*PINS, 2021, 62, 87 – 115*

# Psychic Wounds of Post-Traumatic Stress Disorder camouflaged under the uniform of an SANDF soldier


## Abstract

*The authors explored the lived experiences of traumatisation among active Black military personnel from a psychodynamic (Object Relations) framework. The broad aim of this study was to explore traumatisation and subsequent long-term undiagnosed post-traumatic stress disorder (PTSD) in the presenting behaviour and overall psychological functioning of Black members in the South African National Defence Force (SANDF). N=9 members of the SANDF participated in the study. The study was conducted using a qualitative approach and a phenomenological research design. Data was obtained using individual semi-structured interviews, with IPA as a method of analysis. The findings indicated that participants lived experience of traumatisation is a chronic state of psychic, occupational and relational re-traumatisation. Continuous traumatisation that reactivated past unresolved traumas was characterised by annihilation anxiety, psychic numbing and repression. Phenomenologically overall functional paralysis was evidenced in chronic psychological deterioration, which manifests in irreversible damage to character, with cognitive and relational deficits linked to unresolved long-term traumatisation. These findings highlight a need to incorporate psychotherapeutic models focused on integrative meaning making of psychic distress for adaptive functioning of SANDF members, suffering from long-term undiagnosed PTSD syndrome from pre-integration armed forces combat experiences.*



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## Keywords

*Post-traumatic stress disorder; self-object disintegration; military; combat psychic wounds; phenomenology*


At present, military forces from developing countries, including South Africa, are deployed to participate in many multinational operations, which extend to

supporting international peacekeeping missions across the globe (Kickbusch et al., 2007). 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 et al., 2011). Initially, PTSD was understood to be the result of a onetime severe traumatic incident. However, PTSD 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 who participated in this study.

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). South Africa has an armed struggle history between the statutory and non-statutory forces, which led to an integrated national force in the uniform of the South African National Defence Force (SANDF). It was on the eve of the first democratic general election in 1994, that the various non-statutory forces previously belonging to the internal anti-apartheid political movements were integrated into the newly formed SANDF (Holomisa, 1994). 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).

The integration process was embarked upon to end apartheid rule and the violent conflict in retaliation against it, in attempt at national reconciliation and economic reconstruction (World Bank, 1996). However, the process lacked foresight of the psychological ramifications of the trauma these combatants had endured and the impact thereof in the long-term. Gear (2002) and Naidoo (2007) argued that one of the most pertinent interventions, being psychological interventions, had been excluded during the undertaking of this demobilisation and reintegration operation. 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 combat experiences (Mashike, 1999).

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 normative manner (APA, 2013). 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 highlights the importance of understanding how characteristics of different combat exposures may contribute to new and unique clinical presentations of PTSD (Yehuda et al., 2014). 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.

Despite South Africa's politically and psychologically traumatic combat history there is paucity of psychological studies or treatment interventions aimed at addressing SANDF's members possible overt or underlying residual traumatic stress response trajectories. 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 appear to have not improved to date (Doherty, 2015). 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, 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). Mental health professionals continue to have an ambivalent status in the army at the best of times, as psychological problems are dealt with as disciplinary offences (Doherty, 2015). Thus, the current commissioning of a Posttraumatic Growth Model in efforts to treat posttraumatic syndrome in the SANDF cited in (Mashatola & Bester, 2020), we argue would only be effective for newly diagnosed cases in response to immediate combat trauma thereby excluding members with unresolved trauma from pre-integration combat exposure.

Hitherto, this research study aimed to gain an understanding of how SANDF members live with enduring undiagnosed PTSD symptoms as manifest in psychic impairment from repressed and unresolved traumatisation. This is articulated in a unique analysis through the theoretical lens of Object Relations Theory (ORT) and interpretative lens of Interpretative Phenomenological Analysis (IPA), allowing experiential access into the usually concealed subjective experiences of trauma among military personnel.

## Object relations and trauma

An overview of the *object* in Fairbairn (1943) and Klein's (1959) 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. Specifically, as 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. 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 (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 (Welch, 2004). Object-relations theory models highlight 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. A defining effect of trauma is that basic trust is destroyed, with resultant enduring disruption of the understanding of oneself and the world (Levitt, 2010).

For Klein, when tolerance of frustration is insufficient and emotional reactions are extremes of good and bad, frustration intensifies fear of the object, intensifying the bad-object relationship and leading to greater difficulties in bearing negative experience (Summers, 2014). Furthermore, Klein believed crises can prompt regression to either the paranoid-schizoid or depressive position in all individuals, especially if initially they were not worked through adequately (Burch, 1988; Klein, 1959). 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. Thus, 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. For Fairbairn, 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). 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 (Mitchell, 1981). On the contrary, 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 (Mitchell, 1981). Fairbairn (1943) 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. Therefore, when a traumatic experience triggers the release of bad objects for the soldier, failure of defenses and coping strategies occurs.

Developmental arrests are infantile emotional states that adults regress to when the psyche feels overwhelmed (Stolorow & Lachmann, 1980). Segal (1957) conceptualised this breakdown in symbolisation proper as a result of inadequate containment. 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).

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). In accordance with the self-psychology perspective, psychological disturbance is regarded as involving damage to the self and structures of the psyche. Accordingly, the development of psychopathology is steeped in how patients have internalised their objects (Bacall & Newman, 1990; Wolf, 1988).

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 to maintain the traumatic situation outside the mental space (Jovi, 2018).

Moreover, Haley (1993) 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).

## Method

The aim of this phenomenological enquiry was to explore the *lived experience* of traumatisation manifesting in long-term undiagnosed PTSD among a group of Black SANDF members. 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). Specifically, the focus was on how symptoms of PTSD manifest emotionally, cognitively, physiologically and relationally, rather than on the characteristics of the members who participated in the study.

*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 a possible population for this study, social work officers employed in the military were invited to participate for purposes of recruiting participants from their client population. 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. 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.

*Selection criteria*

The two inclusion criteria were firstly, an experience of a traumatic event related to military activities as evidenced in the responses to the four questions in the Rapid Diagnosis of PTSD toolkit administered as a screening instrument. Secondly, participants had to exhibit symptoms of undiagnosed and untreated PTSD as indicated by their pre-determined score on the Impact of Event Scale-Revised (IES-R) questionnaire, administered by the researcher. 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). Thus undiagnosed PTSD symptoms screened for, cut across both the DSM-IV and DSM-5 diagnostic criteria and informed the recruitment and selection criteria. 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 who met the criteria for undiagnosed PTSD were invited to participate in face-to-face semi-structured interviews.

The final sample comprised nine participants from two Infantry Military Bases in the Gauteng Province participated in this study. These participants were involved in former statutory and non-statutory armed forces and had also been exposed to combat trauma during their SANDF operations. The sample comprised Commissioned and non-Commissioned Officers from the different armies that were integrated into the SANDF. The serving men and women who were interviewed had different ranks in the SANDF: 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. The participants' ages ranged between 46 and 55 years and most did not live with their families. They had served in the SANDF for no less than 20 years and had been deployed externally and/or internally at least twice.

*Instrument of data collection*

Semi-structured in-depth interviews were conducted to gain an understanding of the lived experiences of participants' emotive and experiential reality of long-term undiagnosed PTSD (Castillo-Montoya, 2016). An interview schedule was compiled as a guide for open-ended questions as well as any other themes raised by the participants during the interviews (Ashworth, 2008; Smith & Osborn, 2007; Terre Blanche & Kelly, 1999; Taylor, Bogdan, & de Vault, 2016) and to ensure that the conversations stayed within the confines of the research objectives (Yeong, Ismail, Ismail & Hamzah, 2018). These interviews were conducted in two military bases and were audio-recorded with permission from the participants (DeJonckheere & Vaughn, 2019) and transcribed during the data analysis stage. The interviews were conducted in the language of the participants' choice, either in isiZulu or English.

Although the duration of each interview was self-determining, the duration of most was between 50 and 60 minutes. The schedule was used as a "virtual map" (Smith et al., 2009, pp. 59) to guide the interviewer. These questions were used mostly as a guide so that the interview was shaped by the stories the participants wanted to tell. Questions asked included "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?", "What meaning have you assigned to this

traumatic experience?", "Do you think this event/s has changed or impacted your life? Please explain.", and "In short, describe yourself after the life this traumatic event/s?"

*Ethical considerations*

Ethics are very important when conducting research, and thus the following ethical issues, as advanced by Oltmann (2016); Lancaster (2017); DeJonckheere and Vaughn (2019), were adhered to:

Prior to commencing with data collection, written permission was obtained from Defence Intelligence to recruit active members from the SANDF to conduct the study. The participants were also informed that findings and recommendations would be sent to the Chief of Army for dissemination to the Psychology Directorate. The study was approved by the Faculty of Humanities Ethics Committee of the University of Pretoria (GW20170712HS).

Prior to the interview, participants were assured that they only needed to disclose what they felt comfortable with and that the interview would be conducted at their pace. The establishment of good rapport was ensured so that participants felt safe to share their experiences of how their undiagnosed PTSD symptoms manifested intra-psychically. Furthermore, the recruitment process guaranteed that all participants were well informed of what the research was about and what their participation entailed.

Anonymity was maintained by allocating them participant numbers. Any information that may have led to the identification of participants has been altered to maintain anonymity.

To maintain confidentiality, all information collected from participants was kept in a password protected computer to ensure that no unauthorised persons will have access to the information.

With respect to the emotional arousal participants may have experienced during the interviews, participants were debriefed at the end of the interviews. Each was provided with contact information of a registered counsellor in one of the military bases, should they need any further psychological input. Arrangements were made with this professional to assist participants that might contact her for trauma therapeutic management. At the time of gathering data, there was no psychologist based in any of the military bases in Johannesburg. The registered counsellor would have referred participants to psychologists in Pretoria where indicated.

*Interpretative phenomenological analysis*

Phenomenological understanding rather than empirical knowledge was emphasised in this study. Therefore, the focus was on eliciting and describing phenomena rather

than explaining them. Interest was not on a cause-and-effect relationship between variables but on a range of experiences that afforded an understanding of the experienced traumatisation manifest in undiagnosed PTSD phenomenon in Black members of the SANDF.

The analysis was a cyclical process during which the researcher regularly moved between stages rather than proceeding linearly. In sum, the main stages of analysis involved the following steps as described by Smith et al (2009). During several close readings of the data, detailed reflective comments were noted. 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, important quotations were highlighted throughout the transcript. Notes were also made of any interesting facts and details that surfaced during the initial analysis phase: thought processes, feelings and personal reflections on the process. This allowed the researcher to maintain insight into her 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.

Emergent themes were then assigned to capture interpretation of the codes. Emergent themes were written on to notes and along page margins of the interview transcript. While some of the identified themes were named precisely as they were found in the data, others were named in line with shared commonalities. As commonalities between themes were established, 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. The themes that emerged were compiled in the order they emerged and subsequently reorganised and rearranged to form clusters of related themes. Superordinate themes were identified through the following processes of abstraction, subsumption, polarisation, contextualisation, numeration, and examining themes for their function (Smith et al., 2009). Furthermore, emerging themes were supported by quotations from the transcript (McCormack & Joseph, 2018).

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. 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. Following the analysis of each case individually, a group analysis was conducted thereby eliciting patterns

across participants. 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.

*Ensuring trustworthiness*

Despite there not being a definitive set of criteria for determining the validity of IPA studies, guidelines by researchers such as Elliot et al. (1999); Yardley, (2008); and Smith, (2011) for the evaluation of qualitative research was followed. The verification of findings through a transparent audit trail provided a logical account of how the research progressed from conception to the final report (Smith et al., 2009). Furthermore, the research findings were verified (Yardley, 2008) through another reader. This was performed by the research supervisor who ensured that the data had been systematically analysed and the findings accurately recorded. The third guideline involved ensuring that the methodology is sufficiently detailed, coherent and evidenced (Yardley, 2008). In conjunction with detailing the principles that direct the methodology, each identified theme was supported by the inclusion of a number of verbatim extracts.

## Discussion of findings

Black SANDF members' lived experience of long-term undiagnosed PTSD secondary to (unresolved) combat trauma was afforded a voice, with the phenomenology of the experiences emerging in master themes each with its superordinate themes. Although each theme is discussed separately, it is noteworthy that the master themes are interrelated.

*The SANDF as a traumatising system perpetuating PTSD*

One of the research aims was to understand how participants 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. 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. This study revealed that this led to decompensation into ego disintegration as a result of internalised continued trauma as experienced from the SANDF. 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.*

In a potent description of the debilitating effects of trauma on service men, Kardiner and Spiegel (1947) posited that 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 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.

Past traumatic injuries appeared to get re-activated by perceived frustrations within the SANDF as a persecutory primary object, and 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). 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."*

When psychological distress became overwhelming and manifested behaviourally in symptomatology consistent with complex PTSD, 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 within the SANDF, soldiers from the infantry bases are generally understood to be cognitively, emotionally and functionally impaired, which is exacerbated by their chronic substance dependence.

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. **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."*

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). 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).

*Undiagnosed PTSD symptoms*

When asked about their understanding and experience of traumatic responses, participants provided lived diagnostic features of PTSD, along with the defenses they employed to alleviate the disturbing thoughts and feelings. To survive living 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."*

Sleep became terrifying as participants were thrust back into the depths of traumatic despair of unresolved traumas from pre- and post-integration into a unified SANDF. 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** conveyed this,

> *"You see a lot of us have troubles with sleeping we always want something to relax the mind before you sleep." 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. 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 (Lénárd & Tényi, 2003).

Similarly, to this study, 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.

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. 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.

The participants in this study conveyed an enduring state of feeling at war with their psyche. 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. As the SANDF had become a symbolic reminder of psychic wounds that were resistant to healing. One of the participants recalled not being able to handle a weapon because of debilitating intrusive memories of past traumas. 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." Alcohol*

*also helped participants withdraw from themselves and therefore, a relation to self and self-objects."*

A pattern of self-medication for psychic withdrawal remains prevalent among Black SANDF members. 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.

*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 (Uji et al., 2007; Ford & Courtois, 2009; Ginzburg et al., 2009). According to these authors both syndromes are a response to continuous or chronic trauma. Many of the participants experienced the excruciating pain of traumatisation 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. Non-integrated traumatic experience impinges itself through re-experiencing and is suppressed or split again. The psychic defenses involved are manifest in psychosomatic dysfunction, perceptual hallucination and symptomatic action (Britton, 1998). 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 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).

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 participants experienced life as 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.*

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). 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.

*Lived experience of trauma*

The re-activation of past unresolved traumas can be likened to Continuous Traumatic Stress (CTS), a construct that refers to a 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). 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. Davies and Frawley (1994) explained dissociation as surrendering and resigning oneself to the inevitability of overwhelming, even psychically deadening danger. 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."*

*Impoverished relational patterns*

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." This provides an understanding of the psychic role of interpersonal relating in affect regulation, which is pivotal in the face of trauma* (Schore, 1994).

The participants' accounts of their emotive reality depicted an isolated and overburdened self that 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, lacked the self-soothing structure that would protect 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). This was captured by Lénárd & Tényi (2003) as the solitary, isolated, deprived, detached, exiled life of a soldier who lost the physical and psychological war.

As uncovered 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, participants abandoned their objects before allowing themselves to feel abandoned, which plunged them further into the psychic disintegration of their undiagnosed PTSD syndrome. 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.

All participants experienced the emotional connection with their families as impoverished. They withdrew emotionally and related as appendages to the family. Courtois' (2004) comprehensive diagnosis of complex trauma explicated the incapacity to self-regulate, self-organise and draw upon relationships to regain self-integrity. 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. This is related to the participants' disengaged self and fragmented ego, which 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.

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, was spoken about more than the spousal dyad. Participants appeared to experience an element of restoration of pride in providing for their children despite a painful acceptance that an emotional disconnect existed. As **one of the participants** 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.*"

*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. 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.*

When emotional distress from traumatisation could no longer be defended against, it was made sense of physiologically or physically through increased psychosomatic presentations to the sick bay. A prevalent aspect of traumatisation is the degree to which somatic symptoms are understood to be a common dimension, intrinsic to trauma presentation (Eagle, 2014).

It appears psychological illness is more readily explained away or denied through psychic defenses, however, 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 distress from themselves and others but could not escape its manifestation in physical ailments. 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. Trauma evidently produces over-activity of mental functioning and a mind-psyche, which is pathological. Thus, a 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).

*Feelings of shame and fear about symptoms of trauma*

The participants harboured feelings of shame that their traumatic stress response to combat exposure rendered them psychologically unfit. Several contributors have observed that anger and shame, for instance, are often present in the aftermath of trauma (Eagle, 2014).

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. 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 participants felt weak for not having the psychological strength to have prevented themselves from long-term suffering with PTSD.*

However, the more the participants tried to conceal their PTSD symptoms, the more they found expression through mood, physical and behavioural disturbance. 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). This may partially explain the long-term course of this undiagnosed PTSD among some of the Black members of the SANDF, secondary to traumatisation.

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.

## Conclusion

Although limited in scope, this study attempted to enhance an understanding of Black SANDF members' thoughts and feelings of their experience of traumatisation and secondary long-term undiagnosed PTSD, from an object-relations perspective. In answering the research questions through phenomenological interpretative analysis, this study found that Black SANDF members from former statutory and non-statutory forces carried over unresolved PTSD syndrome from combat exposure into the newly formed SANDF spanning over many years. 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.

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 symptoms of a psychiatric condition (Brooke, 2017).

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 to cope. Part of the distress of their clinical presentation involved the impairment in their relational patterns, leaving them to suffer in shame and silently in physical and emotional isolation. 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 psychically trapped in the trenches of traumatisation.

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. These serving members continually succeeded in masking the morbidity and severity of their undiagnosed PTSD symptoms, not only to defend against being psychically overwhelmed but also against being perceived as psychologically unfit as well as having lost control of their minds and themselves to past and continuous traumatic combat exposure.

From the findings this study aims 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. Specifically, a focus on integrative meaning making could be included in psychological wellness programmes and as part of Comprehensive Health Assessment (CHA) intervention tools.

It is recommended that future research examines secondary traumatisation from PTSD of service men and women's spouses and children. In addition, future research could examine the resilience and possible psychological resources of serving members living with untreated PTSD and how these could be strengthened, from a positive psychology perspective.

## Limitations of the study

Despite the potential beneficial findings of this study, several limitations are acknowledged. First, the sample was homogenous. Therefore, participants were not representative

of the SANDF from a racial aspect. This rather curtails the generalisability of the study's findings. At the same time, it needs to be added that the focus of this study was on depth of understanding, rather than breadth of applicability (Gall et al.,1996). Therefore, the exploratory nature of the study afforded an understanding of individual and shared experiences and development of a beneficial and meaningful body of research to deepen the participants' understanding of their reality (Lincoln et al., 2011). Another limitation is related to data interpretation. In IPA 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.

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 the interest was in the understanding of 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 the exploration of themes shared between cases (Smith et al., 2009).

## Declaration of Conflicting Interests

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

## Funding

The authors received no financial support for the research, authorship, and/or publication of this article.

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