kernberg (1980) explained this in relation to the principle of diffusion in the sense of being split into a soldier and a victim, chronic unmet needs for mirroring and idealising, and vulnerability to self-fragmentation experiences. A responsive self-object environment provides the experiences of living that enable the internalisation of the infant's potential into a creative aliveness and realness to allow for joyful interests and self-affirming experiences (Geist, 1989). This means that the purpose of a responsive self-object environment is to allow the infant to build self-esteem and self-regulation and have a feeling of continuity over time and space that leads to a cohesive self (Kohut, 1971; Wolf, 1998). The participants lacked this kind of emotionally providing environment as it was apparent that their lived experience was that of a traumatic environment instead.

The participants may have experienced an element of regret in having given up an emotionally engaged part with their families to be part of the SANDF system and previously former armed forces by detaching from their family and society at large. However, this was no way to live or for the psyche to survive within the self, organised around such object impoverishment, in that a disintegrating conflict developed around being part of any system. One may ask if disavowing being a relational being could be the self-sacrifice and at what cost. The participants lived in converse to what studies have revealed: emotional attachment is probably the main defense against feelings of helplessness and meaninglessness. This is vitally important for biological survival in children and without it, existential meaning is unthinkable in adults (McFarlane & Van der Kolk, 1996). Participant 5 thus described his relationship with his family:

> That one honestly is like that, if you are a soldier you can't change it. I know they are afraid of me and I hate that part of it. When I'm there I know it and it stresses me. They don't want to be that close to you. And you feel bad, haai, we are paying the price when it comes to that.

This overburdened self not only endured combat trauma, but trauma of unshared emotionality too. Therefore, the participants lacked the self-soothing internal and external structure that protects normal individuals from being traumatised by the escalation of their emotions, especially anxiety (Kohut & Wolf, 1978).

7.3.2.6 Impaired emotional connection with family

All the participants experienced the emotional connection with their families as impoverished. They withdrew emotionally and related as appendages to the family. It was as though they felt ashamed and not worthy of being nurtured and loved. They had somehow extracted love from family and family from love. Consequently, they missed out on both as antidotes to symptoms of trauma. It is ironic that their family did not reject them because if anything, they desired more of a connection with them. The participants, however, appeared to find solace in the confinement of their physical and psychological isolation. These dynamics demonstrate how PTSD and especially, long-term PTSD affected both soldiers and their families and necessitated new intervention approaches. A phase-based approach is proposed, encompassing stabilisation techniques, education and social skills training to help soldiers integrate their experiences effectively, adapt to civilian life and to their role in their families and live productively (Ford & Courtois, 2009).

It is noteworthy that the participants did not mention their families much. This may have been due to a fear of accepting a possible feeling of objectless-ness. This sense of loss of attachment and early object relatedness is reflected in Grand and Alpert's (1993) contention that the gravest threat to one's integrity is the state of objectlessness. This may be explained as a state of not being connected to anyone at all. There is a psychic defense displayed in the avoidance of being with family, which is compounded by the reality of emotional disengagement characteristic of PTSD. The participants may have defended against the pain of having lost their family by having chosen military forces as self-object units over family and the resultant perceived abandonment. In the face of a traumatic collapse of psychic structure and object relationships, the psyche catches any available object to prevent an even worse reality of total objectlessness (Grand & Alpert, 1993). The participants' responses suggested that they did not understand that money is not the only function of a father/mother or spouse within any family unit.

The role of financial provider led to the participants regularly risking possible further re-traumatisation so as to ensure their families' instrumental needs were met. This was prioritised over the participants and their families' emotional needs. This may have been a way of displaying love for their loved ones and distancing themselves from the emotional demands of heading a family. Guntrip (1968) stated that the importance of human living lies in object-relationships and only on such a basis can our life be said to have meaning. He added that in the absence of object-relations, the ego itself cannot develop. This remained a disintegrated ego, secondary to unresolved trauma to the psyche for the participants. Courtois' (2004) comprehensive diagnosis of complex trauma explicated the incapacity to self-regulate, self-organise and draw upon relationships to regain self integrity. Due to frustrations with promotional progression, deployment became a source of extra income. Possibly to compensate for not being able to give family more of themselves, the participants prioritised giving them more money. This

may be suggestive of a perception that when financial stressors are alleviated, so too will psychological distress. Failure to provide for their families financially added to the participants' unresolved trauma and activated feelings of having failed to live up to an idealised sense of self (Ulman & Brothers, 1988) as a soldier and provider.

The participants demonstrated a manner of defending against abandonment and rejection anxieties by finding relational safety in the parent-child dyad. This dyad, despite not being underpinned in emotional connection, is spoken about more than the spousal dyad. Familial problems are centered around domestic violence and consultations with social work officers in desperate attempts not to have their children taken away, rather to save their marriages or relationships. The participants appeared to experience an element of restoration of pride in providing for their children despite a painful acceptance that an emotional disconnect existed. The participants' inability to find solace in their families seemed to exacerbate their deleterious course of undiagnosed PTSD further because they did not have an emotional buffer. If anything, the families suffered the brunt of living with afflicted individuals and the possibility of secondary trauma from the participants' displaced aggression. Despite the provider-child nature of the relationship with their children, they became significant objects held on to at all costs. The participants' experience may have been that they had been bad and unworthy of their children's love (Mitchell, 1981). However, they could be good by being providing parents. The participants' children seemed to represent a self-object unit whose emotional disintegration was blamed on the SANDF. As one of the participant regrettably stated: "Out of fear the child ends up not knowing whether what they are doing is right or wrong when you are around, they behave differently, they don't feel free around you."

The emotional disintegration referred to originated not only from members living apart from their families as they are able to live together when there was willingness, but also from the emotional detachment feature of PTSD syndrome (APA, 2013). This is related to the participants' disengaged self and fragmented ego as well as the manner in which this translated into an inability to be part of integrative systems. Being part of a family elicited vulnerability, which was defended against to a point of denying themselves a place within their families. Holding on to bad internal objects (Summer, 2014) was also transferred to the participants' manner of relating within their families. There was also an element of wanting to conceal information from their spouses with regards to the physical and psychological difficulties with which they presented. It is possible that they feared rejection from perceived shame and weakness if they dared to exhibit their true traumatised self. The literature has revealed that although the object is internalised through an oral incorporative response to frustration, it becomes employed by the ego in its struggle to sustain good object relations. The ego becomes ambivalent about this initially pre-ambivalent object and in attempt to control it, it splits it into gratifying

and ungratifying parts and subsequently, splits the ungratifying parts further into exciting and rejecting elements, which the family has become (Mitchell, 1981).

7.3.2.7 Employing psychic defenses to cope with symptoms of trauma

Honing et al. (1999) noted that the most important long-term impact of trauma often takes the form of enduring character traits that may have originated as coping responses to the trauma. The participants observed these character changes among themselves as a result of ways in which they had to carry their psychological difficulties silently while with the former forces and currently as part of an integrated force. Reich (1990) observed that patients who suffer from chronic PTSD may suffer a deleterious personality change. Ulman and Brothers (1988) stated that the trauma takes on an unconscious meaning, which challenges and compromises the person's sense of self and is subsequently, symbolically manifested in the symptoms of trauma. There is a sense of an *other self* that is either deeply hidden within or felt to have been lost and belonging to a time/life prior to the traumatic experiences endured. There is a tenderness towards this *other self,* almost like an inner child whom protecting at all costs seems to have been worth the psychic battle. Kernberg (2004) noted that the more unyielding and neurotic character traits are, the more they reveal that a past pathogenic internalised object-relation has become fixated into a character pattern and thus, its defenses.

The International Classification code of Diseases-10 added a category for *enduring personality changes after a catastrophic experience* including permanent hostility and distrust, social withdrawal, feelings of emptiness and helplessness, increased dependency and poor modulation of aggression, hyper vigilance/irritability and alienation (World Health Organisation, 1992, pp. 136-148). The following quotation indicates the manner in which the changes in character from fixed *psychic defenses* affected other significant areas of the participants' functioning and personality organisation: "I think a lot about something before doing it sometimes I don't like to involve myself in things that make me feel unsure of the outcome, it is too much of a gamble." These fixed psychic defenses developed in response to disintegrating primitive psychic anxieties.

The participants in this study all feared that they would be harmed, which is a possibility during deployments due to the nature of military operations. According to Garland (1998), universal anxieties that are potentially traumatic for anyone share a single distinguishing feature: the separation from or the loss of anything that is felt to be crucial to life including life itself. Kohut (1977) called this distinguishing feature of trauma disintegration anxiety, an unnamed dread associated with the impending disintegration of a coherent self. Ulman & Brothers (1988) asserted that neither reality nor fantasy results in trauma, but the unconscious meaning of the real occurrence causes trauma by changing the person's experience of the self in relation to self-objects. This connected to the relational and thus,

self aspect of their core that could not be separated from the soldiers they had become. In taking up arms previously and presently in the SANDF, these participants were not acting in defiance of death but in service of their hearts, psyche and its defenses as well as their country. One may assume that the participants bore unresolved psychic traumas from former force activities, which were reactivated with each traumatic incident they faced in the SANDF. Van der Kolk et al. (1996) asserted that a serious complication that interferes with healing involves a particular event that may activate other, long-forgotten memories of previous traumas, which create a domino effect with continuous signal anxiety alerting individuals of an impending situation of helplessness. According to Garland (1998), once the threat of annihilation has been encountered face-to-face, something is altered: once the ego has been traumatised, it no longer relies on signal anxiety in the face of life-threatening trauma, but responds as if it were flooded with automatic anxiety. This may be attributed to the manner in which the participants lived psychologically, physiologically and relationally as though they were always on the battlefield, face-to-face with traumatic combat exposure.

The infant's phantasised attacks on the external object, coupled with fears that the object is retaliating in return, are experienced as violent and bad in their entirety. This relation of aggression and reciprocal retaliation by the object induces paranoid anxiety, thus causing the infant to feel threatened by annihilation. Haley (1993) noted that this manifests in numbed detachment in the face of annihilation anxiety where no internal or external good objects are experienced, resulting in disorganised ego through psychic numbing, profound underlying anxiety and disorganisation. In accordance with this, the findings of this study revealed that this manifested as functional impairment among the participants, which was unfortunately misdiagnosed or misinterpreted as ill-discipline, rather than unconscious *psychodynamics* of PTSD. As a means of defending against the perceived threat of annihilation, the ego splits the bad object from the good in an attempt to protect the latter. These representations encompass individuals' good and bad experiences. The goal is for those aspects to be assimilated and reconciled into a mental representation that is able to both disappoint and please (Siegel & Forero, 2012). However, a vicious cycle ensues, where splitting leads to omnipotence and paranoid anxiety, which in turn is defended against through further splitting of the object as excessively good or extremely bad with alternating states of persecution and idealisation (Anderson, 1992; Klein, 1946). In this study, the participants perceived the SANDF as a bad object and a persistent threat of danger, which may have sent them deeper into a fragmentary state as manifest in undiagnosed PTSD with which they presented. The participants not only perceived persecutory attacks from the SANDF as being responsible for the undiagnosed PTSD syndrome, but may have feared retaliation for being bad for developing PTSD.

When beta elements (raw soma/psyche data) cannot be mentally elaborated and transformed into alpha elements (elements of dream /thoughts) and dream thoughts, in effect they cannot be repressed.

Something that has not yet been represented mentally cannot be repressed, which renders this psychic defense ineffective (Segal, 1986). The accumulation of all that was swallowed experientially only to be repressed and avoiding the capacity to digest it, created an internal world the participants attempted to either flee from or ultimately lose the battle to PTSD. This psychic manner of coping leads to an attack on the psyche, which in essence is an attack on the self. This implies that the elements of consciousness that are usually integrated are not permitted to integrate and the traumatic experience itself becomes disconnected. The psychological defense of repression against the experience of intolerable pain carries immense internal hardship as the psychological sequelae of the trauma continue to haunt the internal world (Kalsched, 1996). When maladaptively repressed psychic material ultimately finds expression, as though in flight from a deadened internal world, it manifests in the physical and trauma-related psychiatric syndrome with which the participants presented. The perceived severity of the traumatic content defended against appeared to threaten the participants' psyche or life. The participants' reality entailed the psychic anxiety of losing their mind or life. Bion (1970) explained that the capacity to repress may seem to be a psychological triumph, releasing the mind from psychotic franticness and finally, autistic encapsulation. However, beta elements, when accreted, propel for evacuation as evidenced in the participants' lived symptoms of PTSD.

Van der Kolk, Weisaeth, and Van der Hart (1996) asserted that once traumatised individuals become tormented by intrusive re-experiences of their trauma, they generally begin to organise their lives around avoiding having the emotions that these intrusions evoke. Avoidance may take a myriad of different forms such as keeping away from reminders and ingesting drugs or alcohol in order to numb the awareness of distressing emotional states, as revealed among the participants in this study. This avoidance of specific triggers was intensified by a generalised numbing of responsiveness to a vast range of emotional aspects of life. The process of integration of the self and within the SANDF implies bringing to the surface the repressed trauma-induced psychological burdens from previous military activities, a risk too grave to take and compounded by conflicting expectations of the training of what it means to be a mentally fit soldier. It was apparent that attempts at forgetting activated certain anxieties that were defended against, which further fragmented the psyche and perpetuated undiagnosed PTSD symptoms.

By *avoiding seeking psychological help*, the participants appeared to have given up getting relief from presenting trauma-induced psychological disturbances. The following statement made by a participant revealed the extent integrated members had lost faith on psychological services: "Even now you can just be there and say company I'm coming this and this for you, people won't come unless you force them, just because they know that thing will not help us, it will not help us." This scenario illustrates a possible intervention a psychologist would propose in a section within a unit. This dismissal

of psychological services may have been linked to feelings of having had their psychic wounds dismissed or misattenuated by psychologists during and post the integration phase, sentencing them to survival with these raw untreated psychic wounds. Even the female participant was loath to seek psychological help, which does not concur with research in military psychology. Studies have revealed that when affected psychologically, women tend to request help more readily than men do, therefore, evading many of the long-term mental suffering that male soldiers are faced with post deployment missions (Breslau & Davies, 1987; Crum-Cianflone, & Jacobson, 2013; Gallegos et al., 2015; Maguen et al., 2012).

Apart from concerns around confidentiality in relation to seeking psychological support, the participants feared that this would mean a loss to their internal battle. Moreover, Hoge (2010) found that members also forego treatment to evade any potential harm to their military careers. The concern around confidentiality suggested mistrust of authority figures, which was exacerbated by them being from different former forces. This was associated with feelings of mistrust towards the SANDF and its perception as a traumatising system. The avoidance of seeking mental health input shed light on how these facilities had not been internalised as secure bases wherein to feel safe by being held and having one's emotions and psychic content regulated post integration or continuously post deployments. This is indicated in participant 9's statement: "For me maybe seeing a psychologist means my mind is no longer okay, I must be sent to ward 7, I can't risk that." When emotional pain could no longer be bottled in and was opened, it was made sense of physiologically or physically through psychosomatic presentations for which medical treatment was sought from the sickbay. An aspect of traumatisation that is prevalent is the degree to which somatic symptoms are understood to be a common dimension, intrinsic to trauma presentation (Eagle, 2014). This possibly explained the influx of members to sickbays and the link between PTSD with increased rates of somatic complaints, general medical conditions and substance related disorders. Herman (1992) also noted that in complex traumatic stress, the impact of exposure to multiple traumatic events over a prolonged period generally involves the development of chronic somatic problems.

It is noteworthy that seeking psychological assistance would have required the participants to trust and connect with the psychologist as a relational object. This presented the participants with the same psychic conflict as that of psychological integration into the family and the SANDF. Again, it became apparent how ruptures in former relationships had become a psychological template for how participants negotiated relational aspects within and outside of the SANDF (St. Clair, 2000). External validation of feelings about the reality of a traumatic experience in a safe and supportive context is a pivotal aspect in the prevention and treatment of post-traumatic stress (McFarlane & Van der Kolk, 1996). This is what accessing a therapeutic space would have ideally availed for the participants had they consulted

psychologists within the system. However, the creation of such a context for recovery can become very complicated if the social network is depleted or unavailable (McFarlane & Van der Kolk, 1996). It is apparent that the participants in the current study experienced the psychological support system as unavailable and aligned themselves more with physical health support within the system. Failure in cognitive shift in this regard caused the participants to suffer with undiagnosed PTSD.

Cognitive and emotive distortion is one of the criteria for PTSD, which was evidenced in the participants' control of psychic defense structures. Rigid control was developed from their experience in the past and current forces, which left them feeling out of control and vulnerable; consequently, perpetuating the chronicity of their PTSD. Cognitive difficulties, which result from persistent untreated PTSD, were also taken into consideration. This may impair the cognitive flexibility aspect of healthy executive functioning. Soldiers are mostly trained to respond cognitively or tactically and not emotionally. They have to take control of their emotive reality and execute their military commands and thus, do not have the option of displaying intense fear, helplessness and/or horror. Furthermore, dissociation at the moment of the trauma appears to be the single most important determining factor for the development of chronic PTSD (Van der Kolk et al., 1996). This appeared to be the way in which participants negotiated their emotions, rather than regulating them. Participant 2 explained, "People say we have hardened hearts just because you have self control." Earlier psychoanalytic theories of PTSD posited that psychopathology manifesting from unresolved PTSD may be observed in rigid defenses operating in the psyche (Freud, 1936). From an object relations theory perspective, this maintains the avoidance of acknowledging the relationship between the self and a perceived unsafe world. This notion still holds as an explication in complex trauma (Zepinic, 2012) and may be inferred from the participants' responses in relation to cognitive patterns resultant from their trauma and the defenses they employed to cope.

The participants' attempt at alleviating their emotional distress was evident from the manner in which they transferred psychic pain from the psyche onto their body. Their psychological distress became more tolerable when located in other parts of the body and thus, they exiled themselves to living in a fragmented state and never worked towards a psychological shift to an integrated self. The *disintegration of the* participants' *psyche-soma* was symbolic of their experience of being in a disintegrating integrated SANDF. This was the result of unresolved previous experiences of trauma, which they brought with them from previous combat exposure from which they decompensated into individuals who had to survive with disintegrated egos and self. It was evident that it would be difficult for the participants to experience integration into the SANDF when their psychic functioning was rooted in operating not only from a disintegrated psyche-soma and therefore, self. Winnicott (1965) explained that where there is a presenting psychiatric disorder, personalities become disintegrated, patients lose

the capacity to dwell in their bodies and accept their skin-boundary and are rendered unable to relate to objects. They feel unreal in relation to the environment and they feel that the environment is unreal, a lived experience expressed by some of the participants.

A successful journey to healing would mean the participants had to move away from over-reliance on mind-object (Corrigan & Gordon, 1995) and/or bodily second-skin sort attempts to hold themselves together. Rather, they would have to find a safer place internally wherein the psyche might reside in the soma. When this is not achieved, individuals have to override the signals of their body about the state of their emotions and rely significantly on their mind. This is typical of the patients Corrigan and Gordon described as relying on their minds as their primary objects; hence, the term mind-object that they coined. The participants appeared to experience a continued psychological warfare, which may have also contributed to the deleterious course of their chronic and untreated PTSD. For Winnicott (1965), it was the environment's emotional holding and responsiveness to the arousal of psychological and bodily states that enabled the psyche to indwell in the body and for the psyche and soma to become intimately entwined. Possibly, if the participants had found an internal safe space wherein the psyche may have integrated as part of the soma and not a traumatising part to be fought off, they may have found a place for integrating their trauma within the psyche. Psyche-soma disintegration entails ego disintegration with characteristic primitive defenses such as splitting from the paranoid-schizoid psychic position.

A unique dynamic was uncovered for those participants who had formerly been in the SADF, which compounded their ability to feel as though they were integrated members of the SANDF. This was different to that of the participants from other former forces who experienced resentment at being absorbed into former SADF structures. The SADF was represented as all good: as related to as part object, it was interesting how previous traumas therefrom were justified and thought to be resolved, unbeknown that they had been defensively transferred onto the SANDF and form part of the undiagnosed PTSD. The participants' defenses are best explained by the paranoid-schizoid position postulated within a Kleinian framework of object relations, characterised by part-relating of the infant toward the breast of the mother as primary object, splitting it into two distinct parts that are either good and satisfying or bad, frustrating and persecutory (Duckham, 2011; Kavaler-Adler, 2014; Potik, 2018; Summers, 2014). Kernberg asserted that psychological development is rooted in the continued cycle of "internalisations of object relations units and defenses against them" (Christopher et al., 2001, p.690) with aspects thereof often rendered unconscious. Failure to integrate positive and negative self-and-object presentations (Summers, 2014) constitutes digressive means of Kernberg's mechanisms of introjection and ego identity (Kernberg, 1997). A failure to establish an integrated self-concept results in what Kernberg conceptualised as the primary defense mechanism of splitting whose resolution may only be achieved through the pivotal developmental step in shifting from splitting to self-and-object

integration (Summers, 2014). A vicious cycle ensues where splitting leads to omnipotence and paranoid anxiety, which in turn is defended against through further splitting of the object as excessively good or extremely bad, with alternating states of persecution and idealisation.

It was apparent that the participants experienced the former SADF as the good breast, while the SANDF represented the bad breast. Unable to deal with its own innate destructive and aggressive drives into annihilation or integrate good and bad parts of an object as a whole due to an immature ego, an infant resort to primitive defense mechanisms such as projection, splitting, denial, projective identification, introjection and idealisation (Potik, 2018). These defenses serve to defend the ego against irreconcilable trauma as manifest in persecutory anxiety that originates from the persecutory bad object (Duckham, 2011). It appeared as though there was a primal part-object relating to the first military structure of which the participants were a part that fed into their internal world around which an element of their psychic structure was organised, which was not based in reality. This revealed unresolved traumas with which the participants were integrated into the SANDF and the compounding thereof by continued military traumas.

It appeared that the participants had a defense against expressing or acknowledging negative thoughts or feelings towards the SADF or other former force structures for fear of possibly having no perceived good internal object on which to hold. Fairbairn (1943) proposed that soldiers have a strong attachment to their bad objects in their repressed state and an acutely repugnant reaction to the release of the bad objects and the consequent breakdown of defenses. This was revealed in the participants' defensive holding on to the SADF as a good object for fear of loss of all objects and what was feared would be a *loss of their minds.* This is subsequently discussed.

7.3.2.8 Loss of overall well-being

The participants' accounts reflected a deterioration of the elements of their minds, bodies and souls as a result of their cumulative combat exposure, which they carried from their former forces and continued into the transition of the SANDF. Kardiner and Spiegel (1947) declared that these these impairments result in "the endopsychic perception of a hostile world and an impoverished self" (p. 325). This may explain why some soldiers from infantry military bases, where the participants in this study were based, are perceived to be functionally impaired in their daily living when not on operations. PTSD can be severe enough and last long enough to impair a person's daily functioning. In addition to the psychological symptoms noted throughout this study, PTSD is marked by clear biological changes and is consequently, complicated by a myriad of other problems of physical and mental health (Iribarren et al., 2005).

Furthermore, it has been revealed that traumatised individuals also present with comorbid personality disorders (Herman, 1992; Herman & Van der Kolk, 1987; Kulka et al., 1990; Reich, 1990; Shay, 1994) including extensive disturbances in affect regulation, dissociation, somatisation and disturbed beliefs concerning self and relationships (Ford, 1999) that impair characterological stability. Honing et al. (1999) noted that the most significant long-term impact of trauma is often manifested in the form of persistent character traits that may have originated as coping responses to the trauma.

It appears as though psychological illness is more readily explained away or denied through psychic defenses while physical illness seems to signal a fragility and functional decline that is in itself traumatising. The participants in this study became adept at hiding their psychological pain/impairments from themselves and others, but could not escape the manifestation of physical illnesses. Psychic defenses are geared towards displacing/separating the psyche from the soma, but when physical ailments erupt, it involves coming face-to-face with the soma wherein disparate parts of the psyche have been displaced. It is as though the psyche has poisoned the body and may be experienced as a threat of imminent fragmentation. Trauma evidently produces over-activity of mental functioning and a mind-psyche, which is pathological. Thus, the satisfactory and mutual interrelation of the psyche and soma is prevented, which impedes the feeling of a sense of aliveness in relation to self and others (Corrigan & Gordon, 1995). The participants seemed to persecute themselves in feeling shame about how they had been affected by their service in the military environment. Kulka et al. (1990) found that veterans diagnosed with PTSD or substance abuse also presented with more chronic physical health problems. It appears physical ailment for which no medical cause could be found signaled defeat regarding control over their internal and external worlds, which personified all the other losses in these participants' lives.

Shay (1994) detailed several ways in which veterans feel impaired that were difficult to explicate and comprised a persistence of factors from combat exposure. Shay's use of language in his description of the persistence of aspects of experience, function, affect and the loss or impairment of other functions represented his attempt to define PTSD in ways that were experienced near to the veteran's experiential reality. It appeared that members of the SANDF presented with undiagnosed PTSD symptoms typically seen among veteran cohorts. This may have been due to the fact that they were veterans of their former forces, which further complicated their psychic conflict. These participants' loss in functioning capacity secondary to trauma encompassed loss in meaning of living.

Van der Kolk et al. (1996) postulated that loss, be it a loss of life, possessions, integrity or beliefs is a primary component of an experience, which becomes a trauma. The participants experienced the *loss of meaning in the work as a soldier* as the loss of meaning experienced from former forces course and operations. In essence, this was a loss of the former force structures. In object relations theory, the absence or loss of a sense of meaning is associated with the loss of the object. Guntrip (1968) stated that

the importance of human living lies in object-relationships and only on such basis our life can be said to have meaning. It appeared that the participants' identity and purpose was deeply ingrained in being a soldier and being active in military operations as well as the trauma they also carried. Although the reality of extraordinary events is at the core of PTSD, the meanings that victims ascribe to these events are as fundamental as the trauma itself (Van der Kolk et al., 1996). Wolff (1995) attributed many of the delayed-onset symptoms of PTSD to a loss of meaning ascribed to the traumatic event. He postulated that many South African soldiers went through severe traumatic situations during the war in Angola without exhibiting signs of PTSD because they could attribute some sort of meaning to the war. After 1994, when that meaning was questioned, the symptoms of PTSD multiplied and the diagnosis escalated. However, the participants in this study, who perceived an integrated SANDF as undermining the meaning of their political military contribution remained undiagnosed and untreated. Their symptomatology was observed from their behavioural, physical, mood, emotional and occupational functional capacity.

The development of a soldier into an undiscriminating killer can be understood as a form of internalising aspects of the external object. In the face of a traumatic collapse of psychic structure and object relationship, the psyche may catch any available object to prevent an even worse reality of total objectlessness (Grand & Alpert, 1993). The SANDF's current mandate was primarily peacekeeping missions, different to the course of former armed forces, which may have been a catharsis for the evacuation of the participants' aggressive and destructive impulses and perceived internal bad objects. There may have been an element of a repetitive compulsion in the participants (pre-occupation) with re-exposure to potential combat exposure and psychological trauma through deployments. This may imply that inactive operationally participants were forced to dwell with the psychological distress of their unresolved traumas, but when active they were distracted from their distressing internal world. What was perceived as ill-discipline and dysfunctional by the system seemed to occur when the members' defenses failed them in their battle with their internal world in the grip of active PTSD symptoms.

Vulnerability is a significant factor in the development of trauma and in the long-term adjustment to living with the legacy of traumatic stress (Van der Kolk, Weisaeth, & Van der Hart, 1996). When people lose their faith that their world is a safe, structured and just place to live in, it colours their relation to it. Accordingly, individuals experience a loss of effectual control over their environment and increasingly experience the world as an unsafe place (Van der Kolk et al., 1996). The participants revealed this in their expression of emotional pain due to the lack of control over what pertained to their overall welfare within the SANDF. This may have unconsciously resulted in the resurfacing of distressing feelings of traumatic experiences during which the participants may have felt vulnerable. Consequently, this exacerbated their symptoms of PTSD and accompanying maladaptive psychic defenses. This concurs

with Kardiner (1995) who argued that traumatic events create levels of psychic stimulation that the individual is inept to master and a severe blow is dealt to the total ego organisation, as was apparent in this study. Individuals experience this as a sudden loss of effectual control over their environment, which results in an altered conception of the self in relation to the world (Kardiner, 1959).

According to Haley (1993), feelings of loss of control manifest in numbed detachment in the face of annihilation anxiety where no internal or external good objects are experienced, thus resulting in disorganised ego through psychic numbing, profound underlying anxiety and disorganisation. Haley added that this can lead to an inability to identify and work through memories and affects, thus contributing to somatisation, passivity and an inability to verbalise guilt about atrocities; this too was apparent from the participants in this study. Feelings of *loss of control* also evoked anxieties about *vulnerability* to the development of PTSD, which was defended against. This was evident in the participants' concealment of PTSD symptoms.

7.3.2.9 Feelings of shame and fear about symptoms of trauma

It is possible that the participants masked their shame about their PTSD symptoms with anger, which also defended against the fear of not knowing if they would ever feel psychologically well. While the diagnostic system has aimed to capture traumatisation in universal and specific terms, the debates about the adequacy of Criterion A in the fifth version of DSM have also extended to whether this set of affects is sufficiently exhaustive. Several contributors have observed that anger and shame, for instance, are often present in the aftermath of trauma (Eagle, 2014).

The participants harboured feelings of shame that their traumatic stress response to combat exposure rendered them psychologically unfit. They were unaware that if their PTSD was to be diagnosed, it would lead to a process of identifying and resolving their psychological difficulties. Accordingly, they would be able to foster insight and resilience, which would lead to enduring psychological hardiness. These psychological processes were meant to have been facilitated in tandem with the process of administrative demobilisation and thus, the integration of members of the former armed structures into the SANDF. It transpired that during integration a *bullet was dodged* by participants in this study in that the administrative processes did not uncover any pre-existing psychological conditions. Furthermore, they were resolute to keep it that way. The more the participants tried to conceal their PTSD symptoms, the more they found expression through mood, physical and behavioural disturbance. However, once they were declared psychologically fit on the system through the CHA process, during which their symptoms were masked significantly, there were no pre-emptive programmes in place, thus leaving the members further isolated in their distress. This may partially explain the deleterious course of this undiagnosed PTSD amongst some of the Black members of the SANDF. According to Schell and

Marshall (2008), data support the claim that fear of discrimination amongst United States military service members forms a significant hindrance to seeking treatment. The military in the United States like the SANDF uses information about psychiatric diagnoses and mental health treatment to determine whether members are suitable for deployment. Consequently, these members forego treatment to evade any potential harm to their military careers (Hoge, 2010).

Consulting a psychologist is equated with having a mental illness and the participants feared that the PTSD symptoms they suffered from may have meant they suffered mental illness from traumatic experiences endured. According to Horowitz (1976), some individuals with PTSD alternate between periods during which re-experiencing intrusive symptoms are more prominent and periods during which denial-numbing symptoms are more prominent, with the latter more pronounced when individuals feel they are psychologically weak.

Seeking psychological help is perceived as a weakness, which relates to the persecutory relationship the participants had with their internal objects. The former and current military forces were introjected as bad objects, which became a psychological template for relating with their external environment. It may also have been a defense because psychological intervention implies a relational dynamic, which may have indicated the participants' core suffering. The participants may have experienced the need for relational objects to meet certain dependency needs as a weakness to be defended against. Fairbairn (1943) asserted that when a soldier's traumatic experience triggers the release of bad objects, the following failures of defenses and coping strategies occur: psychopathological symptoms, in the form of PTSD, is directed by a return of bad objects, which have been repressed. Accordingly, the return of bad objects implies a failure of the repression defense because only that which has been integrated into experience and psyche can be repressed. A participant noted, "…it is like that, how can I put it..? … Eh, I will be punished cause they will think I am weak." This perceived persecution did not only result from external objects, but also internally from the self because the participants felt weak for not having the psychological strength to have prevented themselves from long-term suffering with PTSD.

7.4 Concluding summary

Studies of military trauma experiences have been researched broadly internationally and in Africa including South Africa. Although limited in scope, this study attempted enhance our understanding of Black SANDF members' thoughts and feelings of their experience of traumatisation and secondary long-term undiagnosed PTSD syndrome from an object-relations perspective. Instead of trying to obliterate the influence of the researcher's perspective through detachment, it was embraced and addressed as a component of the process of generating knowledge (De la Rey, 1999; Wilkinson, 1988).

In answering the research questions through phenomenological interpretative analysis, this study found that Black SANDF members from former forces carried over unresolved PTSD syndrome from combat exposure into the newly formed SANDF. This is in accord with Tal (1996) in that traumatised conscripts have carried their psychic wounds into the new South Africa, as Black members in this study have carried theirs from the armed struggle into the SANDF. As in this study, Mashike & Makalobe (2003) indicated that South African former combatants self-reported symptoms akin to those described under the diagnosis of PTSD. According to Abrahams (2006) combat experience has also left many soldiers emotionally distressed, which has been further compounded by their frustration at not being understood by their families, their communities, and society at large. They are also saddled with the stigmatisation of having fought for the struggle but not having anything to show for it (Shapiro, 2012), which was evidenced in this study with regards to promotion in rank. Psychic defenses against this psychic trauma informed participants' experience of the SANDF as an organisation. The study found that SANDF members present with undiagnosed PTSD symptoms from traumatisation in previous and current military service operations, which continues to affect their character as well as relational and familial, physical, occupational and social adaptive capacity spanning over many years. Perhaps most importantly to this study is that Black SANDF members presented their trauma as not driven by anger (appetitive aggression) but by suffering, with significance within 'fellow suffering' as they see the pain in others and how others attempt to defend against it too.

The study also revealed that unresolved psychological trauma endured during past and current military service led to psychological disintegration as manifest in participants' undiagnosed PTSD syndrome. This is supported by an international study by LeardMann et al. (2009), which showed that as these individuals continue to get deployed, diminished mental or physical health status before combat deployment is strongly correlated with an increased risk of new onset of PTSD symptoms after deployment. Within the SANDF, the psychic defenses rigidly employed in an attempt to alleviate psychological distress perpetuated a core pattern of suffering that rendered members' ego, self and self-object relations fragmentary. To survive with undiagnosed PTSD for as long as they had, primitive psychic defenses that undermined a cohesive sense of self and a psychological shift towards healing by giving up introjected bad objects, resulted in the psychological developmental arrest and pathological psychic organisational structures of these members.

The study further demonstrated a holding onto psychic defenses by Black members of the SANDF as manifest in ideological and psychological alignment to former force structures, wherein their ego identity seemed to lie. Furthermore, an internal conflict in holding on to their psychic trauma as though healing would mean erasure of their identity, which had been entwined with their experiences of combat exposure, was evident. This is an indication that therapeutic treatments for traumatised Black soldiers

will be effective only to the extent that their moral and spiritual issues are addressed on their own terms and not just primarily as symtoms of a psychiatric condition (Brooke, 2017). The members' pain centered around loss of self: physically, psychologically and in relation to self and self-objects internally and externally. The members' perception of who they were and who they wanted to be did not connect as their cumulative military related traumatic experiences had not been integrated into their psyche. This may explain why former force members were unable to integrate into the SANDF psychologically as well as into their families and society. In Doherty's (2015) examination of memoirs from conscripts of the South African 'Border War', one conscript poignantly stated that war trauma remains an unrecognised, cancerous growth in the heart of South African society that threatens to undermine every effort to solve the country's problems.

The study also found that the SANDF had been internalised as a persecutory and traumatising object, which is suggestive of displacement of underlying feelings of abandonment depression by former force structures from the process of demobilisation of statutory and non-statutory armed forces. These pathological self-object dynamics compounded the extent of vulnerability and symptomatology from exposure to combat trauma among Black SANDF members, who fought in the liberation movement. The participants' maladaptive defenses in concealing their PTSD syndrome may have contributed to the misdiagnosis of PTSD in the SANDF during and post integration. The anecdotal evidence of the role of psychology in the SADF is that trauma was given minimal recognition by the military authorities at the time. Mental health professionals had an ambivalent status in the army at the best of times, as psychological problems were dealt with as disciplinary offences (Doherty, 2015). This is still evident within the current SANDF. At the time of the interviews, participants were presenting with active symptoms of PTSD and resorting to self-destructive behaviours in order to cope. Part of the distress of their clinical presentation involved the impairment in their relational patterns, leaving them to suffer silently in physical and emotional isolation. They felt ashamed and persecuted themselves for what they perceived to be a weakness in having developed PTSD. This is exacerbated by cultural norms forcing men to endure trauma and strive to gain mastery over its effects in order to claim the status of 'manhood' (Goldstein, 2003). Unique to this study is that after demobilisation, these Black SANDF members have had to psychically mobilise to defensively repress their plight from traumatisation to hide it from others and the self for the most part. This kept them trapped in the trenches of traumatisation as the core pattern of psychic suffering.

In conclusion, this study revealed that Black SANDF members' presentation of mood and behavioural, physical, cognitive and functional disturbance was a manifestation of underlying symptoms of chronic untreated PTSD, secondary to combat trauma. Furthermore, the perceived functional impairment among them was inherent conscious and unconscious psychological and behavioural

defenses of coping with long-term post-traumatic psychological wounds to which the SANDF and psychological healthcare practitioners were perceived to be misattuned. This is despite having developed protocols for "psychological debriefing" by SADF in the 1980s, the implementation of which was not particularly thorough (Dohert, 2015), and according to this study seem to not have improved to date. These serving members continually succeeded in masking the morbidity and severity of their undiagnosed PTSD symptoms from psychology officers in the SANDF, not only to defend against being psychically overwhelmed but also against being perceived as psychologically unfit as well as having lost control and their minds to past and continuous traumatic combat exposure.

7.5 The value of the study

From a phenomonolgical enquiry, this research study was impactful in uncovering the nuances of experiences in the dynamics of the influence of both collective and individual traumatisation of Black SANDF soldiers. The primary value of this research lay in the exploration of what trauma means to these SANDF members, as well as its lived symptoms among them. The study showed how the participants past traumatic experiences of combat exposure were re-activated by continuous traumatic experiences, which explained the chronic nature of their undiagnosed PTSD. Psychologists in the SANDF may learn that symptoms of untreated combat PTSD remain active and may span many years with impairing overall functional capacity of the sufferer. Furthermore, the research also explored conscious and unconscious maladaptive psychic defenses employed to defend against the psychic distress caused by long-term PTSD among Black SANDF members. Focusing on the manifestation of traumatistion in symptoms of PTSD from the participants' lived experience is valuable to understand the complexity of PTSD secondary to combat exposure. This may facilitate diagnosing and treating PTSD in the SANDF context.

This study presents a psychoanalytic understanding of trauma to the psyche and accordingly, PTSD, from an object relations perspective. This facilitated an understanding of how the participants experienced and related to their internal and external world from a traumatised psyche and thus, disintegrated ego and self. The psychoanalytic lens views PTSD as a manifestation of this psychic disintegration due to failure to integrate traumatic combat experiences into the psyche. This assists in explaining why these participants could not psychologically integrate into their families, society and the SANDF. Objects Relations Theory was valuable in understanding these members' self-object relations which developed as a result of their unresolved trauma. Being aware of the self-destructive defenses employed due to introjected bad objects afforded an understanding of the emotional, somatic, mood, relational, behavioural and occupational disturbances observed as a manifestation of undiagnosed PTSD syndrome. Furthermore, internal defensive dynamics against trauma to the psyche influence intra-

personal and inter-personal interactions /conflictual core relational patterns and hence the disintegration in the character of the self and the SANDF soldier.

The findings from this study may be beneficial in guiding military mental health practitioners to establish psychological treatment programmes for military members suffering from undiagnosed PTSD secondary to enduring traumatisation. These could be incorporated into the SANDF's psychological wellness programmes and as part of CHA intervention tools. The findings could also contribute to psychotherapeutic models focused on integrative meaning making of the pain and suffering of soldiers suffering from chronic PTSD. Furthermore, these therapeutic models could enable internal regulatory capacities to facilitate a process of psychologically integrated soldiers and a national defence force. Finally, intensive pro-active psychological programmes could be developed after training mental health care practitioners to understand how enduring unconscious defensive core conflicts from traumatisation underlie impairment in SANDF members' psychological, physical, behavioural and occupational presentations.

7.6 Limitations of the study

Despite the potential beneficial findings of this study, there are several limitations. First, the sample was largely homogenous. The participants were Black, of low to lowest military ranking and one lowest ranking commissioned officer. There was only one female participant. Therefore, the participants were not representative of the SANDF from a racial perspective. The study would have been enriched if White members of the SANDF had constituted part of the sample. Unfortuntaly the latter could not be reached as they did not appear in the social work officers' consultation records from which referrals for the study were made. However, the exploratory nature of the study afforded an understanding of individual experiences and development of a beneficial and meaningful body of research to deepen the participants' understanding of their reality (Lincoln, Lynam, & Guba, 2011) and their experiences in relation to existing research.

Another possible limitation relates to data interpretation. The descriptive methodology of IPA allowed for rich information on individual experiences of undiagnosed PTSD within the SANDF, with value in the abundance of descriptive information extracted. In IPA, however, themes are extracted through the researcher's subjective interpretation. The implication thereof is that the results could potentially be dissimilar if interpreted by different researchers (Smith & Osborn, 2003; Willig, 2008) and conducted with different participants as well as in a different research context. Moreover, as a result of my background working in the SANDF as a Black clinical psychologist, I may have explored and interpreted certain aspects of the participants' narratives while leaving others unexplored and neglected. The use of semi-structured interviews may have been a contributing factor because this guided my area

of interest and some questions pursued. Most IPA studies, however, have been conducted using semi-structured interviews (Smith & Osborn, 2003). I had a set of questions on an interview schedule, but the interview was guided by the schedule rather than be dictated by it. In attempt to enter the psychological and social world of the participants as far as possible, they shared more closely in the direction the interview took. The participants could introduce an issue I had not thought of. In that way participants could be perceived as the experiential experts on the subject and were therefore allowed maximum opportunity to tell their own story in order to produce rich data (Smith & Osborn, 2003). However, in IPA (Smith, 2004) acknowledges that the researcher's subjective position and preconceptions have an impact on data analysis. Therefore, I acknowledge that my subjective position may have enabled or facilitated the gathering and interpretation of data that would otherwise have remained unnoticed or unexplored.

The main limitation, however, relates to the sampling methodology that was employed in the study. In addition to the small and homogenous sample, participants in the study were drawn from only two Batallion Military bases in the south of Johannesburg. However, the focus of this study was on depth of understanding, rather than breadth of applicability (Gall et al., 1996). According to literature, IPA researchers usually try to find a fairly homogeneous sample. The logic is that if one is interviewing, for example, six participants, it is not very helpful to think in terms of random or representative sampling. Through purposive sampling, IPA therefore finds a more closely defined group for whom the research question will be significant (Smith & Shinebourne, 2012), thereby, also making it possible to think in terms of theoretical rather than empirical generalisability. In that way, the readers make links between the findings of an IPA study, their own personal and professional experience, and the claims in the extant literature. The light it sheds within this broader context (Smith & Shinebourne, 2012) judges the power of the IPA study.

Furthermore, the results may have been homogenous due to the collective and historical traumatisation (Eagle, 2004), as predicated by South Africa's traumatic militarised political history and Black SANDF members' uniquely collective experience thereof. Given that I was interested in understanding Black SANDF soldiers' experiences of traumatisation as manifest in their undiagnosed PTSD syndrome, IPA allowed for the convergence of these common experiential themes across different cases, in my exploration of themes shared between cases (Smith et al., 2009). This is because IPA can also uncover experiences that are unique to an individual as well as reveal shared experiences among participants. Thus, enabling the integration of unshared subjective aspects of experiences with the shared experiences within a sub-culture of the sample (Willig, 2013). This is evidenced in how qualitative research enables psychological research to explore the meanings individuals ascribe to life, health, death and illness as well as the lived experience of these constructs, from an individual's perspective instead

of focusing exclusively on group comparisons and the classification of behaviours (Lyons & Chamberlain, 2006).

7.7 Recommendations for future research

Several recommendations for further research can be offered. This study focused on integrated SANDF serving members' experiences of long-term undiagnosed PTSD and the impairing effects on their psychological, relational and functional capacity from an objects relations theoretical framework. It is recommended that future research examines how service men and women's families, spouses and children, are affected by PTSD suffered by their loved ones and possible traumatisation. It is also recommended that quantitative studies on the prevalence of PTSD in the SANDF and in programme evaluation studies for therapeutic interventions be conducted.

In addition, it is recommended that future research examine the resilience and possible psychological resources of SANDF members living with untreated PTSD and how these could be strengthened. This could be conducted from a positive psychology perspective with a focus on their healthy psychological parts so as to develop interventions to strengthen their resilience meaningfully. Finally, with reference to military service, research could be conducted on African perspectives on PTSD in relation to how the symptomatic expression of traumatic stress is understood and managed culturally.

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Appendix 1: Information Letter

*Please note, that at the time of the interviews the title of the study was *"An object relations perspective on long-term undiagnosed PTSD in the South African National Defence Force"*, however, since wrting up the thesis the title was changed to *"An object relations perspective on accounts of traumatisation among a group of Black South African National Defence Force soldiers"*.

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Information Letter / Consent Form

This information letter serves to inform you about a study title *"An object relations perspective on long-term undiagnosed PTSD in the South African National Defence Force"*. This will assist in understanding the extent of psycho-social difficulties that integrated servicemen and women present with and the casues thereof.

This information letter serves to inform you about a study titled "An object relations perspective on long-term undiagnosed PTSD in the South African National Defence Force". This will assist in understanding the extent of psycho-social difficulties that integrated servicemen and women present with and the causes thereof.

The study aims to recruit 9 voluntary participants into the study. Participants will need to meet certain inclusion criteria one of which is to achieve a score on the Impact of Events Scale Revised (IES-R). This is a scale which measures PTSD symptoms. Those who meet this criterion will be invited to participate further to be interviewed using an interview schedule. The interview will take as long as the participants need with follow-up sessions where necessary. The interviews will be audio taped.

Participation is voluntary and withdrawal is possible at any stage of the study, with no adverse consequences for the individuals. Any data collected from the participant up to that point will not be used in the study and will be destroyed.

Only the researcher and her supervisor from the University of Pretoria will have access to the data for data analysis purposes. Once the data has been analysed, interpreted, written up and submitted it will be stored for 15 years in a secure pace designated by the Department of Psychology at the university, Room 11-24 of the Human Sciences Building.

Participants' confidentiality will be protected as identifying information will not be disclosed to persons other than the researcher. No identifying information will be connected to the data as codes will be used to differentiate among interviewees. The data may be used for further research at a later stage but the data remains anonymous if re-used.

Study results will be disseminated in a form of a thesis, and then published as an article. The thesis may also be presented in conference presentations and made available to the military health unit to aid in the development of effective mental health care programmes.

The study has been approved by the ethics Committee of Faculty of Humanities, UP.

Counselling is available should the participants feel the need for psychological support services as a result of participation in the study. This will be through the psychological services of the military. In particular, Lt Dipholo a registered counsellor at the Lenz Military Base Community Centre can be contacted for sessions, or the participants may contact or request any other counsellor or psychologist at the military base.

The researcher invites you as a social worker employed at the military in the psychological services, to volunteer to assist in recruiting volunteers to participate in the study. If you wish to participate in this way you will be informed clearly what factors to take into account when recommending participants for the study.

During the study you may withdraw at any time if you so wish. There will be no adverse consequences if you choose to do so.

For any queries kindly contact the Researcher on:
Sharon Sibanda
072 138 5537/ 012 765 9345

Consent

I understand what has been explained in the information letter and I consent to participate in the study.

Signature: ……. Date: ……

Appendix 2: Information Letter – Social Workers

*Please note, that at the time of the interviews the title of the study was *"An object relations perspective on long-term undiagnosed PTSD in the South African National Defence Force"*, however, since wrting up the thesis the title was changed to *"An object relations perspective on accounts of traumatisation among a group of Black South African National Defence Force soldiers"*.

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Information Letter / Consent Form for Social Workers

This information letter serves to inform you about a study titled "An object relations perspective on long-term undiagnosed Post Traumatic Stress Disorder in the South African National Defence Force" This will assist in understanding the extent of psycho-social difficulties that integrated servicemen and women present with and the causes thereof.

The study aims to recruit 9 voluntary participants into the study.

Participants will need to meet certain inclusion criteria one of which is to achieve a score on the Impact of Events Scale Revised (IES-R). This is a scale which measures PTSD symptoms. Those who meet this criterion will be invited to participate further to be interviewed using an interview schedule. The duration of the interview will be determined by how long a participant needs and follow-up sessions will be scheduled where required. The interviews will be audio taped. Participation is voluntary and withdrawal is possible at any stage of the study, with no adverse consequences for the individuals. Any data collected from the participant up to that point will not be used in the study and will be destroyed.

Only the researcher and her supervisor from the University of Pretoria will have access to the data for data analysis purposes. Once the data has been analysed, interpreted, written up and submitted it will be stored in a password protected computer and hard copies in a secure cabinet in the Department of Psychology at the university in the Human Sciences Building.

Participants' confidentiality will be protected as identifying information will not be disclosed to persons other than the researcher. No identifying information will be connected to the data as codes will be used to differentiate among interviewees. The data may be used for further research at a later stage but the data remains anonymous if re-used.

Study results will be disseminated in a form of a thesis, and then published as an article. The thesis may also be presented in conference presentations and made available to the military health unit to aid in the development of effective mental health care programmes.

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Counselling is available should the participants feel the need for psychological support services as a result of participation in the study. This will be through the psychological services of the military. In particular, Lt Dipholo a registered counsellor at the Lenz Military Base Community Centre can be contacted for sessions, or the participants may contact or request any other counsellor or psychologist at the military base.

The researcher invites you as a social worker employed at the military in the psychological services, to volunteer to assist in recruiting volunteers to participate in the study. If you wish to participate in this way you will be informed clearly what factors to take into account when recommending participants for the study.

During the study you may withdraw at any time if you so wish. There will be no adverse consequences if you choose to do so.

For any queries kindly contact the Researcher on:
Sharon Sibanda
072 138 5537/ 012 765 9345

Consent

I understand what has been explained in the information letter and I consent to participate in the study.

Signature: ……. Date: ……

Appendix 3: Voluntary Informed Consent Form

*Please note, that at the time of the interviews the title of the study was *"An object relations perspective on long-term undiagnosed PTSD in the South African National Defence Force"*, however, since wrting up the thesis the title was changed to *"An object relations perspective on accounts of traumatisation among a group of Black South African National Defence Force soldiers"*.

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Voluntary Informed Consent Form

I, _____, provide consent to be interviewed by Capt Sibanda for her study of 'An object relations perspective on long-term undiagnosed Post Traumatic Stress Disorder in the South African National Defence Force' and I fully understand:

- the nature and purpose of this study
- participation in this interview is my choice
- that I may decide not to answer any questions I would prefer not to
- the interview will be audio taped and the tapes will only be processed by Capt Sibanda and only she and her supervisor will have access to the typed-up copies of what was said in the interviews
- The tapes will be stored in a safe place in her office
- All tape recordings will be destroyed after the research report has been submitted and examined
- That there will be no problem for me if I decide that I do not want to take part and I want to stop the interview
- If I do not wish to participate in this study, I will not be prejudiced in any way whatsoever
- The research will be written in a way that no one can tell exactly who I am, for example my name will not be used. What I say may be used exactly as I say it, but my identity will be protected as my name will not be used
- I will not gain anything directly by participating in this study
- I will be referred for counselling if I should want this kind of support as a result of partici-pating in this study.
- I may contact the researcher or supervisor with any concerns at any stage of the study.
- I have read and understood the explanation provided to me. I have had all my questions an-swered to my satisfaction and I voluntarily agree to partake in this study

…….. **……..**

Signature of interviewee **Date**

…… **……..**

Rank **Signature of Interviewer**

Appendix 4: Voluntary Informed Consent Form for Questionnaire

*Please note, that at the time of the interviews the title of the study was *"An object relations perspective on long-term undiagnosed PTSD in the South African National Defence Force"*, however, since wrting up the thesis the title was changed to *"An object relations perspective on accounts of traumatisation among a group of Black South African National Defence Force soldiers"*.

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Voluntary Informed Consent Form for Questionnaire

I, _____, provide consent for Capt Sibanda to administer a self-report questionnaire on me for her study of 'An object relations perspective on long-term undiagnosed Post Traumatic Stress Disorder in the South African National Defence Force' and I fully understand:

- the nature and purpose of this study
- participation in this study by completing the questionnaire is my choice
- that there will be no problem for me if I decide that I do not want to take part and my incomplete questionnaire cannot be used
- if I do not wish to participate in this study, I will not be prejudiced in any way whatsoever
- the research will be written in a way that no one can tell exactly who I am, for example my name will not be used
- my identity will be protected as I am completing this questionnaire anonymously
- I will not gain anything directly by participating in this study.

…….. **……..**

Signature of interviewee **Date**

…… **……..**

Rank **Signature of Interviewer**

Appendix 5: Permission Letter - Department of Defense

*Please note, that at the time of the interviews the title of the study was *"An object relations perspective on long-term undiagnosed PTSD in the South African National Defence Force"*, however, since wrting up the thesis the title was changed to *"An object relations perspective on accounts of traumatisation among a group of Black South African National Defence Force soldiers"*.

RESTRICTED

Defence Intelligence
Department:
Defence
REPUBLIC OF SOUTH AFRICA

DI/SDCI/DDS/R/202/3/7

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0001
29 July 2015

AUTHORITY TO CONDUCT RESEARCH IN THE DEPARTMENT OF DEFENCE (DOD): CAPT S.B. SIBANDA

1. Request letter AMHU GT/R/104/12 dd 17 July 2015 has reference.

2. Permission is hereby granted from a security perspective to Capt S.B. Sibanda to conduct research in the DOD on the topic entitled **"The Long-term Impact of Undiagnosed and thus Untreated Post-Traumatic Stress Disorder (PTSD) on integrated Members from Former Forces now Serving under the South African National Defence Force (SANDF)"** as a prerequisite for a PhD Degree in Psychology as requested.

3. On completion the final research product must be submitted to Defence Intelligence (DI), Sub-Division Counter Intelligence (SDCI) for security scrutiny before it is released to any entity outside the DOD.

4. For your attention.

(G.S. SIZANI)
CHIEF DIRECTOR COUNTER INTELLIGENCE: MAJ GEN
KS/KS (Capt S.B. Sibanda)

DSTR

For Action

OC Area Military Health Unit Gauteng (Attention: Capt S.B.Sibanda)

Internal

File: DI/SDCI/DDS/202/3/7

Lefapha la Boipheelo . Umnyango wezoKuVikela . Kgoro ya Tshireletso . iSebe lezoKhuselo . Department of Defence . Mahatsho wa Tshireletso
UmNyango WezoKuVikela . Ndzawulo ya swaVurheteri . Lefapha la Tshireletso . Departement van Verdediging . LiTiko laTeksuvikela

Appendix 6: Participant 7's Coded Interview Transcript

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

INTERVIEW 7
(March 2018)

4

A. [Greet and shake hands]

B. (**Purpose**):

I would like to ask you some questions about your background, your job responsibilities, your past military operations, some experiences you have had on external deployments and some of your difficulties you may be experiencing.

C. (**Motivation**)

I hope to use this information to help SANDF psychologists and other health care practitioners understand the workforce better.

D. Thank you for agreeing to talk with me, is it the right time to take some time to respond to some questions I have?

INTERVIEWEE: Yes, it's okay

INTERVIEWER: In your interview with the social work officer, you indicated that you experienced stressful events during your military career that posed serious physical threat to you or someone. Please tell me…

In relation to this stressful event, have you been diagnosed with post traumatic stress disorder or PTSD?

INTERVIEWEE: No, to my experience it can be 22 years in this organisation I have not. They don't assess us thorough anymore(2). The current army is not like the previous army**(7)**. We used to enjoy soldering even if we did not earn a lot**(13)**, so whatever you experience you knew you would be okay**(13)** but now you find that you always have those coming back to you like they are following you**(8)**. We knew that time why we wear this uniform**(2)** but nowadays we find ourselves so stressed we become so vulnerable**(21)** because our current leaders of today they don't look after their soldiers they don't care a damn about their subordinates**(16)**. They only care about their pockets and their promotions, they forget the purpose of carrying those ranks, to lead the people on the ground**(7)**. They forget about their careers, our soldiers today are not empowered enough, they are not looked after enough**(8)**. Their welfare is being sidelined**(5)**.

INTERVIEWER: Mmmhmmmmm

INTERVIEWEE: You understand? That's the reason why soldiers today are so stressed**(3)**. I can give you one example, the courses you find a soldier of more than 20 years, thirty years still a private then there comes someone who is new in the organisation, within three years that person is a leader you understand, but doesn't have the knowledge and experience of how to lead people**(9)**. Us soldiers we are being neglected career wise, promotions and social welfare**(10)**. I don't know before psychologist used to have like their own ..I don't now…communication period whereby they sit with the soldiers talking to the soldiers**(3)** but today you don't see that all those things happening we don't know what went wrong**(2)**.

INTERVIEWER: Yes

INTERVIEWEE: Soldiers used to be counselled on their problems**(1)** but nowadays you can't talk to your commanders because they go spread your problems to everyone**(10).** Soldiers have lost trust in the commanders**(16)**.

INTERVIEWER: And what can you say has kept you motivated and has helped you cope in your line of work?

INTERVIEWEE: Eh.. eh.. my side I used to ignore a lot of things that are negative to my life, ja most of the things that are negative I have tried to ignore them**(2)**. There are things that have happened I have tried to ignore them. There are bad things that have happened before but I concentrate on the positive, I don't dwell on the past I tell myself I have to move on because I know something, dwelling on the past you'll never go forward**(4)**. So the thing that is keeping me going everyday is I can have a grudge with you today, tomorrow I forget about what happened I move on**(1)**. Like an incident that happened when we were on an internal operation where things were bad for me at home, with the mother of my child threatening to leave me and fighting with me**(6)**, and all those things, saying she will bring my child to the camp, we were at Kruger Park…

no-one supported me they made me feel like I was going crazy**(3)** like I told the social worker. Yes I got so angry but I was not going to hurt anyone**(7)**, ja they all turned against me and said I wanted to kill them with an axe**(17)** because I couldn't be released to go home immediately. I was just threatening the one guy who was provoking me**(3).** Like I said you can't talk to leaders anymore**(10).** So even though I am with those people everyday one thing I tell myself the purpose I wake up in the morning early in the morning prepare myself and come to work**(17)**, I tell myself as soon as I enter the gate I forget -about what is happening at home and concentrate on what is happening at work**(12)**. Then at work I don't allow people to come and disturb my plan, my plan I don't allow people to do that**(10).** I concentrate on my task doing what I have to do handing in my submissions and finish that. When I leave this unit I forget about whats happening here and concentrate I'm going home**(12)**. That's how I keep myself going**(3)**.

INTERVIEWER: Mmm and do you find that you are functioning to the best of your ability ad being utilised optimally in line with your mustering?

INTERVIEWEE: I'm utilised in different posts where they need help. It's a matter of what do I need to do for the organisation I take responsibility**(6)**, what do I want to achieve because like currently I am not on my current post you see, I'm feeling in as a CR commander but taking those posts I did not take them to prove something I took them to achieve organisational goals,not to prove someone wrong or be better than another person.

INTERVIEWER: mmm that means your responsibilities change according to the section you are moved to? Is it the same when you deploy.

INTERVIEWEE: Yes, the last deployment I was utilised in the transport section.

INTERVIEWER: And what do you attribute to being so versatile? Does it have to do with particular training you received before, I'm not sure which former force you were with, or is it your long experience in the organisation?

INTERVIEWEE: The reason is I have subject knowledge, I've got experience I'm a former SADF member and whoever puts me in that position he knows that I'll deliver exactly what he is looking for. That is why I'm put in posts higher than the rank that I am in even if there are a lot of people above me, but they task me a lot even on deployments because they know I can. And that makes me have a lot of confidence i don't take it negatively and say this guy is punishing me or whatever.

INTERVIEWER: I see..

and was the transition from previous armed forces to one unified National Defence Force difficult for you?

INTERVIEWEE: Not for me no, but you see I have been in this rank for long there are lot of people promoted before me**(1)** but I always say to myself one day God will provide. Because if I can look at who gets promoted and so on I'll become negative and once I become negative**(8)** start doing wrong things unaware, like I'll start fighting with my commanders and so on**(3)**. Like I know with the incident at Kruger Park most people advised me to write a grievance of being wronged and some said I must go where…that's how I was born you understand I don't correct wrong with wrong. If someone does something wrong to me I'll try to be positive and sit down and analyse the situation**(1)** and ask myself why did that guy do what he did. Promotion and lots of things I've told myself the Almighty will provide one day**(14)** so there is no need for me to dwell on a human being like me. We all have mistakes, we all do mistakes no one is perfect**(4)**. Today it's you tomorrow it's me what if I ask for the same forgiveness, what if I didn't forgive you? you understand, tomorrow you won't forgive me and by tomorrow maybe I'll have done something little and you won't forgive me. So I've learnt something as we pray we say God forgive us as we forgive those who trespass against us**(14)**, so that's what keeps me going, that's what motivates me a lot. I'm like that I don't dwell on the past I'm always moving on**(2)**.

That is why the army is going down because of these former forces**(1)** I believe I've got one concept after in my mind, if after integration they said there is no more former force we are one force with new force number but the problem is today we are still identified by force numbers, this one from MK, this one from SADF, this one from APLA, and so on we are still having that, that is why the army is going down**(2).** Now what happened before integration, remember we had the new government from 1994 and integration happened 1995, there were discussions, negotiations on how can we integrate all the forces. So I'll refer to MK, APLA and ? they didn't have much strength so what they did was they called people and said you we make a file for you that says you have joined MK from this period to this period. That's where things now started going wrong. Cause I grew up with a person his our neighbour then the next thing you hear this guy is an MK he is a member and was in exile from this period to that period and this person has never been in exile, you understand but this person has a file that says you understand. Now what happened after integration we start identifying ourselves as former what- what - what- what accusing one another and say you were working for the white regime, you killed us by then you were against us you understand**(2)**, we we were fighting guerrilla warfare in Tanzania, hey what-what that's where everything starts now identifying ourselves as what-what. Now our commanders when they come they say okay you guys former this-this, you wont be promoted or don't go on course for a certain period, now for three to five years we are going to concentrate on MK and APLA to do courses and get promotions. That's the problem now we are working here we have to teach these people we have to gain experience with these people. They don't have any knowledge, they don't have experience, now they are using us, for example they will always put a SADF member as second in charge for example to help the guys they have promoted to run the units**(9)**. And when you say this man does not know his job they'll say that is why we put you there so you can teach him and show him what must happen. This thing of former forces make things worse**(4)**. There comes another grouping now MSDS…

INTERVIEWER: mmm

INTERVIEWEE: Some of the MSDS people are crying I don't have a problem with them but how can you bridge someone who doesn't have background in the military, why can't you give the person a full military training so he can understand what is happening**(7)** but you give a person a bridging after that to make that person a leader tomorrow you are expecting that person to perform as an old commander**(8)** you understand, you setting uh uh…now there are lots of incidents like let's take an example of (shooting?) for instance, our soldiers are being dropped with weapons every day because what those soldiers are not well trained **(13)** then they want to blame and point fingers. Now another thing is you train a person as a platoon commander then after course you put them as a communication officer**(4),** then come deployment that same person wants to deploy as a platoon commander never worked with the people on the ground, he has never experienced that thing. He is going to work with people with a paper, with a policy that says you do a mistake we charge you cause he doesn't know**(13)**, he never had that exposure…

INTERVIEWER: Mmm..

INTERVIEWEE: …working with different people because working with different people you get different culture, ideas, religion you understand and tend to like them differently. In my family of platoon I have so many weak points and I have so many strong points and I understand that so when you are outside there with the same person and they do a you see him drunk acting like this you can call him and speak to the member what you are doing is wrong why don't you do this and this **(17)**, cause you know this member. Now you find a commander..one big mistake our members are making when they go on a mission they have this idea of making money **(1)**, that is why they get caught off guard most of the time and people die because they are not prepared **(11)**. The only thing they are saying is we are here for 6 months 12 months for making money**(1)** busy budgeting about I'm going to buy this and that, they forget that this is a mission area**(3).**

Transition: Let us now move on to talk about your experience about the stressful life event that you mentioned in your interview with the socialwork officer

(Topic) The Experience of the stressful life event/s:

INTERVIEWER: Can you tell me about that event/s in your line of work where you feared for your life or when something happened that really threatened your sense of safety in returning home safely?

INTERVIEWEE: I'll give you an example 97 I was woking at 2 SAI it was an armoured unit, we deployed and on the 7th of January I remember in the morning around half past six we were showering it was mobile showers as we were showering there was just an explosion we were five inside then myself and two other guys we were critically injured. We were sent back and stayed at 1 mil for 98 days one of us passed away then we were so traumatised **(3)**. We were badly burned. When we found out we also thought we were not going to make it **(18)** and we found out those outside people were already saying we won't make it the way we were injured **(21)**. Myself and the guy who passed away we were staying in the same room. That was the beginning of a fear that I am not safe on deployment and it is still there**(18)**. You are not safe in terms of the army doesn't give a damn a**bout us (7).** The army will give a damn about you while you working, get injured or something happens to you it's up to you how you survive and cope**(8).** Deployments get very dangerous there are lots of people who are getting hurt **(2)** then after that there is no support **(4)** we witness all that also **(15)**. For instance there are people who are getting ill they even get mentally ill on deployment areas then what happens we leave them in the hospitals there and some die there**(15)** and you live with that fear what if it is me next**(18)**.

We have seen and done a lot it's just a person is not trained to go back there**(2)** you know once something has happened we recover and move on**(12)**. I am one person who has deployed a lot and we have been ambushed **(15)**, lost guys**(3)** or some got injured. But we don't talk about it much unless just between us as soldiers who were there sometimes**(2)**. There was an operation where we were supposed to be training but we were attacked with real ammunition which was not even supposed to be there by another country **(21)**…we had to fight there even using our hands and we lost one guy**(15).** By now you would think you would be used to seeing a dead body but having someone just lying there gone just like that…haai…you just start feeling like it opens a storage inside of you of all these thoughts of the similar incidents you have seen **(8)**. When these things happen.

they trigger those dreams we all don't like**(7)**. You see a lot of us have troubles with sleeping**(6)** we always want something to relax the mind before you sleep **(10).**

INTERVIEWER: I see so past traumas get reactivated when faced with life threatening situations.

INTERVIEWEE: Yes you start remembering those past things like they just happened and feel like you are there all over again (8), you understand. It's better to avoid such situations even in your own life**(19)** you don't want to be in a place where there can be fights whereby things can go badly someone ending up being killed**(14).** You restrict your life patterns. That is why we have BPs and all these sicknesses**(4)** because when those feelings attack you the mind and body feel like is happening again it can be really challenging**(11)**.

INTERVIEWER: What meaning have you assigned to this traumatic experience? Has this traumatic experience or experiences left you with a sense of loss?

INTERVIEWEE: meaning it is part of a job I chose**(6),** ja sometimes you feel like you wasted time here and for what?

INTERVIEWER: How have you tried to COPE with these troubling thoughts and feelings?

INTERVIEWEE: It is like punishment always there**(5)** you just ignore and move forward**(2)**

INTERVIEWER: Mmm that can't be easy and in general, How do you cope with other stressors/traumas (such as loss for instance) in your life? Have you ever consulted a psychologist within SANDF? If so concerning what? If not. Why not?

INTERVIEWEE: Psychologists and social workers used to play a vital role in our lives, we used to be frank with them but today I'm seeing you at a distance there is a psychologist I've nothing to do with them that is what is happening**(2)**. You are the last resort to us now**(4),** if something doesn't work and I see I've tried this I've tried that then I'll say eish let me go and see the psychologist but if you can bring back those programmes whereby you interact with the soldiers**(2)** we used to have, in…I remember when I was working at..Maj T* was a psychologist if I'm not mistaken she used to call companies she would draft a programme whereby she would call this company for the whole week Alpha Company, group discussions, having funny things, drawing. It was so nice soldiers starting to focus. You give up on those then you think maybe sports can help us forget all these things, but even with sports, there is sports in the unit that's why we have spots day every Wednesday but the commanders are not supportive because they don't participate themselves so nothing happens people just go home to more stress at home**(3)**. The commanders don't motivate people, it is like they are happy to see people walking around like there is something wrong in their heads **(16)**. They are the first ones to leave the unit early you understand**(4)**. You are looking at the social workers and psychologists then you say those people don't play with them and there's nothing wrong with those people you just have to build that mutual understanding that trust **(6)** you understand that is positiveness so I can understand what is your role**(3)**.

INTERVIEWER: Mmm

INTERVIEWEE: Because I can tell you my wife passed away 2002. In 2003 I did have suicidal thoughts I was so disorganised, the doctor that helped me there I am who I am today because of him. That's when I realised the importance of your profession, psychologists, psychiatrists, social workers have an important role to play in our lives. But

you cannot keep telling people that because they will say oh he knows so much about it that means he had a mental problem **(3)**. Because if you don't understand that's why most of the soldiers look at psychologist and see them as only doing CHA (Concurrent Health Assessment), CHA that is all, they think CHA that's the reason for you to be in the unit. You are here to help them with their wellbeing but members don't understand because we don't get those programmes. You get a person coming to a psychologist where now it is a ticking time bomb. When the problems started no one cared and no one invited a psychologist to come from the beginning, they always want to hide things and look like they are coping with the members but they are not that's the problem**(4)**. Like by the time I went to see the social worker things had already happened on the deployment and I was sent there because I was seen as a problem, instead of having a problem that time**(5).**

INTERVIEWER: (**Transition:** before we wrap up I would just like to ask you a few questions about your wellbeing in light of the traumatic events we talked about)

INTERVIEWER: Do you think this event/s has changed or impacted your life emotionally, mentally and behaviourally?

INTERVIEWEE: Uh like you know after that incident on deployment I asked the Col if I can leave he said I must write down the reasons why I want to leave deployment. I only wrote one sentence on that statement saying I requested to leave deployment because I am not emotionally okay**(5)**.

INTERVIEWER: Mmm

INTERVIEWEE: That is what I said then the Colonel refused to sign and made a comment that no I have to state all the reasons**(10)**. But I said I've stated the reason that I'm not emotionally okay, that word it says a lot there are a lot of things you understand then we fought for that**(5)**. That word of not emotionally okay because if I am not emotionally okay, or emotionally disturbed or abused I am more dangerous than a person who is being physically abused you understand, you are more dangerous because if i can continue being like that the only solution that I'm going to take is going to affect a lot of people. I'll take a rifle I'll shoot a person then shoot myself **(3)**. You end up shooting a lot people before you shoot yourself, after that you get scared you ask what happened then you find out this guy was emotionally abused**(6)**. Emotional abuse is very dangerous, even if uh.. you can abuse a woman physically uh financially and so on verbally but not emotionally, never emotional abuse that's when a woman starts to say enough is enough. On that stage you say enough is enough I can no longer cope because that thing you become emotional you start to become something which I am not I become a bomb, I am not that person anymore I've lost myself. Even a man there are also men who are abused a lot emotional abuse whatsoever like poor soldiers.

INTERVIEWER: Can you explain a bit more

INTERVIEWEE: You see our soldiers are emotionally abused our leaders abuse them as subordinate**s(6)**. You see the leadership of today they are now playing a vital role on the abuse of soldiers on the ground because most of the time when I look at the soldiers the current leaders only care about their own pockets, ranks,career and

going on promotional courses**(5)**, not putting a smile on the people's faces saying okay my people are smiling I can

now smile, a good leader always puts a smile on his people. What is happening here today is no longer an organisation where I can say this is army**(2)** I don't even trust going into war with my platoon, you cannot go as a battalion I cannot go fight a serious war with these people because I've never built that trust from the onset **(9)** I've never built that love from the onset, we've never built that mutual relationship amongst ourselves**(17)** you understand. Soldiers have lost hope and trust in leaders **(10)** because of what they are doing that affects them everyday in their workplace.

INTERVIEWER: mmm..

INTERVIEWEE: As I've said I do what I do here as soon as I'm done I leave everything here **(2)**. One of the things is I am very open person when I'm hurt I'll arrive at home and change, sit with my liquor relax, watch movies, I'll tell myself I want to drink like nobody's business until I don't feel that hurt anymore**(10)**, especially if someone did something and I ignored it **(20)**, it is better if I reacted with a fight back then it's over for me **(14)** before I even get home. And my girlfriend knows to stay out of my way when I come back angry I just want to be alone **(6)**. So here when soldiers tell commanders their family problem or whatever they take advantage **(10)** instead of building the person motivating them talking with the person **(16)**, they want to see the wife for a silly reason for their personal benefit and not for the right purpose. Then it's why don't we do this okay extension ..uh.. phone numbers you understand, that's what is happening you find soldiers complaining that this lieutenant is sleeping with my wife**(11),** you can't trust them anymore so you can't talk to them because of what they are doing **(17)**.

INTERVIEWER: And how have you found your experiences on deployments have impacted you as a person, and those close to you?

INTERVIEWEE: You know there is a difference between deployment time, peace time and time in the unit there is huge difference. Now as a commander leading people on a deployment area I cannot treat that grouping like we are in the unit in peacetime. Now on deployment they have left their homes they have left their comfortable homes, they are now in a place where there is no comfort at all. Now me as a commander I have to make them feel like they are okay this is a second home from my home I have to create that environment but instead of doing that I want to oppress people I want to be a lion I want to be stubborn. Then once people start getting negative I'll start getting some bad results, AWOLS, shootings, drinking, they don't follow instructions they don't care**(3)**. To prevent all this you have to build the members, you have to listen to the members and act on their requests on their problems uh..on their welfare. you don't even have to go far, take an internal deployment for example you have a stick of 5 people and one member is having a serious problem, he is trying to tell me I have a serious problem I cannot go on the field with this problem I need to talk to you, then as a commander I'll say haai don't come with your problems here, we'll sort that that thing when you come back**(16)**. didn't even listen to the member trying to tell me so and so on, after forcing the matter to go to the field then there comes a report saying member shot himself or someone else or member just AWOLed back to Gauteng. Such things then they will say members don't have discipline**(5)**. Where does discipline start? It starts from above then goes to the ground.The above structure doesn't have discipline how can they expect people on the ground. If the father and mother don't have discipline how can I expect discipline from the children I cannot. You see with the incident on deployment where I lost it and threatened to use that axe on them I was charged, I'll even lose my rank**(7)**, members get charged but a psychologist or social worker in the unit never gets called to come and assess the person**(21)** to say when I look at the person I see 1, 2, 3 let's try 1,2,3. Look at now this morning our commander announced that he did close the salary of a member, very proudly, he is happy**(7)**. This person has a family, as a commander before you close the salary do you think about the family first. The member according to him the member was AWOL the whole week, but the member arrived late for duty a few days ago and I just warned him and sent him back home because he was not in a right state. So when he said he was AWOL all week I just kept quiet and asked myself do people follow procedure before they close salaries, like involving the psychologist or social worker. They just add on to the damage in peoples mental wellbeing **(3).** We are a sick army and nobody cares **(4)**.

INTERVIEWER: Given everything you have experienced, how would you describe yourself now?

INTERVIEWEE: Uh now, I'm just a person with my ups and downs, I am demoralised and prefer to drink to feel happy and forget lots of things**(10)**, otherwise I can get very angry and when I'm angry you can't stop me **(14)**.

(**Transition:** Before we end the interview, let me ask you some questions about where you live and your family)

INTERVIEWER: Do you live in or outside a military base?

INTERVIEWEE: I have a house, living in here I don't prefer because you don't want your family exposed to the army way of life. It is not normal like we have been talking**(5).**

INTERVIEWER: Have you had to relocate to this province?

INTERVIEWEE: No I grew up here in Soweto.

INTERVIEWER: Do you have a spouse and/or children?

INTERVIEWEE: Yes, I live with my girlfriend and our little girl.

INTERVIEWER: And how is life at home?

INTERVIEWEE: Ups and downs, we fight a lot and my family has to get involved**(23)**. Remember I said we were fighting a lot whilst I was on that deployment where I eventually had to be sent home. She doesn't not know how to deal with a soldier like me**(6)** and my family always says I must leave her but I think of my child, what if she takes my child and I never see her again **(25)**. It is losing someone again, you understand, I have lost too much I can't **(1)**. She is the only good thing I can say I have in my life**(25).** Ja that's all.

Age: 42

Gender: Male

Race: African

INTERVIEWER: (**Transition:** It has been a pleasure finding out more about you, thank you. I appreciate the time you took for this interview. I should have all the information I need. Thank you once again. You have been of great help. Unless there's something else on your side that you think would be useful for me to know?

INTERVIEWEE: No, I have said everything. Okay thank you.

The above is the coded transcript of the interview with Particpant 7.

Below, in Appendix 7 is the process of theme extraction from the original transcript along with the researcher's exploratory comments.

Appendix 7: Participant 7's Emergent Themes from Transcript

Original transcrit	Emergent themes	Exploratory comments
A. (**Purpose**) I would like to ask you some questions about your background, your job responsibilities, your past military operations, some experiences you have had on external deployments and some of your difficulties you may be experiencing. B. (**Motivation**) I hope to use this information to help SANDF psychologists and other health care practitioners understand the workforce better. C. Thank you for agreeing to talk with me, is it the right time to take some time to respond to some questions I have?		
INTERVIEWEE: Yes it's okay INTERVIEWER: In your interview with the social work officer you indicated that you experienced stressful events during your military career that posed a serious physical threat to you or someone. Please tell me in relation to this stressful event, have you been diagnosed with post traumatic stress disorder or PTSD?		Participant 7, much like other particpants had many years of experience as a soldier. I felt intimidated by his pride and sense of authority in the space as he knew though I'm in uniform and with a higher rank he had more command and experience in military matters The organisation does not care about soldiers. Felt like I was representing the organisation and feelings of inadequacy were stirred up in me.
INTERVIEWEE: No, to my experience it can be 22 years in this organisation I have not. They don't assess us thorough anymore. The current army is not like the previous army. We used to enjoy soldering even if we did not earn a lot, so whatever you experience you knew you would be okay but now you find that you always have those things coming back to you like they are following you. We knew that time why we wear this uniform but nowadays we find ourselves so stressed we become so vulnerable because our current leaders of today they don't look after their soldiers they don't care a damn about their subordinates. They only care about their pockets and their promotions, they forget the purpose of carrying those ranks, to lead the people on the ground. They forget about their careers, our soldiers today are not empowered enough, they are not looked after enough. Their welfare is being sidelined.	Missed diagnosis and treatment opportunities Splitting-SADF idealised object/SANDF devalued Feelings of abandonment by former forces. Defensse-splitting and displacement of anger onto SANDF SANDF bad/persecutory object Feelings of mistrust, paranoia, victimisation harboured towards the organisation	The attack was not lost on me, on my three years in the organisation and having a higher ranking to him. It felt like I was being given a lecture as though he had to show me that he knew more about the organisation and the plight of soldiers. Psychologists blamed for neglecting their duties to soldiers Feelings of victimisation, not enough is being done. These expreinces are carried haeavily, making the atmosphere in the room heavy whilst at the same held together by something that felt fragile
INTERVIEWER: Mmmhm INTERVIEWEE: You understand? That's the reason why soldiers today are so stressed. I can give you one example, the courses you find a soldier of more than 20 years, thirty years still a private then there comes someone who is new in the organisation, within three years that person is a leader you understand, but doesn't have the knowledge and experience of how to lead people. Us soldiers we are being neglected career wise, promotions and social welfare. I don't know before psychologist used to have like their own ..I don't now…communication period whereby they sit with the soldiers talking to the soldiers but today you don't see that all those things happening we don't know what went wrong. INTERVIEWER: Yes INTERVIEWEE: Soldiers used to be counselled on their problems but nowadays yo can't talk to your	Trauma induced psychic disintegration Abandonment -loss of trust in authority figures, leadership Failed empathic attunement Colluding with defenses/system Insensitive labelling and handling of stress reactions	I felt very distant from him in our interaction. I felt shut out, rather than being related to, I felt used as an inanimate for disposal of his internal contents. Here it is apparent that I needed to escape the emotional intensity and anger by defensively moving on to ask about his mustering. An enactment of failed empathic attunement on my part

Original transcrit	Emergent themes	Exploratory comments
commanders because they go spread your problems to everyone. Soldiers have lost trust in the commanders. INTERVIEWER: And what can you say has kept you motivated and has helped you cope in your line of work? INTERVIEWEE: Eh eh my side I used to ignore a lot of things that are negative to my life, ja most of the things that are negative I have tried to ignore them. There are things that have happened I have tried to ignore them. There are bad things that have happened before but I concentrate on the positive, I don't dwell on the past I tell myself I have to move on because I know something, dwelling on the past you'll never go forward. So the thing that is keeping me going everyday is I can have a bridge with you today, tomorrow I forget about what happened I move on. Like an incident that happened when we were on an internal operation where things were bad for me at home, with the mother of my child threatening to leave me and fighting with me, and all those things, saying she will bring my child to the camp, we were at Kruger Park… But no-one supported me they made me feel like I was going crazy like I told the social worker. Yes I got so angry but I was not going to hurt anyone, ja they all turned against me and said I wanted to kill them with an axe because I couldn't be released to go home immediately. I was just threatening the one guy who was provoking me. Like I said you can't talk to leaders anymore. So even though I am with those people everyday one thing I tell myself the purpose I wake up in the morning early in the morning prepare myself and come to work, I tell myself as soon as I enter the gate I forget about what is happening at home and concentrate on what is happening at work. Then at work I don't allow people to come and disturb my plan, my plan I don't allow people to do that. I concentrate on my task doing what I have to do handing in my submissions and finish that. When I leave this unit I forget about whats happening here and concentrate I'm going home. Thats how I keep myself going. INTERVIEWER: Mmm and do you find that you are functioning to the best of your ability and being utilised optimally in line with your mustering? INTERVIEWEE: I'm utilised in different posts where they need help. It's a matter of what do I need to do for the organisation I take responsibility, what do I want to achieve because like currently I am not on my current post you see, I'm feeling in as a CR commander but taking those posts I did not take them to prove something I took them to achieve organisational goals,not to prove someone wrong or be better than another person. INTERVIEWER: mmm that means your responsibilities change according to the section you are moved to? Is it the same when you deploy? INTERVIEWEE: Yes the last deployment I was utilised in the transport section. INTERVIEWER: And what do you attribute to being so versatile? Does it have to do with particular training you received before, I'm not sure which former force you were with, or is it your long experience in the organisation?	Leaders seen as persecutory objects Defenses: Denial, repression, avoidance of emotive reality. Partial adaptation Impoverished self-object relations (within and outside the force, dependence on internalised bad objects Subclinical cognitive disturbance. Inabilty to think clearly in the face of strong emotions, paranoia, and general reality testing. Lack of trust among soldiers- cannot trust each other with each others' pain (brothers in arms no more) Defenses: Paranoid-schizoid position, dissociation Dependence on authority for functional validation Vulnerable-looking to the system to look after them through directives- for ego functioning/strengthening	Pulled into making him feel good about his fulfilment of his duties, rather than sitting with his internal turmoil. Not sure what of my internal struggle is at play here. Trying to show me there is good in him and he is not the 'monster' he has been portayed to be and that I should not be scared of him. Seems to be attempting peel off the tough/angry mask? So I can see him. A sense of a wish that they can be unified as there is something shared among them that does not get spoken about Own experience of feeling persecuted Phantasies of how he wishes he could be treated and helped with his psychological difficulties gets intertwined with his description of his leadership skills Transition to expereince of stressful life event/s Sense of fear of impeding danger and resultant from past experiences that gets masked

Original transcrit	Emergent themes	Exploratory comments
INTERVIEWEE: The reason is I have subject knowledge, I've got experience I'm a former SADF member and whoever puts me in that position he knows that I'll deliver exactly what he is looking for. That is why I'm put in posts higher than the rank that I am in even if there are a lot of people above me, but they task me a lot even on deployments because they know I can. And that makes me have a lot of confidence I don't take it negatively and say this guy is punishing me or whatever. INTERVIEWER: I see.. and was the transition from previous armed forces to one unified National Defence Force difficult for you?		Able to talk about military traumas post the apartheid struggle traumatic events- those from the armed struggle between statutory and non-statutory forces are not spoken about in attempt to bury them even deeper, despite being reactivated by current or continuous trauma.
INTERVIEWEE: Not for me no, but you see I have been in this rank for long there are lot of people promoted before me but I always say to myself one day God will provide. Because if I can look at who gets promoted and so on I'll become negative and once I become negative I'll start doing wrong things unaware, like I'll start fighting with my commanders and so on. Like I know with the incident at Kruger Park most people advised me to write a grievance of being wronged and some said I must go where…thats how I was born you understand I don't correct wrong with wrong. If someone does something wrong to me I'll try to be positive and sit down and analyse the situation and ask myself why did that guy do what he did. Promotion and lots of things I've told myself the Almighty will provide one day so there is no need for me to dwell on a human being like me. We all have mistakes, we all do mistakes no one is perfect. Today it's you tomorrow it's me what if I ask for the same forgiveness, what if I didn't forgive you? you understand, tomorrow you won't forgive me and by tomorrow maybe I'll have done something little and you won't forgive me. So I've learnt something as we pray we say God forgive us as we forgive those who trespass against us, so that's what keeps me going, that's what motivates me a lot. I'm like that I don't dwell on the past I'm always moving on.	Organisation experienced as being dishonest and injuring Religion as a defense Structural and psychological splitting Defenses: denial, repression and acceptance – though more of hopelessness and helplessness not of the depressive position quality Religion Structural and pychological splitting	He is not alone in this-somewhat normalises his experiential reality It feels he is really being in touch with the core of his psychic woundings and therefore himself. I feel I can connect with him at this point
That is why the army is going down because of these former forces I believe I've got one concept after in my mind, if after integration they said there is no more former force we are one force with new force number but the problem is today we are still identified by force numbers, this one from MK, this one from SADF, this one from APLA, and so on we are still having that, that is why the army is going down. Now what happened before integration, remember we had the new government from 1994 and integration happened 1995, there were discussions, negotiations on how can we integrate all the forces. So I'll refer to MK, APLA and ? they didn't have much strength so what they did was they called people and said you we make a file for you that says you have joined MK from this period to this period. That's where things now started going wrong. Cause I grew up with a person his our neighbour then the next thing you hear this guy is an MK he is a member and was in exile from this period to that period and this person has never been in exile, you understand but this person has a file that says you understand. Now what happened after integration we start identifying ourselves as former what- what -what- what accusing one another and say you were working for the white	Lack of psychological and cognitive integration into a unified SANDF -also manifests in inability to integrate experiential and emotive reality in their way of living [mere compartmentalisation and denial] Integration has not integrated forces into meaningful entity- feelings of redundancy	Telling me what it is that soldiers need from me as a psychologist. I'm colluding with the system and this is what my role is- this is how I can help. Social workers seen as a safe space, less threatening as they can't declare them mentally unfit. Psychologist not taken into their confidence and thus state of mental health concealed from them.

Original transcrit	Emergent themes	Exploratory comments
regime, you killed us by then you were against us you understand, we we were fighting guerrilla warfare in Tanzania, hey what-what that's where everything starts now identifying ourselves as what-what. Now our commanders when they come they say okay you guys former this-this, you wont be promoted or don't go in course for a certain period, now for three to five years we are going to concentrate on MK and APLA to do courses and get promotions. That's the problem now we are working here we have to teach these people we have to gain experience with these people. They don't have any knowledge, they don't have experience, now they are using us, for example they will always put a SADF member as second in charge for example to help the guys they have promoted to run the units. And when you say this man does not know his job they'll say that is why we put you there so you can teach him and show him what must happen. This thing of former forces make things worse. There comes another grouping now MSDS…		Curious use of family unit figuratively to denote power dynamics within the organisation. Soldiers compared to women or children
	SANDF- bad/persecutory object	
INTERVIEWER: mmm INTERVIEWEE: Some of the MSDS people are crying I don't have a problem with them but how can you bridge someone who doesn't have background in the military, why can't you give the person a full military training so he can understand what is happening but you give a person a bridging after that to make that person a leader tomorrow you are expecting that person to perform as an old commander you understand, you setting uh uh…now there are lots of incidents like let's take an example of (shooting?) for instance, our soldiers are being dropped with weapons every day because what those soldiers are not well trained then they want to blame and point fingers. Now another thing is you train a person as a platoon commander then after course you put them as a communication officer, then come deployment that same person wants to deploy as a platoon commander never worked with the people on the ground, he has never experienced that thing. He is going to work with people with a paper, with a policy that says you do a mistake we charge you cause he doesn't know, he never had that exposure…	Organisation experienced as dishonest, injurying Feelings of psychological and functional impoverishment / impairment wrt military duties Lack of organisational structure, i.e, holding environment Feelings of psychological and functional impoverishment / impairment wrt military duties Substance abuse	There is underlying anger in the expression of his hurt Boundaries between familial and military issues difficult to negotiate- emotional issues concerned always spill over to the other cause the self is so embedded in identity/being as a soldier Identifies as both a benign leading and persecuted soldier
INTERVIEWER: Mmm.. INTERVIEWEE: …working with different people because working with different people you get different culture, ideas, religion you understand and tend to like them differently. In my family of platoon I have so many weak points and I have so many strong points and I understand that so when you are outside there with the same person and they do a mistake you see him drunk acting like this you can call him and speak to the member what you are doing is wrong why don't you do this and this, cause you know this member. Now you find a commander..one big mistake our members are making when they go on a mission they have this idea of making money, that is why they get caught off guard most of the time and people die because they are not prepared. The only thing they are saying is we are here for 6 months 12 months for making money busy budgeting about I'm going to buy this and that, they forget that this is a mission area.	Financial gain -sacrifice to look after family Loss of lives due to lack of psychological and physical (military) preparedness Deployments as suicide missions Psychological and functional shift (when on deplyment) fails due to weak ego function	Recall of his experience. Idealised leadership qualities and skills speak to righting the wrong he endured. Family unit enecdote again. There is an element of psychologists also being rendered powerless under the command of military authority being communicated here Defence against not being able to manage and cope as well as others 'appear' to have.

Original transcrit	Emergent themes	Exploratory comments
INTERVIEWER: Let us now move on to talk about your experience about the stressful life event that you mentioned in your interview with the socialwork officer. Can you tell me about that event/s in your line of work where you feared for your life or when something happened that really threatened your sense of safety in returning home safely?	Loss of lives- unresolved trauma	
INTERVIEWEE: I'll give you an example 97 I was woking at 2 SAI it was an armoured unit, we deployed and on the 7th of January I remember in the morning around half past six we were showering it was mobile showers as we were showering there was just an explosion we were five inside then myself and two other guys we were critically injured. We were sent back and stayed at 1 mil for 98 days, one of us passed away then we were so traumatised. We were badly burned. When we found out we also thought we were not going to make it and we found out those outside people were already saying we won't make it the way we were injured. Myself and the guy who passed away we were staying in the same room. That was the beginning of a fear that I am not safe on deployment and it is still there. You are not safe in terms of the army doesn't give a damn about us. The army will give a damn about you while you working, get injured or something happens to you it's up to you how you survive and cope. Deployments get very dangerous there are lots of people who are getting hurt then after that there is no support we witness all that also. For instance there are people who are getting ill they even get mentally ill on deployment areas then what happens we leave in the hospitals there and some die there and you live with that fear what if it is me next.	Annihilation anxieties -fears over survival, self-preservation and safety. Feeling vulnerable, out of control -feeds into traumatic response trajectory SANDF bad/persecutory object. Organisation experienced as dishonest and injurying Deployments as suicide missions Lack of attunement and sensitivity to latent communication of distress behaviourally, physically Chronic trauma Defenses: Repression, avoidance (of emotive reality) Dis-integrated psyche-soma	My emotional response to him oscillated empathy and distancing. It felt as though I was fighting within myself to keep a connection with him. It felt as though there was a 'disconnect' between us. I am not sure where the 'disconnect' originated from – me or him. It may have been a combination of both. For me it was also more pronounced when he spoke about his girlfriend. In the end it felt like he was giving me an instruction to report /plead his grievances back to those in position of authority
We have seen and done a lot, it's just a person is not trained to go back there you know once something has happened we recover and move on. I am one person who has deployed a lot and we have been ambushed, lost guys or some got injured. But we don't talk about it much unless just between us as soldiers who were there sometimes. There was an operation where we were supposed to be training but we were attacked with real ammunition which was not even supposed to be there by another country…we had to fight there even using our hands and we lost one guy. By now you would think you would be used to seeing a dead body but having someone just lying there gone just like that…haai…you just start feeling like it opens a storage inside of you of all these thoughts of the similar incidents you have seen.	Chronic trauma Loss of lives (unresolved trauma) Feeling vulnerable, out of control Chronic trauma Flashbacks…and re-enactments (can lead to retraumatization) Troubling dreams become a hidden shame.	
When these things happen they trigger those dreams we all don't like. You see a lot of us have troubles with sleeping we always want something to relax the mind before you sleep.	Troubled sleep-repressed unconscious material re-surfaces in dreams. Alcohol-self medication	
INTERVIEWER: I see so past traumas get reactivated when faced with life threatening situations. INTERVIEWEE: Yes you start remembering those past things like they just happened and feel like you are there all over again, you understand. It's better to avoid such situations even in your own life you don't wan to be in a place where there can be fights whereby things can go badly someone ending up	Flashbacks Avoidance of reminders Propensity for intense emotional reactivity.	

Original transcrit	Emergent themes	Exploratory comments
being killed. You restrict your life patterns. That is why we have BPs and all these sicknesses because when those feelings attack you the mind and body feel like is happening again it can be really challenging.	Sickness-loss of physical health Chronic symptoms of depression, low mood	
INTERVIEWER: What meaning have you assigned to this traumatic experience? Has this traumatic experience or experiences left you with a sense of loss?		
INTERVIEWEE: No meaning it is part of a job I chose, ja sometimes you feel like you wasted time here and for what?	Loss of true self, identity to survive being in the system	
INTERVIEWER: How have you tried to COPE with these troubling thoughts and feelings?		
INTERVIEWEE: It is like punishment always there you jut ignore and move forward.	Feelings of survival guilt (hence re-enactment of trauma) Repression, avoidance	
INTERVIEWER: Mmm that can't be easy and in general, How do you cope with other stressors/traumas (such as loss for instance) in your life? Have you ever consulted a psychologist within SANDF? If so concerning what? If not. Why not?		
INTERVIEWEE: Psychologists and social workers used to play a vital role in our lives, we used to be frank with them but today I'm seeing you at a distance there is a psychologist I've nothing to do with them that is what is happening. You are the last resort to us now, if something doesn't work and I see I've tried this I've tried that then I'll say wish let me go and see the psychologist but if you can bring back those programmes whereby you interact with the soldiers we used to have, in…I remember when I was working at..Maj T* was a psychologist if I'm not mistaken she used to call companies she would draft a programme whereby she would call this company for the whole week Alpha Company, group discussions, having funny things, drawing. It was so nice soldiers starting to focus. You give up on those then you think maybe sports can help us forget all these things, but even with sports, there is sports in the unit that's why we have spots day every Wednesday but the commanders are not supportive because they don't participate themselves so nothing happens people just go home to more stress at home. The commanders don't motivate people, it is like they are happy to see people walking around like there is something wrong in their heads. They are the first ones to leave the unit early you understand.	Missed diagnosis and treatment opportunities Lack of attunement and sensitivity to latent communication of distress behaviourally, physically. Missed diagnosis and treatment opportunities Colluding with defenses Leaders seen as persecutory objects Lack of organisational structure, i.e, holding environment	
You are looking at the social workers and psychologists then you say those people don't play with them and theres nothing wrong with those people you just have to build that mutual understanding that trust you understand that is positiveness so I can understand what is your role.	Avoidance of seeking psychological help Emotional vulnerabilities to be concealed- fear of being declared psychologically unfit	
INTERVIEWER: Mmm INTERVIEWEE: Because I can tell you my wife passed away 2002. In 2003 I did have suicidal thoughts I was so disorganised, the doctor that helped me there I am who I am today because of him. That's when I realised the importance of your profession, psychologists, psychiatrists, social workers have an important role to play in our lives. But you cannot keep telling people that because they will say oh he knows so much about it that means he had a mental problem. Because if you don't understand that's why most of the soldiers	Emotional vulnerabilities to be concealed- fear of being declared psychologically unfit	

Original transcrit	Emergent themes	Exploratory comments
look at psychologist and see them as only doing CHA (Concurrent Health Assessment), CHA that is all, they think CHA that's the reason for you to be in the unit. You are here to help them with their well-being but members don't understand because we don't get those programmes. You get a person coming to a psychologist where now it is a ticking time bomb. When the problems started no one cared and one invited a psychologist to come from the beginning, they always want to hide things and look like they are coping with the members, but they are not that's the problem. Like by the time I went to see the social worker things had already happened on the deployment and I was sent there because I was seen as a problem, instead of having a problem that time. (**Transition:** before we wrap up I would just like to ask you a few questions about your wellbeing in light of the traumatic events we talked about) INTERVIEWER: Do you think this event/s has changed or impacted your life emotionally, mentally and behaviourally? INTERVIEWEE: Uh like you know after that incident on deployment I asked the Col to if I can leave he said I must write down the reasons why I want to leave deployment. I only wrote one sentence on that statement saying I requested to leave deployment because I am not emotionally okay. to emotionally okay because if INTERVIEWER: Mmm INTERVIEWEE: That is what said then the Colonel refused to sign and made a comment that no I have to state all the reasons. But I said I've stated the reason that I'm not emotionally okay, that word it says a lot there are a lot of things you understand then we fought for that. That word of not emotionally okay because if I am not emotionally okay, or emotionally disturbed or abused I am more dangerous than a person who is being physically abused you understand, you are more dangerous because if i can continue being like that the only solution that I'm going to take is going to affect a lot of people. I'll take a rifle I'll shoot a person then shoot myself. You end up shooting a lot people before you shoot yourself, after that you get scared you ask what happened then you find out this guy was emotionally abused. Emotional abuse is very dangerous, even if uh.. you can abuse a woman physically uh financially and so on verbally but not emotionally, never emotional abuse that's when a woman starts to say enough is enough. On that stage you say enough is enough I can no longer cope because that thing you become emotional you start to become something which I am not I become a bomb, I am not that person anymore I've lost myself. Even a man there are also men who are abused a lot emotional abuse whatsoever like poor soldiers. INTERVIEWER: Can you explain a bit more INTERVIEWEE: You see our soldiers are emotionally abused our leaders abuse them as subordinates. You see the leadership of today they are now playing a vital role on the abuse of soldiers on the ground because most of the time when I look at the soldiers the current leaders only care about their own pockets, ranks,career and going on promotional courses, not putting a smile on the	Seeking psychological help seen as a weakness Psychological distress equated with ill discipline Psychological distress equated with ill discipline Organisation -bad breast-needs frustrated- not gratified Feelings of mistrust, victimisation and paranoia harboured towards organization Aggression manifests in violence towards fellow soldiers Emotional abuse Emotional abuse Feelings of mistrust, victimisation and paranoia harboured towards organization Feelings of abandonment by former forces-defended against by splitting (projection) and displacement of anger onto the SANDF	

Original transcrit	Emergent themes	Exploratory comments
people's faces saying okay my people are smiling I can now smile, a good leader always puts a smile on his people. What is happening here today is no longer an organisation where I can say this is army I don't even trust going into war with my platoon, you cannot go as a battalion I cannot go fight a serious war with these people because I've never built that trust from the onset I've never built that love from the onset, we've never built that mutual relationship amongst ourselves you understand. Soldiers have lost hope and trust in leaders because of what they are doing that affects them everyday in their workplace. INTERVIEWER: mmm.. INTERVIEWEE: As I've said I do what I do here as soon as I'm done I leave everything here. One of the things is I am very open person when I'm hurt I'll arrive at home and change, sit with my liquor relax, watch movies, I'll tell myself I want to drink like nobody's business until I don't feel that hurt anymore, especially if someone did something and I ignored it, it is better if I reacted with a fight back then it's over for me before I even get home. And my girlfriend knows to stay out of my way when I come back angry I just want to be alone. So here when soldiers tell commanders their family problem or whatever they take advantage instead of building the person motivating them talking with the person, they want to see the wife for a silly reason for their personal benefit and not for the right purpose. Then it's why don't we do this okay extension ..uh.. phone numbers you understand, that's what is happening you find soldiers complaining that this lieutenant is sleeping with my wife, you can't trust them anymore so you can't talk to them because of what they are doing. INTERVIEWER: And how have you found your experiences on deployments have impacted you as a person, and those close to you? INTERVIEWEE: You know there is a difference between deployment time, peace time and time in the unit there is huge difference. Now as a commander leading people on a deployment area I cannot treat that grouping like we are in the unit in peacetime. Now on deployment they have left their homes they have left their comfortable homes, they are now in a place where there is no comfort at all. Now me as a commander I have to make them feel like they are okay this is a second home from my home I have to create that environment but instead of doing that I want to oppress people I want to be a lion I want to be stubborn. Then once people start getting negative I'll start getting some bad results, AWOLS, shootings, drinking, they don't follow instructions they don't care. o prevent all this you have to build the members, you have to listen to the members and act on their requests on their problems uh..on their welfare. you don't even have to go far, take an internal deployment for example you have a stick of 5 people and one member is having a serious problem, he is trying to tell me I have a serious problem I cannot go on the field with this problem I need to talk to you, then as a commander I'll say haai don't come with your problems here, we'll sort that that thing when you come back. didn't even listen to the member trying to tell me so and so on, after forcing the meter to go to the field then there comes a report saying	Organisation -bad breast-needs frustrated- not gratified Lack of trust amongst soldiers-cannot trust each other with each others' lives. Abandonment -loss of trust in authority figures, leadership Repression, avoidance Alcohol-self medication Continued maladaptive coping mechanisms -long-term impaired functional capacity Propensity for intense emotional reactivity Impoverished self-object relations within and outside the force (reliance on internalized bad objects) Abandonment -loss of trust in authority figures, leadership Leaders seen as persecutory objects Lack of trust amongst soldiers-cannot trust each other with each others' lives Psychological and functional shift (wrt military responsibilities) fails due to weak ego function Leaders seen as persecutory objects Aggression manifests in violence towards fellow soldiers	

Original transcrit	Emergent themes	Exploratory comments
member shot himself or someone else or member just AWOLed back to Gauteng. Such things then they will say embers don't have discipline. Where does discipline start? It starts from above then goes to the ground The above structure doesn't have discipline how can they expect people on the ground. If the father and mother don't have discipline how can I expect discipline from the children I cannot. You see with the incident on deployment where I lost it and threatened to use that axe on them I was charged, I'll even lose my rank, members get charged but a psychologist or social worker in the unit never gets called to come and assess the person to say when I look at the person I see 1, 2, 3 let's try 1,2,3. Look at now this morning our commander announced that he did close the salary of a member, very proudly, he is happy. This person has a family, as a commander before you close the salary do you think about the family first. The member according to him the member was AWOL the whole week, but the member arrived late for duty a few days ago and I just warned him and sent him back home because he was not in a right state. So when he said he was AWOL all week I just kept quiet and asked myself do people follow procedure before they close salaries, like involving the psychologist or social worker. They just add on to the damage in people's mental wellbeing. We are a sick army and nobody cares.	Lack of support in managing soldiers' familial crises Organisation experienced as dishonest and injuring Organisation experienced as dishonest and injuring Psychically disintegrating (military and organisationally trauma induced) Feeling vulnerable (disregarded, out of control, continued organisational stressors	
INTERVIEWER: Given everything you have experienced, how would you describe yourself now? INTERVIEWEE: Uh now, I'm just a person with my ups and downs, I am demoralised and prefer to drink to feel happy and forget lots of things, otherwise I can get very angry and when I'm angry you can't stop me.	Alcohol-self medication Propensity for intense emotional reactivity	
(**Transition:** Before we end the interview, let me ask you some questions about where you live and your family)		
INTERVIEWER: Do you live in or outside a military base? INTERVIEWEE: I have a house, living in here I don't prefer because you don't want your family exposed to the army way of life. It is not normal like we have been talking	Dependence on authority for functionality (Vulnerable-looking to the system to save them or look after them	
INTERVIEWER: Have you had to relocate to this province? INTERVIEWEE: No I grew up here in Soweto.		
INTERVIEWER: Do you have a spouse and/or children? INTERVIEWEE: Yes, I live with my girlfriend and our little girl.	Strained relations when it comes to spouses (disregard them, children perhaps seen as good objects	
INTERVIEWER: And how is life at home? INTERVIEWEE: Ups and downs, we fight a lot and my family has to get involved. Remember I said we were fighting a lot whilst I was on that deployment where I eventually had to be sent home. She doesn't not know how to deal with a soldier like me and my family always says I must leave her but I think of my child, what if she takes my child and I never see her again. It is losing	Impoverished self-object relations (within and outside the force, dependence on internalised bad objects) Preference of relation to offspring than to spouses, children important in these soldiers' lives	

Original transcrit	Emergent themes	Exploratory comments
someone again, you understand, I have lost too much I can't. She is the only good thing I can say I have in my life. Ja that's all. (**Transition:** It has been a pleasure finding out more about you, thank you. I appreciate the time you took for this interview. I should have all the information I need. Thank you once again. You have been of great help. Unless there's something else on your side that you think would be useful for me to know? INTERVIEWEE: No, I have said everything. Okay thank you	Loss of meaning in life	

The above states the themes and researcher comments that were extracted from the original transcript of the interview conducted with Participant 7.

Below, in Appendix 8 is the process of clustering the themes together to create a narrative of Participant 7's experience of living with undiagnosed PTSD, followed by a summary of Participant 7's experience.

Appendix 8: Participant 7's Analysis of Themes

Superordinate theme	Subordinate theme	Clusters	Quote/keyword	Page & Line Number
SANDF as a traumatising system perpetuating PTSD	Lack of a holding environment	Lack of organisational structure	The commanders don't motivate people, they are the first ones to leave the unit early you understand	221: 178-179
		Structural and psychological splitting	This thing of former forces makes things worse	219:98
	SANDF cannot be trusted	Feelings of mistrust, victimisation and paranoia harboured towards the organisation	I said I've stated the reason that I'm not emotionally okay, that word it says a lot there are a lot of things you understand then we fought for that	221: 206-207
	SANDF cannot be trusted	Organisation experienced as dishonest and injurying	The current leaders only care about their own pockets, ranks,career and going on promotional courses	222:221-222
	The SANDF as a bad object	Devaluing of lives and wellbeing	With the incident on deployment where I lost it and threatened to use that axe on them I was charged, I'll even lose my rank	222:261-262
		Frustrated needs	No-one supported me they made me feel like I was going crazy	218:35
	Lack of attunement and sensitivity to latent manifestation of undiagnosed trauma	Psychological distress equated with ill-discipline	He is trying to tell me I have a serious problem I cannot go on the field with this problem I need to talk to you, didn't even listen to the member trying to tell me so and so on, after forcing the matter to go to the field then there comes a report saying member shot himself or someone else or member just AWOLed back to Gauteng. Such things then they will say members don't have discipline	222:253-258
	Colluding with defenses	Insensitive labelling and handling of stress reactions	Like by the time I went to see the social worker things had already happened on the deployment and I was sent there because I was seen as a problem, instead of having a problem that time	221:195-196
		Missed diagnosis and treatment opportunities	They don't assess us thorough anymore	218:5-6
Undiagnosed PTSD symptoms	Difficulties with falling and staying asleep	Troubled sleep-repressed unconscious material re-surfaces in dreams	You see a lot of us have troubles with sleeping	220:151
	Disturbing memories of traumatic experiences	Flashbacks	By now you would think you would be used to seeing a	220:148-150

			dead body but having someone just lying there gone just like that…haai…you just start feeling like it opens a storage inside of you of all these thoughts of the similar incidents you have seen	
		Self-medication	We always want something to relax the mind before you sleep	220:151-152
	Alcohol use assists with sleep and abates troubling symptoms and dreams		I'll tell myself I want to drink like nobody's business until I don't feel that hurt anymore	222:233
			I am demoralised and prefer to drink to feel happy and forget lots of things	223:272-273
Failed psychic integration of trauma characterised by psychic splitting and numbing	Lack of psychological and cognitive integration into a unified SANDF	Integration has not integrated forces into meaningful entity-feelings of redundancy	If after integration they said there is no more former force we are one force with new force number but the problem is today we are still identified by force numbers, this one from MK, this one from SADF, this one from APLA, and so on we are still having that, that is why the army is going down	219:79-81
			Now what happened after integration we start identifying ourselves as former what- what, accusing one another and say you were working for the white regime, you killed us by then you were against us you understand, we were fighting guerrilla warfare in Tanzania, hey what-what that's where everything starts now identifying ourselves as what-what.	219:88-91
Lived experience of trauma	Unresolved residual traumas	Loss of lives	We were sent back and stayed at 1 mil for 98 days one of us passed away then we were so traumatised	220:133-134
			I am one person who has deployed a lot and we have been ambushed, lost guys or some got injured. But we don't talk about it much	220:144-145
	Impairing self-destructive behaviour	Propensity for intense emotional reactivity	I can get very angry and when I'm angry you can't stop me, you are more dangerous because if I can continue being like that the only solution that I'm going to take is going to affect a lot of people. I'll take a rifle I'll shoot a person then shoot myself	223:273
		Continued maladaptive coping mechanisms=long-term impaired functional capacity	I'll tell myself I want to drink like nobody's business until I don't feel that hurt anymore, especially if someone did	221:209-211

			something and I ignored it, it is better if I reacted with a fight back then it's over for me	
	Feeling vulnerable and out of control	Feeds into traumatic response trajectory	There was an operation where we were supposed to be training but we were attacked with real ammunition which was not even supposed to be there by another country. We had to fight there even using our hands and we lost one guy.	220:146-147
			But nowadays we find ourselves so stressed we become so vulnerable	218:9
Impoverished relational patterns	Feeling disempowered and disconnected from others	Sense of being burdened and being a burden, thus denial/unawareness of primitive dependence needs	I've never built that love from the onset, we've never built that mutual relationship amongst ourselves	222:227
			They all turned against me and said I wanted to kill them with an axe	218:36
			We fight a lot and my family has to get involved.	223:287
			She doesn't not know how to deal with a soldier like me	223:289
	Feelings of abandonment by former forces and current force	Feeling damaged parts in the form of wounded psyche from trauma are rejected	So here when soldiers tell commanders their family problem or whatever they take advantage	222:236-237
			Because our current leaders of today they don't look after their soldiers they don't care a damn about their subordinates	218:9-10
			Us soldiers we are being neglected career wise, promotions and social welfare	218:18-19
			We are a sick army and nobody cares	222:270
	Fear of losing relational connection with children compared to spouses	Children important relational objects	My family always says I must leave her but I think of my child, what if she takes my child and I never see her again	223:289-290
			She is the only good thing I can say I have in my life	223:290
Employing psychic defenses to cope with symptoms of trauma	Repression of traumatic emotive experiences	Protects from becoming aware of what troubles them and thereby preventing them from developing a relationship with both their internal and external reality	We have seen and done a lot it's just a person is not trained to go back there	220:143
			We don't talk about it much unless just between us as soldiers who were there sometimes	220:146

			It is like punishment always there you just ignore and move forward	220:164
	Avoiding seeking psychological help	Psychic wounds equated with weakness/failure	You get a person coming to a psychologist where now it is a ticking time bomb. When the problems started no one cared and no one invited a psychologist to come from the beginning, they always want to hide things and look like they are coping with the members but they are not that's the problem	221:192-195
			You are the last resort to us now, if something doesn't work and I see I've tried this I've tried that then I'll say eish let me go and see the psychologist	221:170-171
	Splitting of SADF as a good object and SANDF as a bad object	Feelings of abandonment by former forces defended against by displacing anger onto SANDF as the devalued object	The current army is not like the previous army. We used to enjoy soldering even if we did not earn a lot, so whatever you experience you knew you would be okay	218:6-7
			We knew that time why we wear this uniform but nowadays we find ourselves so stressed, because our current leaders of today they don't look after their soldiers they don't care a damn about their subordinates	218:8-10
Feelings of shame and fear about symptoms of trauma	Shame and fear of being declared psychologically unfit	Emotional vulnerabilities to be concealed, fro fear of being declared psychologically unfit	That's when I realised the importance of your profession, psychologists, psychiatrists, social workers have an important role to play in our lives. But you cannot keep telling people that because they will say oh he knows so much about it that means he had a mental problem	221:187-189
			Because if you don't understand that's why most of the soldiers look at psychologist and see them as only doing CHA (Concurrent Health Assessment), CHA that is all, they think CHA that's the reason for you to be in the unit. You are here to help them with their well-being but members don't understand because we don't get those programmes.	221:189-192

Summary of Participant 7's lived experience of undiagnosed PTSD

In summary, participant 7 was a very interesting participant in many respects. He is very committed to his military obligations and executing his duties to the best of the knowledge and experience he has gained from his many years in service. He also seemed very dedicated to his subordinates and their well being with an acute sensitivity to the trauma induced emotional distress they suffer from, through identification from his own emotive and experiential reality. There was a consistent feeling of his superior military knowledge and experience while interacting with this participant, as he conducted himself in a manner that was of an equal if not senior rank to me. He took command in orientating me as to what my professional role was and how to go about executing my responsibilities in alleviating soldiers' traumatic stress syndrome. In processing the interview with participant 7, I realised that there was a projective identification with his experience of self in relation to his superiors, during which I feared his anger and was pulled to highlight his strengths as though to neutralise him. I also found myself emotionally withdrawing from him as I'm avoidant of expression of feelings of anger and his manner of relating was rather aggressively charged.

In participant 7's account of his lived experience of undiagnosed PTSD, which he refers to a stress, trauma, being sick and being vulnerable it was found that there are five superordinate themes that encapsulate his experience of the perpetuating syndrome. They are; SANDF as a traumatising system perpetuating PTSD, undiagnosed PTSD symptoms, failed psychic integration of trauma, lived experience of trauma, impoverished relational patterns, psychic defenses to cope with symtoms of trauma and lastly, feelings of shame and fear about symtoms of trauma. In sharing his traumatic military experiences, he was aware of their long-term symptoms and their impact on his well being. This linked to his less than cohesive burdened sense of self, in his oscillation between being a victim of the system not given the help he needs, and a commander not given the recognition he feels he deserves.

What was of interest was how he described the impact of undiagnosed PTSD in his military and home context, which seemed to be characterised by emotional reactivity with decompensation into aggressive acting out. There seemed to be a split between good/functional and bad/damaged parts of himself. His experience was that his good parts which enable him to be good at executing his military duties are accepted in the organisation, which affirms his sense of self. It was his traumatised 'damaged' self that becomes emotionally overwhelmed and seems not to be coping as required, that is perceived as bad and thus rejected by a representation of his bad internal and external objects. He was actually charged for this perceived 'ill-discipline' and had his rank stripped away, which continues to be part of his lived exprerience of the SANDF as traumatising and perpetuating his PTSD syndrome. His experience is that of being misunderstood, mistreated and failed by his objects in empathic attunement, especially in the insensitive labelling and management of his stress reaction during a deployment mission. The participant felt unprotected and victimised by his commander and fellow soldiers that his

anger escalated to threats of physical harm towards all at camp. He had this to say about that experience: "*no-one supported me they made me feel like I was going crazy like I told the social worker. Yes, I got so angry but I was not going to hurt anyone, ja they all turned against me and said I wanted to kill them with an axe because I couldn't be released to go home immediately*". This is in contrast to his reported good experiences in the SADF, whislt the SANDF is experienced as a persecutory (bad) internal and external object that is emotionally abusive to soldiers. He reflected: "*They just add on to the damage in people's mental wellbeing. We are a sick army and nobody cares*".

When the distress becomes intolerable, he retaliates in anger which is driven by underlying feelings of pain and abandonment. Due to his disintegrated traumatised ego, he defends against complete psychic breakdown by using religion to try to control his anger and draw closer to the idealised commander he understands himself to be. Due to a lack of sustaining good objects internally and externally he is plagued by bad dreams and traumatic memories which get triggered by continuous chronic trauma and he has come to rely on alcohol to help abate his symptoms. He experiences the SANDF as a less than optimal holding environment which fails to meet his primitive dependence needs, thus perpetuating feelings of loss of control and vulnerability not only inside and outside the battlefield, but also internally and externally psychically. This participant harbours feelings of anger and mistrust towards a system that has damaged him and will not do anything to help him cope with the traumatised parts of himself adaptively and not as battle psychic wounds to be repressed in shame. It seems as though when he dares allow himself to feel he gets overwhelmed with anger, which when not directed outwards but turned inwards gives rise to intolerable pain. It was in moments when he was in touch with this pain during the interview that I felt I could connect with him and he could relate to me, rather than use me as an object for evacuating his internal contents.

Participant 7 strongly pointed out the lack of cognitive and psychological integration into a unified force and how they still identified themselves by their former forces, which may be attributed to psychic defenses against abandonment depression and integration of their traumatic experiences into the self. This mirrors the psychic splitting and numbing of distress from those memories of re-experiencing which he feels always follow him: "*But now you find that you always have those coming back to you like they are following you. Yes you start remembering those past things like they just happened and feel like you are there all over again*". This made me wonder about the psychic function of not only their former force identities but of the symptoms of PTSD in these soldiers' experiential reality.

The losses experienced from combat exposure remain unresolved as their repressed as part of how he was trained to cope and thus soldier on. The defending against conscious awareness of his unresolved traumas comes at a cost of not developing a relationship with his internal and external reality. He finds himself challenged in relationships with others inside and outside the force, as he struggles to find emotional sustenance in them for emotional and self regulation. He speaks of himself as dangerous when

pushed to his limit with a propensity to inflict harm on his fellow soldiers before turning to himself. I interpreted this as mirroring his feeling of being attacked by his introjected bad objects. This participant knows he is suffering from enduring symptoms of PTSD but has kept them concealed and what was of interest was that he knew what kind of psychological help he needed but hides this behind a 'collective need', as though to normalise the avoidance of seeking individual psychological help. It felt as though he was asking for help through instructing me on what my duties were as a psychologist. This perpetuates the perception of psychic wounds being a weakness and the enduring undiagnosed PTSD symptoms. He went to consult with a social worker after his explosive incident on deployment resulting in him being returned back to the unit because of the shame and fear of acknowledging the intensity of his trauma syndrome and being declared psychologically unfit. About which he reflected: "*Like by the time I went to see the social worker things had already happened on the deployment and I was sent there because I was seen as a problem, instead of having a problem that time*".

Despite his tough exterior, it feels participant 7 is alone and scared in his psychic distress secondary to undiagnosed PTSD and his threat to harm others and then himself, which he has attempted, is worrisome and illuminates the impairing course of PTSD on the psyche and the self. However, part of me felt that this was a manifestation of annihilatory anxiety, a residual of his psychic trauma without which he may fear being object-less.