UNDERSTANDING AND TREATING

COMBAT-RELATED POST TRAUMATIC STRESS DISORDER

A Soldier's Story

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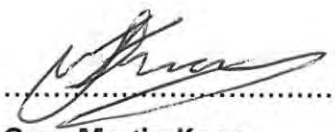
Submitted in partial fulfilment of the requirements for the degree of Master of Arts in Clinical Psychology. Rhodes University, Grahamstown, 1991.

I hereby declare that this Thesis
is entirely my own work.



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Gary Martin Koen

ACKNOWLEDGEMENTS

To Professor Dave Edwards whose enthusiasm and encouragement was always present even when mine seemed to have vanished;

To Dianne, my typist, whose patience and professionalism I am deeply indebted to;

To Nick and Pia whose thoroughness and meticulousness whilst doing the proof reading was invaluable;

And finally, to Neil, whose courage and strength lives on in my memory.

ABSTRACT

This work documents the treatment of a 20-year-old male suffering from Post Traumatic Stress Disorder as a result of his experience during two years of national service as an Operations "Ops" Medic in the South African Defence Force.

The literature review is drawn largely from the body of work emerging from the Vietnam War, and in particular the work of Robert Lifton and Erwin Parson is considered.

The case study consists of a detailed synopsis of the treatment based upon material from the therapy sessions. This section hopes to accurately convey the experience of working with someone suffering from Post Traumatic Stress Disorder and provide insight into the dynamics of such a therapeutic relationship.

Finally the discussion examines the links between the theory and the treatment and attempts to understand the various factors which shaped and influenced the final outcome of the therapy. Special consideration is given to showing how essentially cognitive restructuring techniques are successfully utilised within a more existential, psychodynamic framework. Furthermore, there is a paucity of literature on the subject of combat-related Post Traumatic Stress Disorder in South Africa and it is hoped that this work will both point to a need for further research in this field whilst simultaneously provide guidance for those who wish to become involved in working with individuals suffering from Post Traumatic Stress Disorder.

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Yossarian ripped open the snaps of Snowden's flak suit and heard himself screaming wildly as Snowden's inside's slithered down to the floor in a soggy pile and just kept dripping out. He didn't know how to begin to save him.
"I'm cold", Snowden whimpered, "I'm cold".
"There, there," Yossarian mumbled in a voice too low to be heard.
"There, there."

*Joseph Heller (1965) **Catch 22***

War may be the only way in which most men touch the mythic domains in our soul. It is, for men, at some terrible level the closest thing to what childbirth is for women: the initiation into the power of life and death. It is like lifting off the corner of the universe and looking at what's underneath. To see war is to see into the dark heart of things, that no-man's-land between life and death and even beyond.

*W Broyles (1984) **Why Men Love War.***

The death encounter undermines our magical sense of invulnerability by means of its terrible inner lesson that death is real, that one will oneself die - and this vies with our relief at no longer having to maintain that illusion. The result can be something resembling illumination.

*Robert Lifton (1989) **The Traumatised Self.***

CHAPTER ONE

AIMS AND RATIONALE

The aim of this study is to document the treatment of a 20 year old male suffering from Post Traumatic Stress Disorder (PTSD) as a result of his experiences during two years of national service as an Operations "Ops" Medic in the South African Defence Force. When this person, whose name is Neil, first came into therapy he was suffering from a variety of symptoms that included gruesome and violent nightmares, phobic reactions, intense anger, startle reactions, a high level of anxiety, hypervigilance, mood swings and severe depression. He was disillusioned with his life and despairing of his future. He suffered profound guilt and was filled with a self-loathing that bordered on self-hatred. His hatred extended to those around him, whom he felt had no understanding or appreciation of his experiences, and was particularly bitter towards the military whom he largely blamed for his predicament. During the course of therapy Neil moved from being a person whose life had no meaning, who was tainted and contaminated by death as though a large part of his 'self' had died, and who was at the mercy of symptoms which fragmented his life leaving him feeling as though he were going mad, to being a person who was capable of rediscovering life, able to form and have new relationships that hold meaning for him, and able to rediscover a part of himself that he thought had died. His symptoms disappeared and he came to appreciate how he had been transformed by his war experiences and was able to integrate that transformation into a new outlook on life.

The focus of this study is the documentation and understanding of how an abnormal experience was incorporated into a normal way of life. It attempts to show how a psychodynamic understanding of the effect on a person's self of continuous death-related events, combined with both a directive and non-directive therapeutic approach to these consequences, was most conducive in this treatment of combat-related PTSD.

The study also attempts to link theory with practice and as such to examine how this treatment either adheres or adds to the models available in treating combat-related PTSD. Thus a secondary aim of the study is to show how principles contained in existing theories and models are illustrated by the present case. The existing models include:

1.1 In particular the work of Lifton (1973; 1979; 1988) which will be considered with an emphasis on his principles of the "death imprint" and the symbolisation of the self; of survivor guilt, involving self condemnation and failed enactment; of psychic numbing; of discontinuity of the self; and of the search for meaning accompanying the transformation of the self.

1.2 Parson's (1988) model of Post Traumatic Self Disorder and the use of a multi-model diversiform approach in the treatment of PTSD.

1.3 In addition to the above importance of the therapeutic relationship will be considered, along with issues such as "transference", "therapist as a container for the veteran's feelings", and the issue of how symbols and metaphors are useful for understanding the healing process.

A third and vital rationale in attempting the study concerns the thousands others who, like Neil, also fought in the border war.

The war has effectively been over for three years. During that time the "border" has shifted from the Okavango River in northern Namibia, to the Orange just outside Upington. The Mozambiquan conflict, despite remaining contentious, is seen as a remnant of an old and forgotten era. National Service has been reduced to one year, and the public is seldom plagued by military issues these days. Indeed South Africa even has a new Defence Minister.

Yet what has become of all those who actually fought the war? Have they adjusted as normally as everyone hoped they would? These are difficult questions to answer, as no follow-up on South African veterans has ever been attempted. The military, despite

offering ongoing treatment for those suffering from PTSD, has no literature nor programmes documenting its work. The approach favoured appears to be the use of hypnosis and some cognitive restructuring, yet nothing has been published on what has or can be done. One particular psychiatric registrar, Graham Altman, completed his thesis on a screening method to effectively detect PTSD, yet offered no treatment plan, nor any ongoing means of follow-up in treating these individuals. From a psychological perspective no-one has published anything on the treatment of combat related PTSD dealing with the South African situation.

The media have provided the most exposure of combat trauma, yet even their contribution is limited. Recently an English professor from UNISA announced a new publication in which the poems and the descriptions of those involved in the war would be included. Numerous plays and short stories have been written, most notably Ackerman's *"Somewhere on the Border"*, and Opperman's *"Môre is 'n Lang Dag"*; whilst most recently the Vrye Weekblad newspaper did a cover story on PTSD, titling it *"Bossies"*, (the South African version of the Vietnam syndrome). Darryl Roodt's *"The Stick"* is the best film to date on the South African war, yet went relatively unnoticed on the film circuit.

So where are all the people suffering from PTSD? In my experience as neophyte psychologist, I have only seen one such person. This is his story. However, both in my own experience during and subsequent to the army, I have come across dozens of individuals who still seem to be fighting the war. Their confusion and disillusionment are still prominent; their anger is very tangible and their sadness still untapped and unrecognised. Perhaps this piece of work can be of some assistance to others who may work with these people, whilst also highlighting the need for more work to be done in this area.

A final consideration in the writing of this study must embrace a personal dimension, in that the depth of feeling with which I was confronted, the level of vulnerability, the meaning behind the meaninglessness, allowed for a journey along which my growth as a therapist was but only a part of a more profound experience of growth within myself. In essence, this is my story of Neil's story.

CHAPTER TWO

LITERATURE REVIEW

2.1 OVERVIEW

Post traumatic stress disorder (PTSD) is a generic term describing the effects of extreme stress on the human mind. While the symptoms of PTSD are standard according to the DSM III R, the events that precipitate them are numerous. They can arise from single episodes of life-threatening harm and violence, such as rape and assault; or disasters, both natural and man-made such as floods, earthquakes and air, rail or shipping accidents. More profound and chronic reaction seems to result from being exposed to an environment that is continually life-threatening and dangerous, such as concentration camps, war zones and areas of extreme poverty and violence, conditions not unlike the environment of many South African townships.

In reviewing the literature the focus was limited to PTSD as it occurred and was described in specifically war-related incidents. In this regard the type of war was also important. Guerilla warfare, the type of war fought on the South African borders for the past twenty years, contains many unique features not seen in conventional warfare. These include hit and run tactics, surprise ambushes, extensive use of landmines and booby traps, as well as the stress experienced by people who are primarily town-dwellers fighting a "bush" war. Unpredictability characterises this type of environment, and the uncertainty of either attack or safety leads to a high level of anxiety and hyper-arousal in anticipation of the next attack. The identity of the enemy was equally unpredictable and typically harmless scenes containing elderly folk and young children become places of ambiguity, uncertain as to whether they housed unseen danger in the form of enemy troops, or were simply ordinary people trying to hang onto their rural lifestyle.

Whilst the majority of the South African troops were not involved in actual fire-fights, a significant number were exposed to the conditions described above. It is these soldiers who have been most likely to suffer the effects of such stress. Of particular interest are

personnel from the Medical Corps, particularly the Operations Medics, "Ops Medics", for whom no amount of training could prepare them for the type and volume of wounds they encountered or for the prevalence of death in their environment.

Politically and logistically, the objectives of the war were crudely defined. Those in the bush were oblivious to any specific target, their only instructions being to find and prevent insurgents from crossing the border. Back "home", the actual purpose of the war was shrouded in political rhetoric and controversy, supported by groups who either upheld the moral and ethical dimensions of the war, or those who decried it vociferously. The major conflict of there two groups was between each other and little attention was paid to those involved with the actual warfare. Once National Service was over the individual was expected to slip normally into the mainstream of society, their expectation being that their whole lives were lying ahead of them. Little attention was paid to that what was behind them.

The literature is sparse on the effects that the South African war had on those who fought it, and very little has been written on the treatment procedures for those suffering from PTSD. As such all of the theoretical and treatment models have been drawn from writings on the Vietnam War, the similarities in the nature of the warfare and the controversial matters supporting the two wars allowing for suitable comparison.

2.2 A BRIEF HISTORY OF COMBAT-RELATED PTSD

Psychological stress response syndromes were not recognised until World War II, and even then was met by severe resistance. Mulling writes: "Only since the latter days of World War I has the inability of combat personnel to cope with battle conditions become accepted as a legitimate reason for classifying such personnel as casualties at war. In prior times, such failure of adaptation was regarded as cowardice, weakness, or other moral lapse and was usually dealt with punitively. This attitude persisted even in World War II (Kormos 1978)."

A large percentage of the World War II veterans presented symptoms now commonly recognised as PTSD, and this stimulated a phenomenological re-evaluation of combat-related stress symptomatology. Symptoms such as nightmares, sleep disturbances, guilt, depression, alienation, irritability, startle reactions, flashbacks and anxiety, as well as related problems such as substance abuse and marital and legal/vocational difficulties were subsequently documented. These symptoms could either begin shortly after cessation of the traumatic event and continue indefinitely, or would begin a prolonged period after the event (Kormor & Horwitz 1988).

The recognition that physical traumas were not invariably antecedents of combat reactions stimulated a great deal of thought, some of which we will now consider.

2.3 FREUD'S CONTRIBUTION

Freud defined as "traumatic" an experience which "within a short space of time subjects the mind to such a high degree of stimulation that assimilation or elaboration of it can no longer be effected by normal means (Wilson 1984)". From this experience a traumatic neurosis would arise, "a consequence of an extensive breach being made in the protective shield against stimuli (Lifton 1988)." In essence the events of the environment are of such an extreme nature that the ego is simply overwhelmed. The symptoms which arise are understood as the individual's attempts, through regressive use of repetition to master the implications and effects of the earlier trauma. If the ego is overwhelmed, the individual's usual adaptive capabilities are disrupted and he/she reverts to an early and primitive form of defence - the repetition compulsion. This consists of repeating a disturbing event over and over in an attempt to master the original trauma.

Freud concluded that the "war neurosis" arose, in part, due to "... conflict between the soldier's old peaceful ego and his new war-like one which becomes acute as soon as the peace-ego realises what danger it runs of losing its life owing to the rashness of its newly formed, parasitic double (Lifton 1988)."

Treatment would consist of abreaction, catharsis and then working through the unassimilated material. However Freud's treatment does not pay much attention to the nature of the trauma as a determinant in the individual's recovery.

2.4 LEARNING THEORY

This approach points to the similarity of symptoms across a wide range of population and stressors and concludes that it is a cause and effect relationship, involving autonomic over-activity, REM over-stimulation, and lowered behavioural responses. Those who approach PTSD from this perspective encourage the use of largely behavioural techniques to restore the veteran's control over the symptoms. The main aim is to help the veteran avoid threatening material, using such techniques as systematic desensitisation and imaginal flooding in carefully controlled, time-limited sessions.

Stress management packages focusing on the veteran's current symptomatology have also been developed, which include extensive use of cognitive restructuring and problem-solving techniques to enable the veteran to avoid focusing on traumatic Vietnam events, replacing these negative thoughts and feelings with more positive thoughts and feelings.

Whilst researchers in the above field have reported significant success through use of these techniques, their ultimate goal is the reduction of specific symptoms rather than integration of the traumatic experiences. However, whether the use of such techniques does in fact help the patient to better integrate their experience remains a source of debate. Of equal importance would be to establish which behaviour techniques can best be used in conjunction with other forms of therapy to help master the symptoms and integrate the traumatic experience.

It should be briefly stated that the use of hypnosis to encourage veterans to recover lost memories, discharge repressed affects and to integrate the traumatic experiences have been documented. There has however been no systematic research on the use of hypnosis for treatment, and no objective outcome criteria are defined or empirically measured (Dye & Roth 1991).

2.5 HOROWITZ'S MODEL

Horowitz reports the increase of two broadly defined states following traumatic life events; one is characterised by intrusive experience, the other by denial and numbing. At the time of the event, or immediately afterwards, there is frequently an emotional outcry characterised by painful but brief lived recognition of the salience of the event. Following the outcry there may occur oscillating states of either denial or intrusion. Through a process of working through, the intensity and frequency of these states may be reduced, and emotion-laden memories are allowed into conscious awareness without overwhelming the coping mechanism. The result is gradual assimilation, mourning of what has been lost, re-evaluation of beliefs that one is invulnerable, and the forming of new plans and new attachments. Horowitz conceives of this process as the "psychological metabolism of the impact of the traumatic event (Horowitz 1988)."

Horowitz offers a time limited therapeutic model of 12 sessions, which he felt encourages determined, goal-orientated work on the part of the patient and therapist and which provides a structure that tends to counter diffusion of focus and maximises the therapeutic potential during the termination phase. The ultimate aim is not the full resolution of the traumatic impact, but rather to provide the person with a model of working through which will enable him to continue a normal pattern of healing and adaptation after the termination. However this model is best suited for those who have suffered a discrete traumatic event and is normally not appropriate for those who have had chronic exposure to environments containing on-going stress.

2.6 LIFTON'S PRINCIPLES OF PSYCHOFORMATIVE THEORY

Lifton has done extensive work with PTSD victims (1971, 1973, 1977, 1978, 1981, 1987, 1988) and has, through his work, evolved several core aspects which characterise the experiences of the survivor. He contends that the place of Death, and "death anxiety" has been neglected from most theories and treatment modes for PTSD, an omission he finds striking considering that it is the one syndrome where Death is so close. His psychoformative theory provides eloquent insights into the nature of the survivor, and a rich framework from which to formulate an understanding of PTSD.

2.6.1 LIFE/DEATH PARADIGM AND SYMBOLISATION OF THE SELF

Lifton argues that there has been both cultural and conceptual resistance to confronting the implications that death-related trauma has on an individual, and this has prejudiced both the understanding of PTSD and the treatment of the sufferer. Lifton refers to this experience as the "Death imprint (Lifton 1983)" and describes it as a radical intrusion of an image feeling of death or end to life.

The Death imprint contains a significant degree of anxiety to do with the grotesqueness and the absurdity of the image, its suddenness, its association with the terror of premature death, and its extreme and protracted nature. The death encounter opens up the most primitive fears of human vulnerability and forever destroys the myth of omnipotence. It contains the ultimate in truth about beginnings and endings, and forces a confrontation with one's own transiency and the mutability of life.

Therapeutically, the task becomes immensely profound; as therapist one is required to confront one's own vulnerability and fear of dying, whilst simultaneously working towards an understanding of human continuity, that as survivors individuals are inextricably bound to the "great chain of being" that links them not only to Death, but also to further life (Lifton;1988).

2.6.2 SURVIVOR GUILT AND SELF-CONDEMNATION

Lifton understands this phenomenon as the psychological guilt precipitated by an experience of extreme helplessness at the time of the trauma. Fuelling the guilt is what Lifton calls "failed enactment (Lifton 1988)" which refers to one's instinct at the time of the trauma to halt or prevent the trauma from happening. One is seldom able to do anything at such times and what one does do is often far from the ideal reaction. Failing to achieve what should have been done can lead to a form of perpetual self-condemnation, and a state of helplessness continuing long after the helplessness induced by the trauma.

However guilt is an ambiguous state. Whilst part of oneself remains stuck in the perpetual horror of the suffering, another part experiences great joy at having survived. This joy is in itself ambivalent as the vitality of joy appears sacrilegious in the face of the death and pain of the suffering of others. Transcending the traumatised self requires one to move beyond the devitalising event with its aspect of personal responsibility and guilt, to an awareness of one's common humanity and condition: to forgiveness, relief from guilt and happiness. Whilst this process does not restore innocence, it does re-establish integrity with self and others. It provides insight into the moral and existential aspects of guilt, which require recognition that having felt guilt concerning one's own trauma, one is of necessity required to make moral judgements about all trauma and one's relationship to it. The outcome would be the patient seeing the world through Job's eyes "- to forgive the world for not being perfect, to forgive God for not making a better world, to reach out to the people around us, and to go on living despite it all (Clewell 1987)."

2.6.3 PSYCHIC NUMBING: DISCONTINUITY OF THE SELF

Psychic numbing refers to the effect of the radical discontinuity that characterises PTSD. The sense of self is literally blasted out of time, and an experience of dissociation follows. The self is severed from familiar experiences of compassion, community and value.

The survivor undergoes a radical but temporary diminution in his sense of actuality in order to avoid losing this sense completely and permanently. Kardiner refers to this as "ego contraction" that interferes with virtually all areas of behaviour (Lifton;1988). In effect the survivor undergoes a reversible form of symbolic death, in order to avoid a permanent physical or psychic death. Lifton considers this to be at the heart of the condition, and it is only in the rediscovery of basic human connectedness that the survivor is able gradually to restore the process of healing and rediscover his/her frozen symbolic self.

2.6.4 PROBLEMS OF INTIMACY AND NURTURANCE

Conflict within the survivor has to do both with a special need for human relationships, and an association of weakness with that need. Any help offered is regarded as a

reminder of weakness. This stems from an experience of having been dependent on other human relationships, only to see them taken away in the most violent and grotesque manner. Human relationships are thus characterised by being fragile and unreliable. Consequently one guards against them. Another part of this resistance has to do with the feeling of being tainted by death, of carrying the "psychic stigma of being annihilated (Lifton 1988)." Having been treated so cruelly and annihilated so easily, one internalises the feeling of being small and worthless. The survivor emotion to counteract such inner death, is often to rage and storm at the world. Lifton understands anger as being a more comfortable emotion than extreme anxiety and guilt, and feels that anger may also be, for the veteran, the only psychic lifeline when surrounded by images of death. Unfortunately anger often results in the withdrawal of others from the veteran which exacerbates his feelings of loneliness and isolation.

2.6.5 BEYOND THE DEATH ENCOUNTER: CONFRONTATION, REORDERING AND RENEWAL

Lifton thinks that survivors of extreme trauma need to be liberated from their own inner deadness yet similarly fidelity must be maintained with the original experience, and all its brutal truth.

Lifton sees the three stages of confrontation, reordering, and renewal as the process through which both liberation and integration will occur.

Confrontation demands the necessity of letting go of some of the images that haunt one's memory, and allowing for a relinquishing of the intensity with which one holds on to the memory. It is a recognition of how perpetuation of the war image and the massive personal responsibility associated with it is essentially threatening to one's present existence. This is a difficult process due to the awesome literalism with which the veteran views his reality and his responsibility to it. He allows for no alterability of that state, and of necessity binds himself to it. Confrontation allows for a gradual release and for a new perspective to enter, which signals the beginning of the second phase of reordering.

Reordering is comprised of relentless guilt struggles, particularly in shifting from the numbing guilt to guilt that is more active and allows for forgiveness and atonement, and that especially allows for a more vital relationship with the actual traumatic experience. The introduction of vitality and volatility in relation to the experience allows for the third stage of renewal to take shape.

Renewal involves a continuation of the vitality into other areas of life which include overcoming one's suspicion of human relationships and recognising the need to balance one's anger towards what has happened with the celebration of having survived it. It is the process of rediscovering the courage necessary to believe, however difficult this may be, in the continuity of life.

2.6.6 SUMMARY OF LIFTON'S APPROACH

Lifton's approach can be seen as a process consisting of ten aspects. This is a multimodal approach and each phase is characterised by a variety of different engagements and understandings. The phases occur simultaneously or at times singularly, yet will all be present during the process.

1. Understanding and confronting the life/death paradigm - both personally and conceptually;

2. The concept of being a survivor - survival is an achievement and is not in itself pathological;

3. The human connectedness of survivors - understanding the struggle to reinstate a sense of belonging to a larger chain of being;

4. PTSD as a normal reaction to extreme stress - the stress reaction is a normal adaptive process to an abnormal situation;

5. Confrontation and working through the survivor guilt and experience of self-condemnation.

6. Understanding the dilemma of feeling versus not feeling;

7. Working through the psychic numbing and moving towards a return of emotional vitality;

8. Infusing the experience with a deep and ongoing search for meaning. A vital aspect in understanding the inner impact on an individual of extreme stress.

9. Understanding the moral dilemmas of the trauma - differentiating the legitimate moral behaviour of an individual within a trauma that was immoral and evil.

10. Movement towards transformation of the self - a movement from numbness and stasis towards a special form of understanding and depth, an integration of one's survival of death with one's awareness of the continuity of life.

2.7 Parson's MODEL OF POST TRAUMATIC SELF THERAPY

Parson (1984) introduces a clinical and theoretical model dealing with reparation of the self when working with Vietnam veterans, basing his concept partly on Kohut's theory of self.

2.7.1 KOHUT'S SELF THEORY AND ITS RELEVANCE TO THE WAR VETERANS

Parson understands the crux of the problem for these veterans as rooted in their sense of self. Kohut sees the ideal developmental achievement as a structure he calls the cohesive self. The development of a child from an archaic to a mature self requires both empathic mirroring to transform talents into reality, as well reliance upon an idealised parent figure to provide morals and values, which serve as the source for the child's conscience.

Consolidation of identity occurs in early teens and late adolescence, the critical developmental phase when most of the young veterans began their Vietnam tour. Parson's contention is that just as a developing infant needs the presence of a containing parental self-object to draw warmth and appreciation from, so the returning veteran relied on his country to reflect back deep inner pride over a job well done, to recognise the sacrifices made, and provide a place of healing. Americans' rejection of these requirements amounted to a large scale empathic failure, which would contribute to a subsequent distortion of the veterans' values and further fragmentation of the self (Parson;1984). Bradshaw concurs by stating that "perhaps if our society could have empathically accepted the soldiers and their Vietnam War experiences as meaningful, consensually validating them when the veterans returned, then the soldiers might have been able to transform their warrior identity into a stable peacetime identity (Bradshaw *et al*;1988)."

2.7.2 FOUR PHASES OF Parson's TREATMENT MODEL

Parson proposes a model of treatment that recognises that the veteran's clinical picture changes over time. The approach therefore recognises a flexible and therapeutically adaptable conceptual and technical approach which can first deal with the veteran's initial chaotic and disorganised state, then move into a more profound exploration of the traumatic experience, and finally progress beyond the ego defences to analyse and understand the underlying narcissistic pathology and rage.

Parson allows for four stages:

1. Stabilisation-Maintenance phase
2. Consolidation-Stabilisation phase
3. *In-Vivo* Affective Revival
4. Reintegration-Cohesion

2.7.2.1 STABILISATION MAINTENANCE PHASE

The emphasis in this phase is in helping the veteran regain control over his emotional life and restore inner calm. In this respect the use of cognitive and behaviourial procedures are most effective in bringing about relief from acute stress and thus providing reinforcement for the veteran to remain in therapy. Techniques include:

(a) Therapeutic-education procedure which basically involves educating the veteran as to the nature of his symptoms and what he can expect to happen to him.

(b) Bibliotherapy in this regard is also important directing the veteran towards the relevant literature and articles.

(c) Cognitive restructuring techniques allow for the alleviation of intense guilt feelings about the war; use of *reattribution* techniques whereby the veteran's cognitions are challenged and altered by seeing that his behaviour is due to the extraordinary circumstances and could not have been any different.

Self management and selection of appropriate goals allow for a more cohesive and realistic adjustment to society, as well as reducing the intensity of the emotions associated with the actions.

Parson discourages any premature exploration of the traumatic event, asserting that it can lead to a dangerous exacerbation of the internal chaos and could possibly exaggerate guilt and shame reactions to a psychotic level. The first phase is thus exclusively focused on ego stabilisation and relief from acute internal unrest. The administration of the cognitive techniques must be carried out in a manner that is sensitive and understanding; a mechanistic approach can simply lead to disrespect for the therapist from a patient so used to being treated like an object.

2.7.2.2 CONSOLIDATION - STABILISATION PHASE

This phase is characterised by the therapist becoming less active, and allowing the veteran to use the therapeutic space as a means of exploring his own perceptions, attitudes, ideas and reactions to his experience.

The emphasis is on the stability and calmness of the therapist to provide a facilitative environment in which the veteran returns to trust relationships and overcome the memories of "badness" the war has tainted relationships with. The therapist must him or herself be able to rely on an environment that is containing and must be sure of the potential impact the war material may have on his or her own sense of self.

Furthermore the therapist must communicate an "openness", must risk being able to be human, and show genuine concern and interest in relating to the veteran. He or she must present himself or herself as a living human being with whom it is possible to have contact (Parson 1984).

2.7.2.3 *IN VIVO* AFFECTIVE REVERSAL PHASE

This phase of the treatment is characterised by encouraging the veterans to relive the traumatic experiences with all the brutality and intensity of emotion the original trauma contained. Parson refers to this as the "controlled regressive pathway to the original traumatic experience (Parson 1984)." This phase is now possible due to the internal stability the ego has regained and the strengthening and redefining of the defences as was necessary. Parson uses hypnotic age-regression techniques to facilitate this catharsis, varying between four and six sessions. After each hypnotic session the veteran is helped to assimilate and accommodate previously dissociated parts of his self. This is a vital aspect of this stage, as without this assimilation process the relief provided by expressing previously inaccessible emotions will not endure.

The phase of affective reversal is a profoundly difficult and emotionally draining process, and the veteran relies on the strength of the therapeutic alliance to contain and facilitate

the depth of emotion. In this regard the therapist needs to be unyielding in the face of such onslaught, and be ready to deal with the full force such emotion can have on the therapist's own self, to acknowledge his or her own vulnerability without acquiescing to the threat of dissolution.

2.7.2.4 REINTEGRATION - COHESION PHASE

Parson divides this stage into three subphases.

(a) The first subphase is characterised by a similar stability seen in Consolation - Maintenance phase, where the therapist although less active, remains essentially empathic and involved in assimilation of difficult aspects and emotions experiences during the *In Vivo* stage.

(b) Subphase two however, is marked by the use of interpretations in bringing about more profound character change and striving for a more cohesive self. Parson contends that as the patient's ego resources return and his experience becomes more structured and understood, so evidence of a narcissistic "developmental arrest" becomes clearer. The aim of therapy now would be to shift the veteran from regarding the therapist as an "archaic self object" upon which he is dependent, to conceiving of the therapist as a whole person upon which transference displacements can be projected. The focus is not to analyse the transference, but rather to illuminate for the veteran how his maladaptive behaviour perpetuates his lack of self-cohesion, and how his unwillingness to place his war experience in perspective prevents him from getting on with his life. The veteran needs the therapist to guide and mirror his fumblings for a while, just as an adolescent needs his parents. The eventual aim of both relationships is to separate and grow up.

(c) Subphase three represents a shift from difficulties regarding identity diffusion to issues revolving around unresolved unconscious conflicts. The

direction is the enhancement of the self-reparative process and lasting integration of the war experience. In effect a deeper intrapsychic exploration can now begin.

2.7.3 Parson's MODEL - ADDITIONAL THOUGHTS

The value of Parson's approach is his stress that due to the nature of combat-related stress disorders, the combatant's psychological needs change from time to time in therapy, and that it is the model that needs to be flexible. A further point of importance is the realisation that each veteran is different, having had a different experience and different responses to combat situations, making each treatment procedure a unique experience, despite the shared qualities of the model.

2.8 EQUIPPING ONESELF FOR THE THERAPEUTIC TASK

In the words of Blank (1979), "the need is for a therapist who can experience, without backing off, can suffer controllably, and can enter into the veteran's experience fully." The issue deals essentially with the therapist's internal stability and as such counter-transference reactions have critical implications for the therapeutic process.

Therapists can adopt a range of stances as eloquently articulated by Morgolin:
"Some therapists view Vietnam veterans as victims, others as villains. Some believe they are both, others that they are neither. Some recoil in fear when a Vietnam veteran enters their presence, others all too eagerly welcome that stranger with open arms.
There are those who insist there is no such entity as "post traumatic stress disorder", that it is simply manifestation of pre-existing pathology dismissing the encroachment into psychic structure of life-and-death trauma. Others, viewing these veterans as a constellation of symptoms, are prepared to treat these, symptom by symptom, with an armamentarian of specialised techniques, much in the way I have seen orthopaedic surgeons examine a limb, oblivious that it is attached to small child (Parson;1988:*op cit*)."

Parson outlines three main counter transference experiences that therapists should be prepared for:

(1) Confrontation with one's own personal vulnerability to catastrophe;
(2) The challenge to one's moral attitudes about aggression and killing;
(3) The fear of the intensity of the countertransference and the transference (Parson 1988).

Wilson describes the transference as being a process of symbolic rebanding, whereby the therapist is connected to the veteran in ways that are associated with the trauma. As such the therapist can become either the veteran's buddy, a commanding officer, or somebody from a particular battle incident. This rebonding is necessary to establish the deeper levels of trust needed to work through the depth of pain and shame the war has brought.

As Egendorf notes: "Although therapists are usually well-trained to recognise when feelings such as lust, jealousy and anger arise in them, they are generally less skilful in discerning and acknowledging such sentiments as hate, distrust, repugnance, condescension and contempt (Egendorf 1979)." The therapist must prepare himself or herself for dealing with such emotions and finding means of resolving them. A cognitive awareness of the nature of the war is insufficient. Wilson furthermore warns of the danger of adopting a psychodynamic "blank screen" approach saying the veteran will perceive the therapist as fearful and unwilling to deal with the intensity of the emotions evoked by the horrors of the war (Wilson:1988).

The therapist must prove himself or herself as human. Hiding behind theoretical blankets or a rigid adherence to mechanistic techniques serves to obscure the ultimate aim of psychotherapy with PTSD, which is to reconnect with the human condition. Transference and countertransference events are vital aspects of the therapeutic process, and it is towards this vitality that we must move to ignore these transference phenomena can have the serious consequence of derailing the therapeutic process. However, if the intervention is correct, the timing is correct, the alliance will be strengthened the rapport deepened. This is typical of both positive and negative transference (Lindy 1988).

2.9 ESSENTIAL PRECONDITIONS IN DOING "POST TRAUMATIC THERAPY"

"Post traumatic therapy" (Ochberg 1989) focuses on the recent trauma, examining the coping skills and strengths of the individual, the realistic available options, and the myriad of distorting self-perceptions that have arisen as a result of the trauma and which are impairing emotional healing.

The basic premise being that exposure to prolonged stress will have an effect on everybody. That everybody has their "breaking point". This allows for equality and respect in the therapeutic relationship and acknowledgement that the healing process requires equal commitment by both therapist and patient. Wilson (1988) offers several preconditions as essential when embarking on such a relationship:

(1) Non-judgemental acceptance of the veteran - keeping an open mind and conveying a non-judgemental attitude is imperative in facilitating the veteran's story, which for so long he himself has regarded as repugnant.

(2) Willingness to be tested - the veteran will naturally regard the relationship with suspicion and mistrust. Tolerance of these attitudes combined with a frankness and directness on behalf of the therapist will aid the process.

(3) Assumption of PTSD as caused by war stress - a belief in the psychological health of the veteran and in acknowledgement of the overwhelming nature of the war circumstance is recommended. Viewing PTSD as the resulted of premorbid psychic pathology will be counter productive.

(4) PTSD is cyclical in nature - assimilation of the trauma takes time, and ego resources will determine the length of working through, often encountering old attitudes time and again.

(5) Alcohol abuse severely aggravates PTSD - the alcohol impedes the person's capacity to feel the necessary psychic pain. Several other side-effects may also occur such as sleep difficulties, states of disinhibition, nightmares, affective flooding, lowered self-esteem and poor health.

(6) Locus at responsibility for recovering rests with the veteran - the therapist's responsibility is to mobilise the pain involved with the trauma, and help the veteran assimilate it. The therapist must not try and deny the pain, remove the pain, feel responsible for the pain, or avoid the pain. Over-involvement complicates the treatment and is destructive for both therapist and veteran.

(7) Struggle with PTSD often results in positive character traits - out of the struggle to transform the impact of trauma in one's life, the individual often utilises character traits of enormous strength and integrity. However, in the aftermath of trauma, these are often neglected and ignored. The therapist should focus on the veteran's self-image and allow him to re-discover those abilities that enabled him to survive and continue his life.

(8) Recovery from PTSD is a lifelong process - extreme stress leaves a psychic legacy that, although it may dilute over time, will never be forgotten. Impendent life events in the future may re-evoke the old symptoms. The possibility of this happening should be made known to the patient, as well as advice on how to effectively dispel them and return to normality.

CHAPTER THREE

METHODOLOGY

This paper follows the case study method as outlined by Bromley (1986:p38): "the way we describe and analyse a person's behaviour and psychological characteristics in relation to a set of circumstances". It is a method of research using detailed description and analysis to arrive at a deeper understanding of the behaviour, and to further practical application in related areas of interest.

A psychological case study is a slice of an individual's history reconstructed and interpreted to gain a deeper understanding and perspective of the relevant issues influencing that particular experience. The case study method does not seek to exhaust the understanding of the situation, but restricts itself according to the needs of the study. As such the boundaries are arbitrary and are defined according to the discretion of the investigator/s involved.

Edwards (1990:p10) describes psychotherapy as "an exercise in applied science. Every case is new and unique and requires the systematic and careful observation and conceptualisation that is typical of a scientific exploration of a new phenomenon". The case study method is a naturalistic, idiographic approach, which locates itself within a general conceptual framework within which all the various cases can be described and interpreted. The scientific character of the approach is derived from the "abstract concepts which allow us to make sense of individual cases (Bromley 1986:p6)."

Case study research requires a detailed description of the individual case from which theoretical developments and general principles can be extrapolated. The development of theory is seen as an imperative prerequisite of the case study method, on which Edwards (1990:p102), quotes Mitchell. "A case study is essentially heuristic, it reflects in the events portrayed features which may be construed as a manifestation of some generally abstract theoretical principle." The investigation thus basically seeks to attach meaning to the information we have about the experience, and establish a pattern of understanding associated with the experience.

In dealing with the interpretation and the meaning of the event, one is necessarily involved in considering the hermeneutic circle in establishing the validity of the case study. Edwards (1990:p13) points to Eksteen and Bromley as exponents on the validity of the case study - "the intensive, largely retrospective study of individual cases can be as rigorous and informative as the extensive, prospective study of samples of people, whether in survey or experiments. One can generalise from individual cases, and many important real-life human problems cannot be studied effectively, or at all by experimental methods of enquiry".

Kruger in Edwards (1990:p10) adds further support for the case study as a viable means of research whilst also succinctly illustrating the limitations of quantitative research methods in a discipline such as psychotherapy: "In contrast to the highly intuitive insight of the founders of psychotherapy, psychotherapy research tends to involve persistent and excruciating attempts to objectify and quantify experiential and behavioral data in order to isolate variables which supposedly would make up psychotherapy as it is." It is thus through the case study method that one has access to the unique experience which constitutes the psychotherapeutic relationship, and as such can only be carried out by those whose skills are sufficiently developed to do such research.

Bromley (1986:p24) clearly supports this "... the inquiry deals with episodes of deep emotional significance to the person, ... and can be carried out properly only by someone trained and equipped to establish and manage a close, fairly long and possibly difficult personal relationship."

In understanding the importance and depth of the therapeutic relationship, one must necessarily become part of the hermeneutic circle: "one enters the circle of understanding at some point and them considers the parts, and then again the whole, and go round to see if the interpretation is sufficiently refined (Kruger 1989:p10)." Thus one understands the conclusions at which one arrives are not structured in a linear fashion, one on top of the other, but are characterised by an infusion of meaning and depth which makes sense of the research.

Edwards (1990) defines four types of case studies which form a continuum of case research ranging from largely descriptive accounts to those designed to challenge and test developed theories.

They are:

1. The exploratory-descriptive case study;
2. The descriptive-dialogic case study;
3. The theoretical-heuristic case study;
4. A crucial or test case study.

The basic method of this research incorporates both the exploratory-descriptive as well as the descriptive-dialogic case study methods. It provides an accurate and richly detailed description of the individual case, which opens up the experience, making it accessible and understandable to the reader. Fischer and Wertz in Edwards (1990:p18) describe good case synopsis as those which: "provide readers with concrete examples that reverberate with their own lives, thus intimating the full structure of the phenomena." In my attempts to reproduce the case in its full descriptive immediacy, I have made extensive use of literary devices which both enhance the telling of the story and retain the flavour of the exchanges as they occurred in the room. This necessary includes the use of metaphor and symbols. In addition I have felt it necessary to switch during the narration of the therapy from the past tense and reported speech to direct dialogue and the use of the present tense. I hope this will convey the therapeutic situation with heightened immediacy and also indicate the crucial changes in affect and emotion experienced from moment to moment in the process.

Simultaneously it attempts to embody general principles already articulated in the literature, and dialogue them with the descriptive account, to provide first-hand insight and understanding into a complicated phenomena. The process is an attempt to make sense of the description through the dynamic and experiential use of the theory.

Procedure

The procedure adopted in this study was to provide a synoptic account of what occurred throughout the process of this therapy. Neil and I had 50 minute sessions, twice a week over a period of seven months amounting to approximately 24 sessions, of which only a few were audio-taped.

The sessions would be presented to my supervisor each week, which allowed for inter-subjective interpretation of the case material, and incorporation of suggestions and guidance in continuing the therapy.

Much of the content of Neil's experience may be left unsaid, as the reproduction of the therapy has been to a large extent reliant upon the notes I made following each session. This may extend to a criticism of the validity of the study as there was no clear systematic observational procedure. However I feel I have accurately captured the flow and the ambience of Neil's experience, and have carefully portrayed it in terms of the undertaking of this study, which was to show how Neil shifted from his position of internal confusion, self-condemnation and rage at the world to a deeper understanding of his experience, a re-embracing of that savaged side of him, and a realignment with the world of others.

A further consideration is that I was both therapist as well as investigator in this study; I played an integral part of the process and as such, much of my interpretation and understanding of the material has been influenced by this role. I have attempted to provide as accurate a perspective as possible on Neil's experience, in this respect my ongoing supervision allowed for necessary distance and reflection in understanding the process, however ultimately there can be no doubt that this account includes a large portion of my own experience of what transpired.

CHAPTER FOUR

THERAPEUTIC PROCESS

NAME: NEIL **(This is his real name. When permission was obtained to document the treatment, the use of a pseudonym was discussed. However Neil indicated that he would not object to his real name being used)**

AGE: 21

SEX: MALE

OCCUPATION: STUDENT

REFERRAL SOURCE: RHODES PSYCHOLOGY CLINIC
SELF-REFERRED

4.1 PRESENTING PROBLEM

Neil arrived at the clinic suffering from a wide range of acute and highly distressing symptoms; these included nightmares, inexplicable outbursts of temper, continuing anxiety and tension and a pervasive depression, all arising from his experiences in the SADF. He had been a medical orderly during the period August 1987 to June 1989, and said that although he had coped at the time, he was now very "freaked out" and was haunted by the anguish and pain of human suffering.

At the time of the interview he was drinking up to 18 beers a night, his girlfriend had recently left him and he felt ravaged by a sense of despair that all of life was meaningless and that everything that he attempted was doomed to fail.

He described his world as being fragile and his friends as "strange"; often when with them he would have images of their heads being blown apart and their bodies mutilated.

At night he would suffer two recurring nightmares, one in which he would walk into a room where a body lay on a table. Suddenly the head would start vomiting blood, the room would fill with blood and he found himself drowning in it. In the second dream he

would be lying in a body bag with his friends around him looking down. He would look down to discover his own body mashed like red mince. In each instance he would wake terrified, gasping for breath, unable to control his heartbeat and unable to go back to sleep again.

His days comprised of a sensation "like walking on eggs" where something bad was going to happen at any time. Any loud noises evoked an instant terror in him followed by an intense rage then depression and a sense of hopelessness. He no longer knew who he was, being unable to identify with his condition, and found himself adrift and alone in the world.

4.2 FAMILY HISTORY

His parents were divorced and when at home he stayed with his mother.

Mother: Aged 54 - Company Buyer. Initially Neil described her as very gentle and caring, a person with whom he got on very well and to whom he was very close. However, in recent months he had been growing increasingly angry and frustrated with her, and now found it extremely difficult to speak to her or spend time with her. He was unable to communicate his experiences in the army to her and what enraged him is that she apparently continued to idolise that time. In Neil's eyes, their relationship continued to deteriorate.

Father Aged 60 - Accountant. Neil had a poor relationship with his father, saying that as far as he was concerned he hardly knew him.

Neil said that his father was away from home a lot during his early years and only seemed to get to know him when he was about 11. He experienced his father as being quite selfish and manipulative but hoped that their relationship would improve.

Bother Aged 30. Neil described him as being like a father-figure. He was very kind and supportive of Neil and they got on well.

Neil also had two sisters, aged 32 and 33, with whom it appeared he had a vague and superficial relationship.

4.3 PERSONAL HISTORY

Neil was the youngest in the family by nine years, although a child had been still-born some two years before his birth. He was safely delivered by Caesarian birth and was breastfed in his early years. He remembered his childhood as being uncomplicated, although he described himself as being a very quiet and withdrawn child. The home atmosphere he felt was uncomfortable as, although his father was away a lot, when he did come home, his parents fought.

He reported nothing in particular about his early schooling, but found himself surprised to be suddenly developing a relationship with his father shortly before going into high school. His parents' relationship remained unpleasant; money issues seemed to be the focus of the majority of the tensions and outbursts.

He involved himself in a variety of sports and had a small but close group of friends, some of which he had known since Grade I. At the age of 17 his parents were divorced and he experienced this with some relief as it meant an end to the stultifying atmosphere at home. Round about this time he started dating and entered a relationship with a girl his age which lasted up until a few months after he had been conscripted. Their relationship had not been a sexual one, but he described her as being very kind and loving, and so he was extremely angry and hurt when shortly after his basic training he received a 'phone call saying that she was having a sexual relationship with someone else. He described smashing his fist into a wall after having spoken to her on the 'phone. Shortly thereafter he volunteered for training as an Operational Medic. He had since had a brief relationship with another woman which ended at the time of his arrival at the Clinic. Neither relationship was sexual and he was still a virgin at the time of referral.

During the active phase of his training as an Operational Medic he spent a short time in a Natal township where on one occasion he witnessed a necklacing, arriving at the scene seconds after the victim had been set alight with a blow-torch. This remains one of the most vividly shocking memories of the time spent in the army, forming part of the collage of horror that he now carries with him after his experiences in Mozambique, where he was then posted for the duration of his national service. There he became part of a grotesque world of maiming, decapitation, gross disfigurement and incessant screaming and pain - a mindless environment of continuous human suffering shackled helpless beneath a brutal force of military authoritarianism.

Throughout these 18 months he received four weekend passes, over and above the official army leave; the rest of the time was spent either dealing with the dread of waiting for the next incoming horror, or actively involved in the chaos of the wounded and the dying. Those that died were unceremoniously dispatched in body bags, the only trace of their existence being the last ghastly moments imprinted in the memories of those that treated them. Racked with guilt, Neil recalled the numerous times he promised them life, only to pry their dead fingers from his wrist and turn away. Those that survived were evacuated and never seen again.

Not once, he said, throughout the entire period, did anyone take the time to ask how he was, to show some appreciation, some care. Towards the end of his national service he remembers being overwhelmed by despair, and upon consulting a counselling psychologist who was stationed there, was told he was suffering from fatigue and should rest.

The list is endless, the suffering virtually incomprehensible. For Neil, a year later, nothing seemed to have changed. It took less than four hours to get out of the bush and back on the streets again, and although he was now more than half way through the first year of his degree, he still remained in that environment.

4.4 PERSONALITY

Neil appeared to be an amiable and relatively easy-going person who was able to adapt and fit in well with most group situations. It seems as though he was regarded as something of a leader in his present group of friends, and they often looked to him for support and advice. This gave rise to some conflict within him as he felt compelled to help them yet was loath to assume any responsibility for anyone any more.
Nonetheless, despite his experience of becoming increasingly withdrawn from others around him, he regularly participated in social activities and was fond of sport and group outings.

Although he felt that he was kind and giving in his friendships, he found that he could also be cynical and was prone to being overly critical of others. He said that he derived some malicious pleasure from some of these exchanges and was frightened by this and felt guilty about it, stating that it "was not like him."

My sense was that he has a remarkable capacity for coping and always appearing as though he was in control, and was finding it more and more difficult to have to protect others from what he felt had gone unnoticed within himself.

4.5 MENTAL STATE

There was nothing about Neil that would strike one as being unusual. He was reasonably well built with a pleasant face and deeply hooded eyes; his dress was typical of many students, being somewhat conservative in fashion.

However, he was seldom relaxed in the room; his body was constantly filled with tension and agitation and he rarely made eye contact, keeping his head averted for a great deal of the session. On the occasions that he was able to turn and look at me, it appeared to require some effort and the gaze was never sustained.

He spoke rapidly in staccato bursts, as though it was important to get the words out of his mouth before looking too closely at what he was saying. Thus although he spoke at length, it required enormous effort and energy. His tone of voice was difficult to define, being neither apologetic nor defiant, often lapsing into something like an impassive monologue yet generally reflecting both the anguish and the desperation of his situation. The pervasive feeling throughout was one of desperation and despair. His moods remained a source of confusion and anxiety, often dwelling on the nature of death, and being generally perplexed by society and the world he found himself in.

Neil often shifted rapidly from a baseline expression of depression to an outburst of anger, followed at times by an experience of sadness, at others a sense of hopelessness. Although he spoke about suicide, and appeared quite serious at times, he also continued to struggle and be propelled by a search for some meaning and some value in his life: "I haven't the gut to kill myself" was turned into: "I have the guts to live".

There were no discrepancies in the organisation of his thoughts, and although he appeared to be in full possession of his thoughts his mind was sometimes crowded with images of carnage and destruction - particularly at the time when he was drinking heavily, although it occasionally happened when just sitting with a group of friends. The images did not last for long and also had not occurred in the few months since the therapy began.

For all intents and purposes, it could be said that his content of thought revealed signs of disturbance; however, given the social context from which these experiences arise, we can recognise them as being disturbing without there being a disturbance. Neil suffered a pervasive dread that at any moment something awful was going to happen; the sight of people running filled him with anxiety, as in his experience people only ran from danger or from death. Thus his every situation was infused with a sense of catastrophe.

In the most acute form, Neil experienced himself as being contaminated with death - his entire body was covered with blood, and he felt that he would never be clean again. In these moments he would hear the screams of those he had seen die and literally have to block his ears.

Occasionally he reported still hearing footsteps as though someone was running behind him; upon turning he would discover nobody there. He had also wakened terrified one night with the deafening noise of a siren in his ears, unable to establish whether it was real or not. However, these experiences had also not repeated themselves for some time. His general level of awareness was good and he was fully orientated within his environment, although confused by his place in it.

There were no problems with his memory and despite the intensity of his struggle, he was still able to perform well academically.

Although he was able to link his experiences with the SADF, he still was reluctant to acknowledge that what he was suffering from is a normal reaction to such stress. For him it reflected an inherent weakness, a sense of having "cracked", and as such he still battled to acknowledge his need for help without feeling that he was inferior or abnormal in any way. This proved to be a complex dilemma; Neil was unable to tell anyone of his pain yet simultaneously wanted them to know what he was feeling. Thus he felt justified in wanting to hurt anyone who he perceived as threatening or irritating him, yet was then consumed with guilt as they would then recognise how bad he actually was. He regards himself as being contaminated by a past that had to be kept a secret lest it reveal his own inherent rottenness and badness.

4.6 DIAGNOSIS

Axis I - Post Traumatic Stress Disorder
Axis II - Deferred
Axis III - None
Axis IV - Severe - multiple combat-related stressors
Axis V - Fair to good - coping academically yet socially withdrawn.

4.7 THERAPEUTIC PROCESS

Therapy with Neil was an intensely stressful and painfully draining process. The first few sessions were spent allowing Neil to explore the possibility of being able to tell his story, the full force and impact of what was to come being only hinted at by the occasional outbursts of anger and bitterness which peppered these exchanges. What then followed was a seemingly endless account of mutilated pain and suffering, whereby Neil would fill the room with blood, reeling off one nightmare after the next, speaking in a semi-detached, impassive tone, as if commentating on a ticker-tape from Hell.

Gradually the rupture in his world of what is, and what has been began to be accessed and with that came the full immediacy of all the deaths that still writhed within him. At one point he began to hear all the screams he had ever heard all at once, and sought to hide from the noise, eventually finding some refuge in his own anguished cry for help and care. The emotion within him was still hot and raw, and he vacillated between the extremes of wanting to rage at the world, attack it and all its inhabitants, strip from them their glossy facade and smash their complacency, and falling to his knees and crying out, desperately craving and seeking care and protection from that very same world.

Neil found himself completely alienated from those around him, myself being the only person he felt who understood his world, yet constantly wanted to distance himself from that understanding and its implications. Therapy is a reminder of a world that he wished to disown - a world of guilt and despair and shame. In some way he had failed miserably, as a man and as a human being, and his suffering was a confirmation of that failure. He attempted to tell another woman of his experiences and although he admited that she was very understanding and comforting, he felt that she has distanced herself from him, and that was both a betrayal on her behalf and a further indictment of him, accentuating his incompatibility with those around him.

The therapeutic process gradually shifted towards allowing Neil to acknowledge the impact his experiences had on him, moving away from the self-criticism and guilt he felt towards himself. A profound moment occurred when it became clear that the therapeutic

relationship had been conceived by Neil as being an officer/troop engagement and we were able to unravel the various thoughts and feelings around that experience. Neil was subsequently able to conceive of therapy as being a place of growth and utilise it accordingly. The final moments were intensely poignant and meaningful. Neil rediscovered an aspect of himself which he felt he had lost forever and welcomed it back.

4.8 PSYCHODYNAMIC FORMULATION

To gain some meaningful insight into the nature of Neil's extreme condition requires both a personal and conceptual confrontation with death. The challange is to describe in some way a paradigm where life and death retain and regain a mutual significance which is able to encompass suffering whilst simultaneously embracing celebration. For Neil the shift was from that of a survivor, locked in the numbing paralysis of suffering, to acknowledging his survival as a source of insight and growth. Neil's guilt and self-condemnation came in the wake of a sense of failure, a failure to prevent suffering or to halt the path of some evil or trauma. It is as though he was still trapped by the frail grip on his own ordinary human standards, whilst not comprehending the radical disassociation that had occurred between him and his human connectedness with others. He remained helpless, and as such forever traumatised and also forever a recipient of guilt and condemnation.

His search for meaning in his own experiences led him to a significant encounter with the goodness or badness of mankind, and to the degree to which human beings are related to one another. All initial attempts to re-establish such a bond and forge a new continuity of self-evoked a tremendous moral dilemma within Neil, as he could not seem to escape his own responsibility for the death of others. Whether this was realistic or not seemed immaterial when confronted with his bitter acknowledgement that he too would have used a weapon to protect himself. This contrasted harshly with his knowledge of the ghastly destruction that such weapons wrought. The dilemma, in stark irony, highlighted that path that needed to be forged in regaining and integrating Neil's world.

Neil regarded his efforts to save others as having been futile and useless, yet in such an acknowledgement there was evoked within him a cry for life, a cry to avoid staying numbed by the death throes of others, and a move to more insight and perhaps even a special sort of illumination.

4.10 THERAPY

4.10.1 THE BEGINNING: CHAOS AND A MOMENT OF MEETING

The first session occurs just before the April vacation. The opening moments are filled with preliminaries where we contract for twice a week sessions, extending until the end of the year.

He is edgy and agitated, impatient to begin. Asked how he is feeling, he begins speaking immediately, his words coated with despair, his language evocative.

His daily life is one of fear and anger, as though he is "walking on eggs" all the time, a constant feeling of doom that something bad is going to happen at any moment, a sword of Damocles over his head. He describes an incident when standing in his room alone, a friend surprised him and he reacted with anger and rage, hand drawn back, almost hitting his friend. Neil recounts this incident with disgust and self-loathing, saying that his friend looked at him as though he were some kind of animal, and now hardly speaks to him.

He feels like a coiled spring, that something ... something bad is going to happen, and its going to transport him back; back to this pit of despair, which he has only just crawled out of, that he is on the edge, and whatever is going to happen will push him right back in again. He describes this place as "Death. People going to die. Death and hopelessness." His head is bowed, he barely moves, his hand resting on his chest.

Neil: Y'know, it's strange. But I can almost pinpoint a place in my body that has died. A blackness. Eighteen months of actually dying.

Short pause.

Therapist: Something has happened to you. That's what you are saying.

Until this point, Neil's voice has been dark and heavy, his presence weighted. Suddenly he becomes very angry, smashing his fist down onto the side of the chair. The force and the fury of the sound catches me by surprise, and I am suddenly aware of how much more is going on inside of him.

He is furious with the army for putting him through this. With the government behind the army, his parents for not knowing what he has been through, his friends who may think him crazy, with all those who did not go to the army, with those who died in the army - and finally he is angry with himself for having to suffer so.

He was a medic on the Mozambique border. He feels all he did was promise people life and then they died. He would hold their hands and they would beg him to help them and he would tell them they were going to be OK, and they died. He experienced their deaths as something they inflicted on him, mocking him, saying - "I'm gone. And now YOU'RE stuck with this." And nobody understands. He gets back home, and everybody thinks its something great that he has done. Nobody knows what it feels like to hold a body in your arms, shuddering as the person haemorrhages, skin peeling off, babbling stupidly. He winces recalling an incident on campus where an End Conscription Campaign member accused him of upholding the regime, of being a baby killer. He wanted to kill the guy, but that would just mean more death.

Neil feels isolated and alone in his environment, and feels unable to tell anyone of his experiences, and this fuels his frustration and anger.

Neil: They are all so happy and contented. What do they know? I've seen what nobody wants to see and come back. But I haven't left it. It's come back with me.

Up until this point, I have said very little. I feel that everything he says is loaded with so much emotion that needs to come out. At the moment he is simply speaking, his mind alights on a topic and he spits it out.

There has not been much personal interaction and although I feel he needs to explore the space, I also feel he needs to be grounded to be heard. Really heard. That if therapy is to be of value, it will be a commitment we both must share. The moment comes toward the end of the session.

Neil: People don't want to hear because it shatters their little dream. People avoid me. I'm this psychic trip wire. I want to tell them. I want to tell someone. Is it worth it?

Therapist: You can tell me.

Neil: I guess I'm going to have to. Is it going to change anything?

Therapist: Yes.

Neil: The scab is off but the disease remains. Everything dies. Nothing is important. What does it matter? Life goes on. Nobody cares. And if they do care, for how long do they care.

Therapist: But you care.

Neil: Maybe I was the exception.

Therapist: It seems you think there was something wrong with that.

The above exchange lasts for no longer than a few seconds however, despite its brevity it contains real power, because for a few moments amidst the chaos and the anger, the pain and despair, we do relate.

The session concludes with me saying quite simply that he has been through a helluva rough time and that everything that he is feeling must be very hard for him to deal with.

His face softens, tears form in his eyes. He nods, sighing 'Yeah'.

I am aware of the rawness and confusion of his emotions. I have a vague sense of the journey ahead. He leaves to go on vacation. I tell him he must rest.

4.10.2 ALONE AND IN PAIN

Neil returns from the vac, a black and brooding presence. He feels isolated and alone, cut off from humanity by despair and hopelessness.

Neil: A black pit full of despair
A mass of pain
A skull stripped of emotion filled with pain.

He feels estranged and alienated from his mother, whose utter non-comprehension of his experience is portrayed by her having washed all his army equipment and neatly hung it up in a separate cupboard "Like a shrine!" Neil says, having smashed his fist through the cupboard door from pure frustration and rage. He recounts a nightmare he had, of his mother lying on her back with her throat cut and the blood just gushing out; and all the time she is speaking, saying things. But he can't hear her, all he can do is stare at the blood, and she doesn't seem to notice.

He is speaking with bitterness and resentment of his aloneness in the world, yet what he is saying contains significant anguish, and it is on this that I pick up.

Therapist: You're hurting, aren't you.

Neil: (Clutches his face in his hands) You have no idea!

The emotion breaks through so strongly and I have such a sense of the need for it to come out that I am impulsive in my reaction.

"Tell me" I urge, and know immediately that I should have been quiet.

He remains still for a while, then carries on speaking, his voice blunt again, the feeling gone.

However, the display of emotion casts a different sense of expectation over the room. He returns to speaking about the dread that lives inside of him, of something really bad going to happen, and I have a strong sense of the anger and fearful pain to come. I need to let him know that I know that there is a lot to come. But that we have time. That I can wait.

Therapist: The feeling that something bad is going to happen is very real, because for you, it has already happened.

Neil nods, and then says that talking is like being dissected, and today another bit has been cut out of him.

4.10.3 DEATHS BEHIND THE NIGHTMARES

Neil has a strong sense that there is something desperately wrong with him, and my supervisor suggests that I show the diagnosis of Post Traumatic Stress Disorder to him, and explain to him that under abnormal circumstances, abnormal reactions are normal. However, thus far I have little knowledge of his external experience; despite my conception of them being shocking, their sheer horror eclipses imaginations.

The session begins with him speaking with detached callousness about how he has come to accept that he no longer belongs in this society. The army has claimed him, he has been spawned by the violence.

Neil: I don't know where I belong. I can't relate to things here. It's like I was spawned by the violence.
I really can't go back there. But that is almost where I belong.

He recounts a violent nightmare in which two guys dressed completely in black are holding a girl who is bleeding profusely. They are holding her against a door, when two shots ring out through the door, blowing her almost in half. But she is not dead yet, groaning, dying, and they take out this huge knife and start carving her face up. Huge pieces. Bits of face.

His own face contorts into a grimace spitting the last words out. Not being able to sleep again that night. At this point he turns to me and asks what is really going on with him. Is he really losing his head? No simple explanation will be sufficient to account for his feelings. Nonetheless, I explain the diagnosis to him, outlining the symptoms, explaining their cause and manifestations. He listens for a while. Then he kind of laughs and tells me that I make it sound so clinical.

I want him to read the diagnosis for himself, to go through it with him, but he's already talking.

He says, quite sadly, that it really feels as though he has lost his head. He says that today, while on his way to therapy he suddenly saw a woman running. And she was running with such a sense of urgency that he found himself running with her, and had to force himself to stop.

Neil: Suddenly I was back there. I mean, that is just what it was like. Back there you ran for two things; bleeding and fire. Otherwise you didn't run. If you ran, you knew somebody was dying.

At this point, it's as though Neil detaches himself from my presence. The atmosphere in the room seems to change, becoming dark with anxiety and heavy foreboding. His voice remains clear as he begins to recount horror after horror, never needing to pause ....

Neil: We went out to the scene of this accident. Three of our guys in a car had collided with a horse. I don't know what speed they were going. Must have been 150km plus, because there was nothing left. Two guys in the front, one was decapitated, the other stuck on the steering column. The third guy was OK, breathing, internal haemorrhaging. But there was just intestines. I don't what they were. Horse intestines, Human intestines, all over the place. Chunks of meat - and this head. This grotesque head. Just lying there. Almost comical. Y'know these rhymes about somebody losing their head. Well there it is. I almost kicked it. Like a soccer ball. Wondered whether he would feel anything. Of course not. He's dead .... dead bodies, guys taking panties off to have a look .... dead bodies in body bags looking at you through the plastic - you know they're dead, but you almost want to check to make sure you're not suffocating them .... Guy's head crushed by a troop carrier, I had just unstuck his head from the wheel, it was wafer-thin - in his wallet was a photograph of his wife. She would get a letter saying 'We regret to inform you, but ....', she wouldn't get told that his head was flat like a wafer filled with mashed potato and his brains like milkshake... . Babies on barbed wire, little stomachs ripped open, little arms and legs chopped off. Huge six foot men crying bitterly because they have a baby in their arms with no stomach and there is nothing they can do..... . CPR, first smack over the heart the ribs crack like wish bones.... . A guy haemorrhaging so badly, vomiting all over the ambulance, all over me, covering me with blood, head to foot, my whole uniform was full of blood, I could feel it in my boots like when your socks get wet. Black blood - and then we get him in the hospital and he dies

and I want to scream "You stupid fucker. Wake up. Why pick on me to do this to and then die!".... . Bullet wounds, guys with stomachs as hard as drums, gone beyond pain, staring at you, not caring.... . Tension. Tension. Tension all the time - phone rings - both a relief and a curse. The cry 'CASSEVAC' - and it is something to do, more dying, or waiting for the dying - one always seems better than the other.... . The screams - one night this guy prangs his car, breaks his back in three places, he was in such pain he had to crawl. We couldn't find him, all we could hear was the screams. Screams in the dark go right through you, through your own spine, eventually you're screaming too and his pain becomes yours, and eventually you find him and he doesn't say anything. He just screams.... . Little boy broken femur, bone like powder. He screamed as well. Can't explain to him, can't sooth him, can't take away the pain, his pain becomes yours. You want to say 'Shuddup!!'. Kick them. But you can't..... . Snake bites - you know what will happen -can't stop the stages:- Sweating, like fevered rain, then the fits and spasms, his bowels release, Ugh - the stench! And suddenly - cardiac arrest! CPR until you can't move, you force the mouth open to get the tube in. You break teeth when you do that. They can hear everything but can't do anything.... . You mess up - someone dies. You can't feel anything because someone dies.... . Everybody's the same. I would feel no animosity towards the terrorists. I would try and save them just the same. Then would see what they have done to others, and would just want to rip out their tubes keeping them alive. I remember this one 'Ter' whose face had been blown apart, lying there with all these IC drains attached to him, and this other medic walking into the room, going straight up to the guy and smashing him in the chest. The blood just drained from his body, spilled all over the floor. Killed him instantly I .... almost felt good about it. I tried to save him, now I was willing to thank the guy that killed him.... . Our troops were no better.

> These refugee camps on the Mozambique border. They would simply throw them into these cages. 80 people in cages the size of this room. Urinate and defecate where they stood. Would stare at you, either blankly or with hatred - I would want to explain 'I'm not the one'; but I am the one. But what could be done? ....

Up until this point I have said nothing. Simply listened. The room is like a slaughterhouse. Atmosphere thick with carnage and blood. The tension of the pain is unbelievable, Neil seems fragile as an eggshell. I know that time is almost up, that the tape has been running and is going to switch off at any moment; it is a big tape recorder and the sound when it switches itself off can be very jarring. I say to him, very gently, that I don't want to interrupt, but the tape is going to switch off at any moment and I don't want him to get a fright. He pauses, as if to think deeply about what I just said, then gives a weak laugh, nods, saying 'OK'. Again there is a pause, and then as if unbroken, he continues. However this time his voice is more muted, despairing.

He recounts being in the army only four days when someone slit their wrists. Realising then, that being in the army was no longer a game. Another incident of a paratrooper landing in a tree, splitting his face completely open, like a pear, blood like a geyser, and the insanity of trying to stitch someone's face together.

He stops now - and his shoulders heave, he's breathing deeply, shaking his head. Sighing.

Therapist: You can't cry for all of them. Can you cry for yourself.

Neil: All of them are me. I shared all their pain. If I cry for one, I cry for them all. I can't do that.

Therapist: Can you cry for yourself.

Neil: Pain is the common bond. Too much pain. Can't acknowledge that. Can't cry. Maybe I thought too much. I don't know, it never seems to end.

Therapist: It's you who you must cry for. They went through it once. You keep on going through it.

The session ends with Neil feeling as though he must leave. He needs to walk, and walking helps. I let him sit quietly for a while, then he goes.

This session stuck with me for days afterwards; I wasn't able to share it with anyone, not knowing how to share it. It seemed too much, and to even mention it in passing left me feeling that it was not something that I could control. I had no perspective and it threatened to overwhelm me. We have group supervision once a week, and it was for this session that I was saving myself. The session proved controversial. Knowing the content, and simply needing to speak, I unloaded. My class were totally unprepared for the cruelty and horror of the content. Some were unable to speak, while another, not believing my ability to contain it, asked me how I was with the session. During the actual session, and now during supervision, having unloaded, I felt OK, and able to deal with Neil's experience. I replied as such, and she said that she didn't believe me. The situation got hostile, I felt unsupported, she felt responsible for the rest of the groups feelings. The situation was salvaged by my supervisor, who said that what I needed to do was share it, share the experience. The groups reaction illustrating just how difficult it is to hear and understand something so violent. It took some time before I felt comfortable with the group in sharing not only the content of the therapy, but my experience thereof.

4.10.4 DIFFICULTY FEELING

The next session was characteristic of both the disparity between Neil's university experience and his army one, and the way that incidents happening in the present linked him instantly to the past. Someone had thrown a firecracker into Neil's room. Neil's reaction had been murderous, recognition of the person had just prevented him from seriously injuring him. What bothered Neil about this incident was that he could quite easily have attacked this guy, and would not have felt guilty about hurting him. It is this aspect of not feeling guilty that he <u>was</u> feeling guilty about. I tried to pick up on what he was actually feeling. Neil was unequivocal.

To start to feel would mean to start to cry. To cry would mean to stop functioning, and to be incapacitated means that somebody would die.
To point out to him that this was no longer true was very difficult, because he could not seem to acknowledge that he was no longer in the army, when for all intents and purposes his experiences indicated that he had never left it. I discuss how difficult it was to react normally in any situation after what he had been through, and that he could not expect to remain unchanged by his experience. I brought out the diagnosis and we discussed it briefly. He didn't seem that interested and left in a hurry.

4.10.5 MISSED SESSIONS, A NECKLACING AND THE IMPORTANCE OF NOT BEING THE RES MEDIC

Neil did not come for the next two sessions. He did not excuse himself and I had no idea how he was. I found myself becoming very anxious and concerned, and reflected on the previous session to determine whether anything that was said or done could have account for his absence. I concluded that showing him the diagnosis had been a mistake as he probably felt that his experience had not been heard and instead felt reduced to a series of clinical elements. Also, the diagnosis in his mind probably confirmed his suspicion that there was something "wrong" with him. I felt confused and uncertain as to what to do. After the second missed session I wrote him a note explaining that I had been wondering how he was, and that I would be available at the time of our next appointment.

Neil arrived for the next session. He was feeling bitter and morose. He apologised somewhat curtly for missing the previous two sessions, offering tests as his excuse, and went quickly on to talk about how uncaring the world around him seemed. He was angry and bitter with his friends, who had come to regard him as the Res Medic, always seeking some attention for whatever aches and pains they had; he was also feeling very mistreated by society. He wanted to open an Edgars account, and the assistant wouldn't let him until he had obtained his parents' approval. In disgust he left the shop.
To him, the inexplicable insanity of a world where he could be coerced into a situation filled with the screams and blood of the dead and dying, yet could not buy clothes for himself because he was not old enough, was insupportable.

Neil's anger quickly became confusion and pain; he felt as though he could not escape his experience, and everything seemed to remind him of the army. An incident in the Kaif illustrated his volatility; the Sunday Star had carried pictures of a necklacing, and Neil had found himself explosive with rage, had kicked a few chairs around, had wanted to tear the place down. It transpired that prior to being sent to the border, he had spent some time in the townships and had actually witnessed a crowd of people setting someone alight. The army patrol had been a couple of hundred metres away when they noticed the chanting group. They all knew what was happening yet could do nothing to prevent it. Neil described running, every ounce of strength going into the effort, and the desperate futility of it all, seeing a figure disappear in a whirlwind of flame, thin screams reaching his ears infinite metres away.

This session was quite important as I was able to point out how much it hurt him to see such violence, which allowed him to take seriously how much he was hurting. We also addressed the issue of being the Res medic. Whilst on the one hand it afforded him a role, and allowed him to be liked and respected, it also filled him with deep resentment. By asking students to stop coming to him for help, would imply acting on behalf of himself rather than them. As he was now able to make a choice, he should choose something that best suited himself. I also pointed out that it was not as though he would never help anybody again; his skills would not disappear. At this stage however he needed his energies for himself.

4.10.6 CONFUSION AND SANITY

There followed a further shift in the direction of Neil's emotional pain. Whilst still feeling dislocated from those around him, and frightened to allow himself to feel what was happening inside of him, because of how others might react, he was also beginning to understand why he was hurting so. It was as though he was able to grasp just how distorted this normal world of ours would become when placed under extraordinary circumstances. He related a horrific story of somebody being trapped in a bakkie after a bulldozer working above the bakkie had veered out of control and landed on top of the vehicle. Somehow the engine block of the bulldozer had cracked, and hot oil had leaked

out, splattering on the person trapped, unable to move inside the bakkie. It took rescuers over five hours to cut the person out, by which time he had been virtually boiled alive. Neil described the insanity of it all. One moment the person was alive, healthy, could smile and sing - the next moment his body was racked with torturous convulsions and all he can do was scream. The realisation was that this could happen to anybody. Myself, himself, anybody.

Neil experienced this kind of realisation as very confusing, yet somehow was also able to see that his confusion also reflected his sanity.
The confusion was also all his pain, that his pain was made up not only by what he felt for himself, but also at having seen and been with so many others in extreme pain. His tears were actually, also their tears.

Neil says that he has come so close to crying but each time has to block himself. Pull away.

Neil: I'm frightened that if I start crying I will never stop.

Therapist: Do you feel you have to?

Neil: If I don't stop crying I won't be able to function. Can't have that.

Therapist: I don't believe that you will stop functioning. Nobody has ever died from crying.

He half-laughs at this point. Shaking his head saying he can't believe how much pain is inside of him.

The session was characterised by a definite shift, from a rage at his isolation to a knowledge of it. A recognition of his experience and a recognition that such experiences were crazy even though they were of this world. Nobody else seemed to know what it was like, and being misunderstood, and not acknowledged especially by those closest to

him exacerbated the feelings of isolation; however this did not mean the experience was not real.

4.10.7 THE SIREN AND IRRITATING FRIEND. PAST COMING BACK

In this session there occurred a further resurgence of the horrors from the past, which Neil recounted as manifesting themselves in the sounds, actions, smells and scenes of the present environment in which he found himself. The smell of paint evoked images of a burnt-out car wreck in which two people died; dust-bin bags are body bags. He awoke one night to the sound of an ambulance siren, so loud, exploding in his head, and he was up and virtually running, hunting for his uniform. And then there was nothing. Just silence. Recounting this incident he was anxious, because his biggest fear was that nobody else seemed to have heard it. I didn't know if what he heard was a real sound or an imaginary one, but one thing I was sure of is that he heard it. Ambulance siren - the sound of emergency. Neil needs help.

Among his group of friends, there was one particular individual who irritated him immensely yet he was unable to either express his irritation nor understand the reason for it. Probing revealed that he related to this person as somebody who didn't pull his weight, someone who was content to allow others do the work while he just cruised, offering arbitrary criticism yet contributing nothing. Neil's anger towards this person was exaggerated, and what emerged was that there was a person from his army experience who had behaved in a similar, self-centred, indifferent way; and in one particular incident in which Neil was involved, an injured person whom they had been treating died. This guy had been sent to get some medicine, he walked, didn't run, brought the wrong medication and the person had died. Neil had wanted to kill this guy, to explode, shout and scream - and yet he had not. He sort of shouted at this guy, who just laughed at him.

That anger remained; however I felt it very important to draw the distinction between the past and the present situation. That the person in res was definitely not responsible for the other person's death, and although his behaviour might have been irritating, it would not result in anybody dying.

Neil's anger was enormous at that stage, and I felt there was a big need to access it, express it. In summary, there was again a shift towards Neil acknowledging he needed help; there was an increase in the intensity of his confusion; and there was an accute need to express his anger.

4.10.8 DREAMPAIN: SHARING THE MOMENT.

The next session was important.

Neil enters, I immediately have a sense that he has something important to tell me. He sits down and begins speaking immediately. He'd had a dream the previous evening:

He and a friend from Res are walking along this country road, when suddenly they came across a whole lot of people trying to leap over these huge iron pylons, like a gigantic high jump structure. As they get closer, one of the group launches themselves at the object and smashes into the metal with such force that he seems to explode, landing a bloody pulp at Neil's feet. Neil tries to grab him, but the body is covered with blood and slips away. Each time Neil tries to get a grip on the body, his hands slide away. He keeps on trying.

Suddenly the scene changes. Neil is on a parade ground, everybody is preparing for a march, standing in regimental order. Neil himself, is trying to hoist the flag, each time, just as he gets the flag up, it falls down again. At this point he hears a sound, a cry, more anguished, more full of pain then anything he has ever heard before. As Neil describes it. 'Worse, much worse than anything that could be physical'. The sound is coming from inside a room. It is a person crying. Somebody he recognises as a doctor from the camp where he was stationed. The person's name is Jan Simons. Jan Simons stands for everything the army wasn't. Neil greatly admires and respectes this man. He is both an officer, and a doctor, yet treats everybody, especially the NCO's like Neil with respect, kindness and fairness. It is intolerable for Neil that a man of such stature such gentleness and strength could feel so much pain. The sight of such a man in pain eclipses any of the grisly horrors that Neil had ever encountered. His pain is worse. Much worse. He represents humanity for Neil, standing alone amidst the profane indifference of war.

It is the agony and desperate suffering of Neil's own humanity that confronts him in his dream. The symbolic power of the dreams, the witnessing and recognition of humankind's pain amidst the numbing, mindless bloody conflict of war and all its petty contrivances allows for a profound moment in the room. There is one further component fuelling the impact - I know Jan Simons. I did my basics with him. We were in the same squadron together. We played chess together. The moment contains an overwhelming sadness, and I feel an extremely deep bond with Neil. I am now more than psychologist, I am now fellow soldier, and as such, fellow sufferer. My first words:

"I believe that you know what it is like to feel such pain, and have also heard that sound inside of you."

Neil just nods, almost as though he can't bear to speak, lest he forget the moment.

I am still feeling overcome by having recognised Jan Simons, to have known him, and in a way to have shared the primitive intensity of the pain. I cannot help myself, I need to share this recognition with Neil. The sound is real. The pain is real. Neil's reaction is one of short surprise and then, almost as though everybody must know Jan Simons, went on speaking about what an amazing guy he is.

He begins musing about whether any of the other medics feel anything similar to himself. He is frightened that they won't, which further compounds his feeling of isolation. He feels that others, friends of his, saw much more than he did, and they seem fine.

I address these issues, by saying that he doesn't know how others are feeling because he hasn't asked, and if any of them had to look at Neil, they would definitely think there is nothing wrong with him. He is doing well at university, has lots of friends. So they may well be feeling as though they are also the only ones in pain.

I then also share some of my experiences that I had with other soldiers when I was in Angola. Telling him that it was enough to be thrown into such a brutal and violent situation, to feel the chaos and the fear, and then have nobody to talk to. Amongst all of

those I worked with, their biggest concern was that there would be nobody to talk to once they got home, because nobody seemed to understand, or wants to understand, which leaves the soldiers feeling as though there must be something wrong with them.

Neil does not know that I had been in Angola, nor even that I had ever been in the army. At any rate I know something about the situation, and that seems to offer tremendous relief for Neil, that he is not alone. That there are possibly others out there who can understand.

This session reflects a definite shift in the therapeutic relationship. For the first time I feel that Neil and I are communicating, that I am engaging rather than just intervening. The moment is bigger than coincidence, changes everything that has gone before our relationship. It is as though we both recognise there is a real war to fight. Talking about the war won't do it. We have to fight it. Together.

Despite the power of the moment, its intensity, its warmth - it remains thus only a moment; to easily swamped by the black futility of his pain, to easily replaced by the malevolent hatred such horror produces. To vulnerable, like the children.

4.10.9. CHILD-DEATH

In the next session Neil's presence is a flurry of nerves and edginess. He cannot get comfortable in his chair, his legs and arms twitch, he doesn't quite know what to say; several times he almost begins to speak, before sighing, shaking his head. Begins at last.

Neil: I've ... I've been feeling so much just recently. More ... than I've felt before. Just realising how much there is to speak about. So much happening, it's all around me now. And I just don't know where to start. Y'know, am I going about it the right way?

Therapist: I think what you are asking, is whether it's helping to come here.

Neil: Everything is so very painful, just makes me think so much. I just want to get rid of it but it comes back so powerfully. So painful - Does it ... does it really help to come?

Therapist: Yes it does. But it does hurt, because there is so much hurt inside of you.

Neil seems subdued. He shakes his head and goes on to speak about how he just wants to be normal. That he feels so different to others, all he wants is to forget about it all and just live normally. But he can't and his mood is becoming more volatile, tempestuous.

Therapist: It's so unfair that you can't just be normal. That you have to come here and others don't.

Neil: It's not fair! Why me?!! Why did this happen to me.

Therapist: Of course. Of course it's shit. Because you never had a choice.

Now his mood is becoming more fragmented. He's swearing at the army, for all they did to him to others. How could they? So callous, so indifferent; and he is smashing his first on the side of the chair, and he's getting lost now. His speech is becoming quicker, more violent; his body seems to be shuddering, his head jerking around the room, eyes glazed. No more logic, no more sense in the room, he clasps himself and pulls his torso down to his lap, whipping back into the chair, upright as though impaled, and his voice is broken with anguish, and he's making noises as each horror seems to flash before his eyes, groaning with despair and anger; and all the time I'm saying 'Let it come'. He begins to sway in his chair. He's gasping sentences out. The children ...

Neil: Coming into this native village. Abandoned ..... Just this old woman, sitting on a log ..... Swaying. Broken cooking pot lying on its side in front of her. And her arms are clasping something. She doesn't seem to notice us, and I go over to her, and in her arms is this baby. And this baby is dead. And she just carries on swaying. And I want to <u>HIT</u> her!! And scream at her to STOP! But she just carries on swaying.

All the children. So defenceless, so vulnerable. Nothing. But nothing, they can do.

Why? Why? Why? - The children!

And he's slapping the side of the chair, his arm heavy as though broken. And he begins to sob. Like the dry heaves. It's as though the horror has closed in on him because he is cowering in his chair, and he's screaming, shouting for the voices, all the screaming voices to stop. Hands on his ears, jumping rigid, as though being assailed from all corners of the room. His face is contorted as though he is going mad. Here I intervene saying loudly, calling his name:

Therapist: Neil! Neil! Look at me. Look at me! I'm here. It's OK.

My voice penetrates, and he looks at me, and slowly his face sinks into his hands. His shoulders heave. There is silence for a while, just his breathing.

Almost unexpectedly he begins to speak. His voice quiet yet filled with purpose. He tells a story of how he had been dispatched to the scene of an accident, involving a mini-bus and an army vehicle. The passengers of the mini-bus are dead; a small child is the only thing alive. Neil was alone in the back of the ambulance, and this child, an infant was thrust into his arms. The child was haemorrhaging very badly, and Neil, being tossed around in the back of the moving ambulance, could only try and try, to keep the child alive. And the child died. The child died in his arms. Here Neil breaks into deep anguished sobs. His mouth opened and he bellowed with the pain, the despair, the agony of his soul unfolding in the eruption of heavy sound. He relived the incident, again and again, and it ended each time with the child dead in his arms. He screamed with rage, at the unfairness of the army for putting him in the back of the ambulance, and not a doctor, but each time returning to the child's death, and blaming himself.

All the time I have sat by and let him cry. His pain is unbelievable. His sobs shudder through the building. In the other rooms, my colleagues are compelled to cease doing therapy, the noise of Neil's crying being too disruptive.

Neil cries for a long time. Within myself, I sink in, searching for a metaphor, something to contain the pain. It is simple. "The child has died", the mourning is incredible, the pain virtually insoluble. We sit together, there are no words to describe the sharing.

I murmur throughout, 'Very painful', and even the sound of a human voice brings the pain wracking through. The tears are not hard, they don't squeeze out like water from concrete, they are not torn from within as though stuck to his bowels. No. These tears simply erupt with the volcanic force of undeniable pain. This is the sound of Jan Simons. This is the cry for us all.

The session has gone on longer than 1 ½ hours. Neil has stopped crying, and in the silence gradually comes back into the room. I find myself able to speak. I explain to Neil that everything is very close to the surface now. That we have seen the pain, and shared in it; that for a while he may find it very difficult to function, to concentrate. But that I am here, and we will meet in two days again, and that he must take care.

He has pulled himself together, he says he will be fine, that right now he needs to walk, that walking helps. I have given him my telephone number, in case he needs to reach me.

He leaves, and I feel exhausted. Despair overwhelms me, and I feel paralysed by an enormous futility. I feel no hope, no solution; internally I feel savaged. Relief comes much later that night, my tears seem to come ceaselessly, and I mourn, I to mourn for the death of the child.

4.10.10 A WORLD OF DEATH

Neil arrives for the next session, his movements are laboured, his complexion ashen with pain.

Neil: I'm not feeling that good. I've cried so much since I left here. Everything seems to be a reminder. I don't know if I have any tears left.
Everytime I think about it, I just start crying - its only a little child's life.
This is the worst its ever been. I hurt so badly now. The whole day I can just feel everything. I thought it had reached its worst, but its much worse now.
I let so many people die. Could have done more, I'm sure. I as good as caused them to die.

Therapist: I think it hurts a lot more to know there was nothing more you could have done.

Neil: You know that there is something that can be done. That must be done, but you don't know what it is - you get so desperate. But you know something <u>can</u> be done - something can always be done - but you don't know what. Clutching at straws.

Therapist: Sometimes there's nothing that can be done.

Neil is unrelenting in his self-condemnation. He is convinced that his lack of knowledge, his inadequacy caused the deaths to others. He starts to cry, very painful sobs, as he recounts an incident holding this young guy's hand. The soldier had begged him to not let him die, yet he was so badly injured nothing could save him. He had lost a leg, internal haemorrhaging, had lost so much blood, and what Neil had wanted to say to him was that there was no way he was going to live. That he was definitely going to die. Instead he told the guy things would be OK. Two minutes later he died. Neil is certain he betrayed the guy. That he had lied to him. And he is so angry with the guy, for putting him in that spot, for making him lie. This type of incident happened again and again, and all Neil wanted to do was run away, run far away - yet there was nowhere to go because everywhere there was horror. And the only way to deal with it, was to own it.

Neil: ..... Caused so many deaths. Caused so much pain. Guys I spent 20 minutes doing CPR on, I broke ribs. I punctured lungs. Caused so many people to die. So many children. Could have saved. I remember picking up three children. They were just lying in the gutter, in the ditch, in the bush. Felt so revolted I had to do it, couldn't leave them lying there. It happened once - a family was killed in a car accident. Mother decapitated, Father looked OK. The child. God! He just looked dead. Had to check the genitals to see what it was. Had no face. Survivors went in the one ambulance. Three of us took the bodies back. No room in the front, and I was left to sit in the fucking (hits chair with tremendous force) back with this little body!! I had to sit there. There's no body bag, big enough or small enough for a child. Had to take an adult body bag and wrap up this little child. All wrapped up, and I remember thinking "It's like lunch. Just like lunch. Just raw meat. Flopping around. The child fell off the stretchers. The noise it made - it - it was an IT - when it hit the floor. Like so much meat. And I would have to pick it up - with my bare hands. No gloves. Because they can't fucking afford them. Who are we anyway! Blood on my hands. Can't get them clean. Ever! I should come home on pass. And the first thing I would do would be to have an hour, hour and a half shower, and bath. Try and get the blood and death off you. Never works. Because you can't get it off you, and then it comes back. The smell - (starts to sob)

Fuck! Why did I let so many of them die!

The smell. The bowels release. And you're stuck. The smell of gaping wounds -

He's shaking. His fists are clenched, knuckles white. And suddenly, he lifts his arm and drives the back of his fist into his face with incredible force. Several times, the sound like wet fish being slapped against bricks.

Therapist: Let it go. Neil! Let it go. Unclench your fist. Neil, let it go man. Let it go.

And it comes again. Screaming "AAAHHH GOD!!!" (Sound twists through his throat)

Therapist: It's horrible. Fucking horrible.

Neil: The little kids - AAHAH. The babies. The noise.

Therapist: I know.

Neil: UHGHNN (Sounds ripped from his mouth. Smashes his fist against the chair. Gasping)

Therapist: Let it out.

Neil: I'm fucked! I'm foul!

Therapist: It happened. I know.

Neil: I killed these babies!

Therapist: Uh Uh

Neil: So dirty. So full of death!

Therapist: Breath out. Out.

Neil: Oh God! I just feel so useless. So senseless, because I've taken it all in, at the expense of everything else.

Therapist: Yuh. At the expense of yourself.

Neil: I'm just so full of everything. They killed everything I had.

Racking sobs. Pain like fire, burning his mind.

Neil: So angry. They killed me they really did. Don't know who you are anymore, because you don't have anything. Nothing you have makes sense anymore. How can it make sense. How can it. This life. But life is vile. I feel so dirty. So very dirty. ..... They killed me. I hate myself so much. I'm part of them. I hate them. I hate myself.

Therapist: You're not part of them. They're part of you. You've got to get rid of them.

Neil is in great distress. He hates people so much. All of those around him. He feels he suffered for them, and they don't give a damn. What was it all for? And it was all for nothing.

Neil: ..... You were just there to take it all for them, and you just take it, take it, take it. Tired of it. They can suffer now. Can have their pain back. Try to stop them from dying. Stop the pain, but I couldn't stop the pain. And I tried and I tried and I felt all the pain for them. Every time somebody dies, all I felt was the pain. (Punctuating every sentence by smashing his fist on the chair)

Therapist: So much pain for such a young boy.

Neil: (sobs) I'm 22 next month, and there is no more life. The waste. I was 18. It seemed like such a good age. I was so excited - everything is shattered. No gain. The tension. God! You couldn't hold cups of coffee in front of people because you shake so badly you spill coffee (sobbing). You wait. And you turn grey. Grey fucking hair. And you can't hold cups of coffee.

Its a world of hatred. Everybody hates everybody else. Medics lives are so full of pain and death nothing else seems to matter, and everybody hates them because of that attitude.

Neil: ..... and suddenly you go home, and suddenly, suddenly, nothing is like that. Its normal. But its not the same ..... they can't understand why you wake up screaming in the middle of the night. My mother doesn't know why I sit and watch the test pattern at 5 o'clock in the morning. But you cannot tell her. Because she cannot and will not understand. You can't tell her.

People look at you so strangely when you - jump! Because you're so nervous. A loud noise and you're not there anymore. They stare at you because you're so abnormal. "What the hell are you?" I did it all for them. And they feel nothing for it.

Therapist: You've been fucking badly hurt for nothing.

Neil's confusion and distress is so painful. The sense of unfairness, the lack of comprehension reduces him to bitter, pitiful tears. The huge disparity between life on the border and life at home shatters him.

The session is almost over. It's hard to believe it has only been 50 minutes. It feels like three days since he first walked in. There is so much happening in the room, so much emotion, the atmosphere awash with confusion and distress. I don't feel as though I am really reaching him anymore. Everytime I speak it plummets him into more confusion. I am very concerned about his safety, and address this directly. I tell him that everything is flooding back so quickly now, and there is so much of it, and that I feel we need to meet more regularly. He is reluctant to commit himself. I want to contract with him that he contact me on both Saturday and Sunday at 4pm in my office. Neil is not enthusiastic about the idea, it's almost as though the thought of coming to therapy is loathsome to him. He feels the need to leave the office. I amend the contract, saying that I will be available at that time, should he need to speak. He is much happier with the arrangement. I also have a very good book on Post Traumatic Stress, about Vietnam survivors. I give it to him, thinking that if he needs to make some contact, some reassurance, the material in the book will, if not contain him, inform him enough that he is not going mad. That people do understand what is going on.

4.10.11 GOING HOME AND THE FEAR OF SEPARATION

Neil did not come to either of the two weekend sessions. He canceled the sessions for the week. The university was in the middle of writing exams and I knew that he was very busy. I also felt confident that if he needed a session he would contact me. The next time I saw him was shortly before the June holidays.

He was smiling although not relaxed. The exams had gone really well and he was feeling quite proud of himself. He said that he had not read much of the book, but that he had been thinking that what he wanted to do was contact some of his medic friends who were working in Johannesburg.

He said he was really looking forward to the holiday, that he had a part-time job that would occupy his time and that he didn't anticipate spending much time at home.

As he talked I became aware of myself starting to feel very uncomfortable. My neck began to hurt and I had a sense of feeling tremendously strained and burdened. Looking at Neil I am struck by the disparity between the content of what he was saying, and the prevailing mood.

It suddenly struk me that all Neil's talk about the vacation disguised a real fear of what the time ahead would hold for him. That effectively there would be no therapy for approximately six weeks. This is no surprise as I had discussed it with him several times in the past weeks; however for the first time I became aware of how anxious Neil was about the separation.

I enquired about his feelings about being away from me for so long, and he responded with some relief, that in actual fact he was very worried about what he would do if for some reason things started going badly. That in fact he was frightened of the time ahead. I had been thinking for some time about potential contacts in Johannesburg that he could 'phone, and had made arrangements with these people; one, a woman clinical psychologist whom I trusted; the other a medical doctor who had been in the army with me. I had intended giving Neil their names and numbers anyway, but was pleased that the opportunity had arisen to address his fear. I was also conscious of the pain in my neck having disappeared. Neil was grateful for the numbers. There was also now the opportunity to speak about the issue of telling people. That others might well not understand, and when that happened, and he felt like he needed help, that he should 'phone. I personally was not going to be contactable by 'phone in the weeks ahead, but others would be. That by 'phoning what he was doing was not a sign of weakness, but of strength. That it is the beginning of caring for oneself when one acknowledges that one needs help. This was an issue that we would return to again and again in the remaining session, the focus always being a dispute between the risks of isolation versus the risk of being misunderstood.

4.10.12 BITTER DIVISION

This is the first session after the holiday. Neil's mood is brooding and angry. He hadn't 'phoned anybody. He almost did but decided against it, feeling that he had some dignity to preserve. The vac had been unpleasant, his mother had irritated the hell out of him and was glad to have left home, but that coming back to Grahamstown was no relief, he felt all his actions to be futile and meaningless. He feels callous and indifferent to the world.

I can feel his resentment and anger; nothing is changing, therapy is futile, nothing is worth it.

Therapist: Nothing seems to have changed. The outside world is still a strange place. Your world, where you've come from, nobody knows about it, or wants to know about it.

Neil: I just want everything to go away. If I could only just be normal again. And fit into the world. But the thing is - I find myself very critical of those around me. I look at what they are worrying about, and I just think 'Your hassles are so fucking trivial!'. Their world is so petty.

He speaks about how he had just longed for somebody to notice that he had changed, that they would see something different about him. But they hadn't. He speak dismissively of an incident with his sister who had remarked that there was something different about him. He had thought "At last. Somebody has noticed something." But then she said, "Oh, You're wearing glasses." His heart sank.

He becomes bitter again, lashing out at the shallowness of others and the futility of relationships.

The mood in the room is turbulent, confused with resentment and pain. There is a strong need to contextualise what is happening.

Therapist: You rage against the world, and want to break it down, and shatter and disrupt the lives of these ignorant people, and tell them what you are feeling. And yet, simultaneously, you want to fall down and cry, and plead for help, and be picked up and cared for by this same world.

I say this with a lot of affect, and Neil is moved to tears by this. He nods his head, I feel this to be an extremely important moment in the therapy. The reality of his dilemma is confirmed, his acknowledgement thereof is crucial in moving towards a different kind of integration.

Neil becomes suddenly angry, attacking himself for being such a coward and not telling others about his feelings, and again I intervene, expressing just how difficult it is to tell others, because he will never see the world through the same eyes again. That what he had experienced was not going to undo itself. That it is going to be very difficult to include others in this experience, and that even by telling others, the experience will not vanish. But at least he can start to move towards ways of belonging to the real world, to create a new world for himself and possibly then invite others back into his world.

It is an extremely painful moment for Neil to acknowledge that he has been changed by his experiences. However the pain is vital, it makes his experiences real, he sees the difficult involved in telling others, the likelihood they won't understand.

Neil does not want to accept that he has changed, and his way of denying it has been by coping better than ever, meanwhile, every moment of the day he is faced by his own loss of innocence, and that by him refusing to recognise his own pain, simply alienates himself further. He allows himself no satisfaction from how well he is coping with his life, nor any relief from his pain, by refusing to share it.

Neil missed the next two sessions. He did not cancel them, and for the first time I felt irritated by his behaviour, feeling it to be quite contemptuous and indifferent. When we met again I made a mental note to address his inconsistent attendance.

4.10.13 RELATIONSHIPS: THE WOMAN AND THE NUT

After the second missed session Neil does arrive. His mood is morose and his apology perfunctory.

He begins speaking, his tone initially bland becoming more desperate. He has met a woman on campus, whom he likes, and she has showed a lot of interest in him. He has found himself suddenly becoming anxious about the possibility of having a relationship, but the thought of getting close to another person frightened him because of all the responsibility it implied. He does not clearly articulate the true nature of his thoughts. As he sees it, it would be somebody else's feelings to deal with, and this he does not want. At any rate he went around to see her, and explained that with all the pressures of work he didn't want to get involved in a relationship and felt it was better that they did not see one another. He had been tense and edgy when telling her this, and she became upset, not believing him, insisting that there was something else. He had protested that there wasn't but she wouldn't believe him and kept on wanting to know the real reasons, until, unable to contain himself any longer, he broke down and told her everything, well, everything that came out. A deluge without focus, ending with both of them crying. However, he now feels that she has erected a block, a barrier towards him. He begins to get very angry with himself for having told her. Bitter with recrimination that he was led to believe it would be any different.

In Neil's view, she now knows what he is really like, and he feels vulnerable to attack from her. In a sense she has betrayed him, all he wants from her is a sign, an acknowledgement that everything was OK. Now he doesn't know what to say to her, what to do, nothing makes sense. That she must think he is a real nut, but all he is, is just a normal human being, still a human being.

I pick up on this theme immediately.

Therapist: Do you think you're a nut?

Neil: Others seem to think so.

Therapist: Do you?

Neil: The way I behave, it's not normal.

Therapist: Was what you went through normal?

Neil: It's changed me. The way others see me. She doesn't want to know me now. I shouldn't have told her.

Therapist: It seems to me that you expected her to see you as some kind of nut. That there is something wrong with you to feel the pain and the horror of what you saw. That somehow you just shouldn't feel it.

Neil: It..... it, just doesn't seem normal. Such a waste of time.

Therapist: No. It seems that you don't want to know that part of yourself. You can't accept that you're not a nut, but somebody who has experienced something terrible and is suffering a lot because of it.

Neil: Doesn't seem any way out of it. I'm lost. It's what I've become.

Therapist: It's very hard for you to see that what you've been through is horrible. That for anyone to see what you've seen is wrong. That anyone who has to suffer that much, including himself is wrong. But that doesn't mean there is anything wrong with you. When someone is suffering the person needs kindness and care. Instead you seem to treat yourself as though you don't deserve it.

This is all very hard for Neil to accept. His anger and bitterness of those around him precludes understanding; his own pain confuses him. I remain intent on pointing out how I understand his confusion. What he has experienced was awful. Unable to accept that part of himself he distances it. When it does come out in the company of others, because Neil feels the behaviour to be awful and unacceptable, automatically he expects them to as well. That in a way he does that with therapy. Therapy comes to represent that part of himself he doesn't want to know. By missing therapy he can forget his disgusting side, he can avoid that part of himself. But then all he finds himself doing is having to run and hid because now he can't allow anyone to know.

I try and instil in him the realisation that to even hear what he has been through will be difficult for people to do and they will certainly not be able to take that experience away from him.

Neil: I can't tell anyone.

Therapist: You can. It's very difficult, very painful and frightening, and I know they won't be able to take what you have experienced away.

Neil: I don't expect them to. I just want to hear what I say.

Therapist: That you can want. But it still won't be easy.

The session ends very painfully. Before he goes I insist that if he is not going to come, he must notify the clinic secretary, so that I can know. He promises to do so.

4.10.14 UNDERSTANDING AND CONTAINING THE ANGER

The next session follows a theme similar to the previous one. Initially Neil's mood is less morose, more belligerent. He has decided to cut all ties with the girl, making a conscious attempt to avoid her. His anger and contempt is palpable, he speaks arrogantly about an episode that occurred over the weekend. At some or other Residential gathering, somebody had thrown sherry all over him (whether this was accidental or not was never established), and Neil had lost his temper, taking five others to pull him off this guy. Later

that night Neil had gone hunting for this person in order to settle it. Not finding him he had punched the wall and badly bruised his fist.

He changes topics rapidly and begins speaking in a very existential way about Death, as though wanting to engage me in debate with him. I am feeling confused by his mood; there seemes to be something more clinical and detached about his presence than I have witnessed before. For a fleeting moment I actually thought he is considering suicide.

He is becoming more animated now, speaking about how the good die young, and how much he hates them for dying because they live on inside of him. His voice is caustic and vicious, as though completely disgusted that the human condition could deteriorate to such a state. He speaks in graphic detail about the sound a sucking chest wound makes, and then, almost unable to sustain the tirade, his voice weakens.

Neil: ..... sound of boots running towards where we slept, kicking the doors open and everyone knowing what to expect. Running, no time to think. Functioning on automatic ..... all the time.

Therapist: And in all that time, there was nobody to come up, and just ask how you were doing.

I feel I am trying to tap the loneliness and the sadness Neil must be feeling, caught alone in his experience. Just how small and frail he is when faced with the hugeness of the world's pain. To some degree I feel I succeed; he speaks about how his nickname was Dr Spock because of all the time he spent with the children - talking to them, reading to them - but his tone grows harsh again, reflecting on all the children he had not saved.

Whilst there is a lot of pain in the room, I feel that there was something else going on that I am missing. I am struck by the confusion and volatility of his exchanges and have a sudden sense of things being out of control. Neil doesn't want any more pain. He doesn't want to explore his soul any longer. He needs something to change, and he needs some control. Some boundary. I again become aware of the sense of "killing" in the room, and I realise that he doesn't necessarily want to kill himself, rather it is others he wants to kill. He has spoken about the rage and how he never wants to be fucked around again, but

what is so clear is that his anger is in fact a denial of what has happened to him. He is angry, so angry with himself for feeling what he does, and he wants to take this anger out on those who remind him of where he has been.

I find myself intervening in a very direct, very confrontational manner. When he lies in his room and hears somebody running down the corridor, he feels sick and dreadfully afraid, but he does not check that feeling and say that "the reason I am feeling this is because it reminds me of my army experience", because if he does that then he has to admit to what he has been through and just how much pain he is in. This he can't do and instead he gets angry and freaked out with whoever is doing the running, that it is their fault he is feeling like this. I tell him, in a very blunt fashion - that it is not their fault; nobody in his res, in this university, is responsible for what he is feeling.

Neil is angry and bitter, but he acknowledges what I say, saying that he knows that he has to experience the pain in order to feel better, but he hates that fact, and he hates coming to therapy because of that fact.

Therapist: I know. But I believe that you, Neil, believe that you are a nut and a fuck-up because of what you have been through. That you believe others think so too. And you're going to prove it. You cannot get freaked out, and want to beat the shit into everybody who irritates you, or reminds you of something bad. You are going to have to walk away. You cannot expect everybody you tell to just automatically understand and want to take care of you. That is not going to happen.

You say that you have so little energy left over. Well, use the energy for yourself.

> And I'll tell you why you are coming to therapy. To save yourself. No-one else.
>
> And I know how painful it is. But now you have a choice. You either live it, or you die. It either stays in you, or it comes out.

I feel firmly in control of the session, and there is a wave of relief in the room. Neil leaves, and there is a real feeling of somewhere to go.

4.10.15 CALMING DOWN

The following session Neil is quieter, almost cagey. He says that it has been another difficult week, but somehow things have seemed better. He'd wanted to get angry a couple of times, but each time has managed to calm himself down. One occasion where he had nearly lost it was when watching a rugby game over the weekend. Some guy behind him, supporting the opposite team was behaving in a raucous and provocative manner, shouting insults and pushing those in front of him, including Neil. Neil said that he was on the verge of attacking the guy, when, he says, he suddenly heard my voice, warning him of what was happening. He remembered what I had said about him thinking he was a nut, and then proving it, and what he did was simply get up and move to another place. He found himself calming down quite quickly, and then able to reflect on the incident, realising that in actual fact, the guy doesn't really have a clue about life, and certainly wasn't worth the consequences of attacking him. We explore the feelings that have arisen from these acts of self-control, and just how much better he had felt about himself. Emphasising also that it is not going to be easy to walk away each time. That he will probably still feel the rage at each instance and that to fight it may be more difficult for a while. But the important thing is to hang onto these good feelings about himself and, more importantly, realise that he is the one who is in control of those feelings, and must therefore take care of them. The emphasis being one of taking care of himself. Looking after who he is and respecting what he has been through.

4.10.16 JASMINE AND HYDRAULIC DRILLS

The following session Neil appeared looking cheerful. Although not completely relaxed, he had a smile on his face and there was lightness in his voice. He said that he felt that things seemed to be coming together. On the way to the session he found himself, almost for the first time, noticing the sunlight amongst the trees and the smell of the jasmine and it was like he felt some real life inside of him again; as if the shadows had parted for a while.

He went on to mention, almost apologetically that he had spoken to the girl (mentioned earlier) again, or rather, she had come to see him, demanded to see him. He hadn't quite known what to expect, and was quite astonished at what she had to say. She had said that she felt hurt and angry with the way he had been treating her. She didn't understand the way he was behaving, she felt it unfair and she felt used. Neil had initially been shocked by these allegations, and initially felt angry towards her for not understanding about how he was feeling and why he needed to behave the way he did. But most importantly, as I pointed out, and he came to realise; it was not his experiences, the horror and nightmarish quality thereof that had hurt her, but rather his behaviour towards her afterwards. His dismissive, off-hand, curt and abusive manner, unprovoked and uncalled for: this had left her feeling hurt and confused.

It was very difficult for Neil to assimilate that somehow he had a responsibility towards her that lay outside the realm of his present suffering and past horrors. That he had wanted her to treat him like a human being yet himself hadn't behaved like one. He had expected her to treat him in exactly the way that he ended up treating her. So, if she had carried on avoiding him, it would be because of his attitude towards her, and not the other way round.

Neil suddenly felt very guilty about hurting her, and this generalised into a fearfulness about hurting anybody. He began speaking about an incident that had occurred in Mozambique. Intruders had been spotted and he had been sent along as patrol medic. A helicopter was circling the area and they suddenly opened fire. Neil's group was close enough to hear the gunfire, and Neil was certain that he had heard this dreadful sound, a shout of human pain, anguished, as the bullets struck.

Neil juxtaposed this story with another, when, on patrol one night, coming into a village that was pitch dark, outlined only by the moon's glow and shadows, suddenly a figure darted from one of the huts, and Neil, terrified as he was, almost opened fire, catching himself in time as he realised it was only a child, probably as frightened as he was. Neil was shocked by the realisation that he could as easily opened fire, and been responsible for the same pain that so frightened and disgusted him when inflicted by others.

He didn't shoot the child though he could have. Although he has hurt the girl through his attitude, she has survived and so has he.

I never got the chance to make any of these links, because suddenly there was an intrusion, both unexpected and unwanted. There was a group of contractors working outside, and the sound of a hydraulic drill filled the room. Neil's reaction was immediate - he jerked forward in his chair, his eyes shut, frozen for a moment. He turned to me, his gestures almost pathetic, wanting me to make them stop. We both knew it was a hydraulic drill, and Neil was very embarrassed by his reaction, quite desperate, still frightened and angry, because although it was only a hydraulic drill, he still wanted to scream and just tell them to "Fuck off. Stop!!"

The whole incident caught me by surprise. However I was able to intervene quite strongly, working with the immediacy of his reaction as it happened. I was able to talk him through the sound, distinguishing between the sound of the drill, and the sound of the gunfire. Both the similarity and the difference of his feelings, showing him that he was able to control the experience, that he could distance himself from it, despite for a moment also feeling trapped by it.
That the world of the now is full of reminders of the past, but the past is behind him.

We were also able to touch briefly on the uncertainty that his good feelings and good experiences would be sucked into unreality by events such as those just experienced. We touched also on ambiguity that would lie ahead, that the same world so full of jasmine and sunlight is also the one of horror and pain, that he has access to both; but whilst previously the latter could cancel the former, now Neil had discovered in himself the capacity to enjoy the good things about life. It was now up to him to hold on to it.

4.10.17 TERMINATION: OFFICERS AND THERAPISTS

Neil walks in, and his demeanour and posture immediately suggest that he has something to say. On his face is a stern and purposed look, and his tone is formal, however he is uncomfortable and shifts nervously in his chair.

Neil: I don't quite know how to do this ... I've given it a lot of thought, and uh .... whether it's right or wrong .... It's what I want to do.

I don't say anything although I know what to expect. I experience two different reactions. The one is immediate and close to the surface. I know that he is wanting to leave therapy and my instinct is to stop him, tell him he is making a mistake. However on a deeper level, this comes as no surprise, and I find myself working very hard with the feelings that are being evoked inside of me. There is something that I need to understand about what he is saying, and until I do, my feeling is that I will not let him leave.

Neil: I want to stop coming to therapy. It's .... it's nothing personal, y'know, its just that I feel that I would like to try on my own now. I'm feeling much better now and for that I've got a lot to thank you for. But I feel like I want to now concentrate on my life. I've got a lot of work to do, and I think now is the time to do it.

As he speaks, mentioning two or three times, that he has a lot to thanks me for, I have this really strong feeling that he is not disclosing all; I also have a sense of a lot of anger being directed towards me.

Therapist: I can hear what you're saying. And it seems to make a lot of sense. Yet I have the feeling you are not telling me everything.

Neil: Well not it's nothing personal y'know. It's just I feel that now is the right time. It's important for me to do.

Therapist: Well. I'll tell you what I'm feeling. Hearing you talk reminds me of the time you went and told that girl that you couldn't carry on seeing her because of all the work you had to do. When in actual fact it had nothing to do with the work at all.

Neil: What do you mean?

Therapist: I have the sense that you're not leaving therapy, that what you're actually trying to do is get away from therapy.

Neil: Well, It is very difficult. All this pain. Never seems to end.

He is becoming more flustered now and I can feel the anger surfacing.

Therapist: And I feel that something is very painful. And I feel that it <u>is</u> personal. Because it's as though I am the one making you come. Therapy is painful and it's as though I'm the one who is putting you through it.

Neil: Well yes! That is true. So many times I didn't want to come, and then feeling as though I must. And just never, never being able to forget. It just hurts so, and I just didn't want to see you. It was always me. I was the one that felt the pain ...

Therapist: And I became responsible for making you go through it.

Neil: Well, not really responsible. But, yeah, everytime, never seemed to go away. Coming here was like going back to the army. Couldn't get away.

This is a crucial moment. Because while I feel that we have already gotten somewhere, there is still something missing. And this is something that I have instinctively known for a long time now, always wondering when it would surface. It harkens back to Session six, when I disclosed that I know Jan Simons which meant of course, that I must be an officer.

Neil hates officers. Somehow I wanted Neil to say it, to acknowledge that what was happening had a lot to do with the fact that I was an officer. I try and establish what it is about coming here that reminds him of the army. It's as though he's already lost the anger cutting off very guiltily, and eventually I say:

Therapist: Neil, I wonder it a lot of your confusion has got to do with the fact that I was an officer in the army.

There is a moment's silence. "Yeah" he says. The weight of the admission making the sound drop heavily into the silence.

Therapist: So all this time, you've been relating to me as though I was an officer.

Neil: (Shakes his head) Y'know in the army one just never trusts the officers. Here I thought, well y'know he does seem different. But you never trust an officer. For a time I just forget. But then it always seemed to just be there.

This place came to feel like a duty room. Y'know like I was being placed on orders or something.

Therapist: Therapy became an order.

Neil: Y'know ... y'know that I never, I never sat down before you did. I always waited. Sign of respect, the officer always sits first.

I personally never noticed, but the power of the exchange is formidable. It felt like the room had been packaged and bound tightly with string, and was now being loosened, and we found we could move.

For Neil therapy was a place one came to be in pain and to be serious. There never seemed any relief.

Another important aspect was that therapy was something that as an officer I had to carry it out. Neil's role was the recent nightmares, while mine was to listen to them. He could never come in and just be himself, because that wasn't allowed. I wouldn't approve. He could never come into therapy and just laugh and joke. It was a serious business, like fighting a war.

Neil recounts a few incidents in the army that were meaningful and special to him involving friends. They were not serious incidents, they were fun. Good fun.

I point out to him that therapy is more than just war; it is about him, and his life. He can choose what he wants to use therapy for. I'm not an officer and I don't give orders, he is relieved if not somewhat embarrassed. He agrees that he would indeed like to know that therapy is a place that he can come to if he needs it. I offer our initial arrangement of twice a week. He would prefer once. I have a sense that he is still very unsure about what has happened. This has turned out so differently from his expectations when he first walked through the door. There is a need not to forget about the situation to soon. The army scenario does not just vanish.

Therapist: Well listen. If I'm going to be an officer to you, then the next time you come in here I want you to salute.

He is quite taken aback by this and fumbles around saying "Yeah, Kap a salute. I couldn't even remember how."

Therapist: Well then you must leave it behind.

The session ends and I am struck by a feeling of completion, that so much of the past year has fallen into place. Although initially not thought possible by Neil, change has occurred. Things can be different.

4.10.18 GETTING BETTER

I don't see Neil for a while. He cancels his appointments timeously. These cancellations do not evoke any anxiety in me. I feel satisfied that he is coping well with his life and is not avoiding therapy. After about three weeks he confirms an appointment. The reason he hasn't been coming to therapy is that he has been involved in a tutoring programme in the township, assisting Standard Eights and Matrics with preparations for the end of year exams. He is enjoying the work and really feels that what he is doing is of some value.

Every area of his life reflects a deepening of warmth and improvement. He has been nominated as a sub-warden for his Res, and feels certain to be accepted, as well as being nominated for a foreign exchange programme, part of AISEC, as their representative for the following year. He has begun a relationship with the girl mentioned earlier, which has grown and become quite meaningful.

He concludes the session by recounting an incident occurring a few days previously. He had been watching a video with a group of students on the Ethiopian famine, and had found himself being moved by the extent of the disaster. More surprisingly for him was that he found himself feeling very compassionate towards his friends, some of who were very distressed by the video. He was able to empathise with their distress. I point out that by treating his own experience with compassion and understanding, he could understand the pain of others, and experience a communion with them rather than the alienation he had felt thus far.

He can now find it in himself to acknowledge his experience, acknowledge his pain and allow himself to experience that pain. It is only through the acknowledgement and experience of the pain that any release follows. Having discovered he can do so. He can allow himself to share with others, not only what he has been through, but also more of who he is and what he has become.

We have two sessions left before the end of year exams begin. A time and date for the last session is set.

4.10.19 REBIRTH: A CELEBRATION

Our second to last session.

Neil comes in and again is a bit agitated. He says he has something to ask me, something he has been wondering about and that is: "What can I expect now?" I have the sense that it's not really an answer that he is looking for, rather some kind of insight into what lies ahead. At first I attempt to summarise the therapy, briefly pointing out to him how his attitude towards himself and his experience had changed; shifted from feeling that he does not belong in the world, feeling that his experience had contaminated him, made his deplorable; just as he could not relate to himself, nor others, so he expected them not to relate to him or want to relate to him; and that only by gradually exploring where he had been, recognising and feeling the pain, as well as the anger at the unfairness of it all, so he had come to feel compassion for himself, and allow himself to become re-united with the world and those around him. That by hating himself for what he had been through, by raging at the world, by cutting himself off, and hiding from his feelings, he alienates himself further. It is only by treating himself with the compassion that anybody who has felt like that deserves to be treated, will he find relief.

Although Neil acknowledges these things, I have a sense of something else remaining. I feel that it has to do with the fact that therapy is coming to an end, and there is an uncertainty as to what lies ahead, but more immediately is his need for something to hold onto, something that could be construed as lasting whilst not necessarily being tangible, something which depicted what he had been through. Something metaphorical.

Therapist: It's been a brutal year for you. You have been ravaged by your experiences. You have shown extraordinary courage and bravery in dealing with it all, and now, as the year comes to an end, it feels very strange and new to be back in the world again. It must feel something like being reborn, and you feel very vulnerable.

Neil is deeply moved by the idea of being reborn. He contemplates this for a while and then says something that fills me with a profound warmth and joy.

Neil: Remember when I told you that I felt that something inside of me had died. That a part of me was dead. Well now it feels like I'm back. Like someone who you thought had died and you wouldn't see again, and then suddenly you find out that they're alive. That is how I feel.

Here again something ironical emerges from the strange kind of elation that has ensued. For all intents and purposes, nobody else knows of what he has been through; therapy has been conducted "in secret". Now that he feels he has come back, nobody else knows any differently. Neil admits that it does feel strange, feeling as though he does want people to know all of a sudden. He has this idea that he would like to throw an intimate little gathering at which he would like to drink a toast to himself, and say, "Welcome. Welcome back".

I support the idea, and so filled with the elation of the moment myself, am tempted to suggest he bring a little bottle to therapy, and we can drink together. What I do do though, is explore how much it is others have to know about his experience. Neil is uncertain in this respect, as he now admits that he is generally not used to telling others about himself. Here we acknowledge the fact that therapy is indeed ending too soon.

I explain that I have arranged for someone to be available to see him the following year, if he needs to. The person is a Clinical Masters student, who himself had extensive war experience in Zimbabwe.

There will be people who know, who he can tell. My leaving does not take away the space. Space will be available. But I also speak about the fact that he can tell others as well. His peers, friends and family, but that he must choose wisely, because there will be some who will not handle what he has to say. I reinforce this by saying that it is not so much a case of them accepting you, but more of you accepting them.

The session concludes with a reassimilation of the fact that his life is contiguous with his experience, that the two are inseparable.

That only by recognising and releasing the emotion can any relief be found,a nd that due to the emotionally charged nature of his experiences the release will probably come in the form of a catharsis. But that if he needs help it will be available.

An understanding that the fear of his vulnerability and of the memories returning, his sadness of what he has been through, his elation of his recovery, are all part of his ritual rejoining with the world, combined with the ironic reflection that his is a re-entry into a world that never knew that he had left. The army is, and will always be, a feature of his life.

4.10.20 FINAL SESSION: SOME NORMAL CONFUSION

The final session is not without its hiccoughs. A miscommunication by the Clinic secretary leads to my not receiving a message that he was unable to make our scheduled time, requesting an alternate time. Not receiving the message I am angry and quite disappointed that he hasn't come and write him a letter suggesting another time, saying he must confirm with the secretary. I offered him a choice of times, and again a misunderstanding ensues. He confirms one time and the secretary tells me a different time. Neil turns up for the appointment and I am not around.

Chance has it that we bumped into one another a short time later. We are both irritated, and our agitation combines to make the exchange rather tense. Discovering that the mix-up was neither's fault, causes the tension to ease and a final session is scheduled.

We discuss the confusion for a while, both admitting to our anger at the other's non-arrival. Unfortunately, the issue is not properly explored, and in some ways regarded as an intrusion as it obfuscates the real issue of this comprising the final session.

Neil thanks me sincerely. I acknowledge his thanks, also pointing out that he has himself to thank. To a large degree his determination and courage are what brought him to therapy, and helped carry him through. He then takes my address in Johannesburg, and extends his hand. We shake hands. I feel I would like to hug him, but don't.
The parting is very emotional, although largely hidden. So it goes.

Synopsis of the therapeutic process linking session title with session number.

SESSION TITLE	SESSION NUMBER
The Beginning	Session 1
Alone and in pain	Session 2
Death's behind the nightmares	Session 4
Difficulty feeling	Session 5
Missed sessions, a necklacing, etc	Session 6
Confusion and sanity	Session 7
The siren and the irritating friend	Session 8
Dreampain	Session 9
Childdeath	Session 10
A world of Death	Session 11
Going home	Session 12
Bitter division	Session 13
Relationships	Session 14
Understanding and containing the anger	Session 15
Calming down	Session 16
Jasmine and hydraulic drills	Session 18
Termination	Session 20
Getting better	Session 21
Rebirth: A celebration	Session 22
Final Session	Session 23

The sessions not included are:

Session 3, which formed a continuation of session 2, dealing with the difficulty in distinguishing between civilian life and army life;
Session 17, which focused on similar issues to those in session 16, which was learning how to control himself in difficult situations and focusing more on improving relationships with those around him.
Session 19, which was a short session just before the October holiday in which his plans for the holiday were discussed.

CHAPTER FIVE

DISCUSSION

5.1 INTRODUCTION

The discussion will focus on the advantage of having used a transtheoretical and goal-directed model of psychotherapy when working with this particular PTSD veteran. The model is necessarily diversiform and will focus on how the treatment utilises a variety of technical and theoretical orientations in order to meet the patient's needs. A model of this nature was developed by Parson (1984; 1988. See section 2.7) and I will show how his model is useful in informing the treatment as presented here.

5.2 PRESENTING PROBLEM

A phenomenological understanding of post-traumatic stress disorder could be expressed in terms of somebody who has literally been blasted out of time. Events in an environment so unlike our normal experience of reality have produced emotions of such intensity and force that they appear impossible to assimilate with a daily experience of living. Lifton (1988. See section 2.6.3) refers to the aftermath as a state of "psychic numbness" and a "discontinuity of being". In effect the person has been dislocated from life. The event of therapy is an attempt to reconcile the feelings and perceptions evoked by the trauma with the continuity of daily life. It is an attempt to deal with the meaning of survival, and how, having survived, one can best continue and appreciate one's life.

Neil brought to therapy a range of severe and debilitating symptoms that intruded upon him and affected him to such an extent he considered his life to be without meaning. Neil was plagued by a terrible feeling of foreboding that his life was constantly being threatened by a portentous force capable of destroying him. He was racked by anxiety and tension that left his nerves raw, with a feeling of unhealthy exhaustion. He suffered the most gruesome nightmares and was afraid to go to sleep. For a while he drank heavily but would experience grotesque flashbacks that frightened him sufficiently to cut down

dramatically. He felt desperately alone and isolated, trapped in a world of terrifying experiences from which he could find no relief. He felt bitter and angry at his isolation, directing his anger at others for allegedly not caring, and also at himself for having such violent emotions.

I will attempt to show how Neil's life shifted from this position of chaos and despair, to a position of stability where he was able to utilise his inner resources to give different shape and meaning to his life.

5.3 THERAPEUTIC EXPECTATIONS

A necessary mention must be made of my own expectations of the therapy. Having virtually had no exposure to PTSD, my only understanding was that the symptoms represented powerful repressed emotions, experienced by the individual as either being too painful or too destructive to be expressed. Treatment would then focus on two levels, one being to "normalise" the condition, by explaining that such reactions are normal in abnormal circumstances; having established that, this would in turn allow the repressed emotions to be accessed using flooding techniques which would allow for an emotional catharsis. The dramatic relief that would come following the diminishment of intensity of the repressed affect would gradually lead to the symptoms fading and the veteran's life returning to normal. However from quite early in the therapeutic process this perspective changed. What alerted me to the deeper implications the trauma had on Neil was his reluctance to confront the impact the violent nature of the trauma had on him, instead chastising himself for feeling such emotions, for suffering at all.

The incongruency of his guilt and his self-condemnation in the light of his sufferings led me to consider further the destructive relationship towards himself that which he had internalised. The therapeutic process thus deepened to include not only a means of dealing with the acute savagery of his symptoms but necessarily required a re-examination of his relationships, with the world, with others, and with his own frightened and vulnerable human self.

The task of therapy was to include techniques that would enable Neil to avoid re-

experiencing the symptoms of PTSD, whilst simultaneously providing a passage for the mastery and integration of the traumatic experience as a part of his life.

5.4 THE IMPLICATIONS OF THE DURATION OF THE THERAPEUTIC PROCESS

Therapy was by all accounts a short term process stretching over a period of eight months. The therapeutic contract was only for one year, however this was rather open-ended, as the actual number of sessions was never defined, nor was the possibility of continuing into the following year excluded. However the one year contract became a therapeutic reality when it was conclusively established that the therapist (myself) would be leaving Grahamstown at the end of the year. Termination was thus inevitable; whether Neil would have continued with therapy is open to speculation. However, that he appeared capable of leaving therapy, and continuing with his life also seemed to be true.

It appeared that Neil at the end of the therapeutic period had gained control over his symptoms, the nightmares had all but ceased, his depression had lifted, and he appeared more relaxed and easy when in the company of others. Whether Neil had fully integrated his experience is difficult to assess, as I have had no opportunity to follow up on Neil's progress. That the process of integration was underway is largely illustrated by Neil's insight and understanding into what he had been through in the course of the year; the recognition of having overcome the effects of the traumatic experience on him, and to have grown from it. To have been "reborn". There is also evidence of Neil being able to utilise his experience of suffering to understand the suffering of others, and furthermore a tendency towards a general reintegration into the world of others through constructive use of his inner resources to attain realistic goals in a confident and open manner.

The important question is whether he has been able to maintain this growth and continue his development. By all accounts, he has not returned to the Rhodes Clinic to ask for further help, and I can only assume he is doing OK.

However, I believe that there is room for argument that he would have benefitted from the continuation of therapy on a more longterm basis. Consider the fact that by the end of the year, only two people (myself and his girlfriend) knew both about Neil's war experiences, and that he had also needed help (therapy) in dealing with the impact the war experiences had had on him. There is no saying that Neil would not have been able to begin incorporating others into his world of war, indeed the discovery that he was in control of choosing who could and would be able to share his world being a large feature of the therapy. However it is also clear that even at the conclusion of therapy Neil was still plagued by an amount of uncertainty as to the legitimacy of his experiences, and some self doubt as to the reality of his experience of "wellness".
It is at this point that one must differentiate between an understanding of PTSD as the consequence of a premorbid narcissistic disturbance, or understanding it as the consequence of the fundamental impact of war has on the individual's perception of self, an understanding of the implicit "narcissistic wounding" (Kohut 1976) that occurs as a result of the brutal and impersonal nature of war. War strips away the illusion of omnipotence and immortality that are the products of our narcissistic defences, and exposes with unprecedented grotesqueness the reality of our biological vulnerability.

There are aspects of Neil's presentation that would suggest narcissistic disturbance - his belief that his vulnerability and pain is a sign of weakness in the eyes of others, and that they might reject him because of it. The shame he experienced because he failed as a man for suffering the way he did. The difficult relationship he had with his mother remained a source of anxiety throughout the duration of therapy: they had always been close, he had always been able to tell her everything, and yet she was oblivious to his pain and suffering. What would have been the impact of the shattering of this closeness, the fact that Death had in effect separated them? Furthermore what were the possible implications of not having a father figure that was both strong and understanding?

These are all symptoms of a narcissistic disturbance. However to conclude that Neil was suffering from PTSD, because he had a premorbid susceptibility to the disorder would be to make the fundamental error of ignoring the enormous impact the volume of Death had on Neil. Death is the ultimate separation, and to be in an environment surrounded by the

continuous presence of the dead and dying would invariably tap into one's most primitive anxieties concerning every separation one has ever suffered, right down to one's earliest.

It is with issues dealing with the deepest implications of separation and loss that a continuation of therapy would have helped, in order to provide a richer understanding of Neil's present relationship with himself and the world, and how his experience will continue to influence and shape his relationships to come. It is in these aspects, of integration and cohesion, that the present therapy must, in essence, be considered to have been too short.

These were issues only peripherally dealt with in Neil's therapy, the pervasive feeling being that to have delved deeper into issues dealing with his mother, and his earlier relationships, would have unnecessarily complicated the process, allowing for the influx of further confusing and disturbing material on top of the already conflict-ridden world Neil was having to cope with.

However, I do not believe that the therapy could have been any shorter. To have used Horowitz's (1987. See section 2.5) brief focus model of 12 sessions, could only have had a limited result. Although the goal of his model is ultimately the integration of the traumatic experience into the individual's life, the model invariably deals with only a single traumatic episode. The focus is thus very clear (dealing with the death of a spouse, an incident of assault etc), and there is also an understanding between therapist and patient that it will be the only issue that they will be dealing with. In Neil's case, with his multiplicity of traumas, and the ebullient flood of conflicting emotion surrounding his experience, to gain such a specific focus, and work through the tremendous impact the experience had on him in such a short time would not have been possible.

Furthermore to have approached the case with the sole goal being the eradication of the symptoms through goal-directed avoidance techniques would have ignored Neil's own needs in relation to the trauma. Neil's inclination was towards uncovering some personal meaning the experience had for him, and any attempt to simplify his experience, explain it away or avoid it, was summarily opposed or dismissed by Neil himself. It was ultimately towards an understanding that he was working, and this came about primarily through the therapeutic relationship.

As it was, the use of such cognitive techniques proved invaluable in aiding the reparative process, yet it is important to add that they were concomitants of the healing process, and not the curative agents in themselves.

A word of caution is therefore necessary, in that to have treated Neil as a narcissistic personality disorder would have obscured the process completely, serving only to exacerbate Neil's sense of alienation, and possibly also communicating one's own reluctance as therapist to deal with the impact such material would have on one's self.

5.5 OPENING SESSIONS: THE IMPORTANCE OF THE THERAPEUTIC SPACE

The opening sessions were particularly important in determining the direction the therapy was to take.

Neil eloquently described the impact that the trauma had on him by saying that as a result a part of him had died. His own life force had been extinguished by the brutality and the volume of all the deaths he had witnessed. His presence was weighted and his words clouded by black funereal despair. The aim of therapy was thus to return Neil to life, to engage with that force within him that brought him to therapy and to lead him to discover the inner strength that had enabled him to survive. Although the initial sessions were typified by certain blankness of expression and absence of emotion, the sudden displays of anger and pain were encouraging in that they pointed to the emotional volatility and life that seethed beneath his cut-off and defended facade. I had a sense of the need that Neil had for a place to bring that emotion, to safely express it, to be contained within it, and to try and understand it. I acknowledged that need, and in a sign of therapeutic faith, I communicated that therapy could provide that space.

I believe that such a display of confidence has further implications for therapy in that it contains a fundamental recognition and belief in Neil's regenerative powers and faith that he will be restored to health, as well as asserting that a large part of the responsibility for recovery would rest with Neil. He would be the one who was going to have to reformulate and find meaning in his experience. That was his task. Mine was to listen; but he was the one who had to tell the story.

A significant feature of this particular therapy was the faith I maintained in his reparative powers, which remained consistently part of the whole process. Although I could not anticipate the levels of pain and despair that ensued, and at times felt quite broken myself, essentially I never doubted that he would pull through.

However, an aspect of faith that I needed to learn upon beginning work with Neil was patience.

Parson, in his model, reflects the need in the opening sessions for the therapist to be active and empathic whilst engaging with the veteran, employing a variety of cognitive and behavioural techniques in order to have a "stabilising influence on the combatant's state of mental chaos (1984)." He cautions against premature exploration of traumatic events which he says often plunges the patient into an "internal whirlwind of chaos" resulting in heightened anxiety and lowered self-esteem. This is a particularly valuable warning as illustrated by a need for my own therapeutic zeal to be tempered, where having touched on the core of Neil's pain, I hastily urged him to divulge the content. His subsequent withdrawal into numbness and silence was a necessary rebuke for my impatience.

In this respect an understanding of the graphic lack of organisation that characterises a war situation is important. Events happen without warning and without sense. The soldier is unable to conceive of events occurring in a linear or contained fashion, as for instance somebody who was watching a movie on war. There is no sense. There is simply chaos, and to urge a soldier back into that chaos without spending time in allowing him to reorganise his emotions and cognitions, differentiating past from present, is dangerous.

5.6 COGNITIVE RESTRUCTURING

Parson offers a variety of different techniques with which to engage the veteran, providing him with a means of regaining a sense of emotional stability and some relief from the acuteness of his pain.

Parson (1984, 1988. See section 2.7.2) seems to advocate their use primarily in the initial phases of therapy with the aim of improving the veteran's internal control and providing necessary stabilisation and consolidation before undertaking the trauma work. The principle is that the trauma necessitates fragmentation and chaos as the full power of the underlying emotion explodes, and on an ego where the calming and controlling resources are not available, reintegration will not be able to take place.

In this particular case I found the principles of cognitive restructuring to be of significant value throughout the treatment, both prior to and after the necessary flooding of the trauma work.

5.6.1 BIBLIOTHERAPY

The early phases of the treatment consisted almost of a series of "mini courses" where Neil was educated as to the nature and manifestations of his disorder. A word of warning in this respect: whilst a discussion of the symptoms, along with careful explanation of the phenomena that "abnormal" reactions in "abnormal" situations are "normal", helps to ground the veteran in the reality of his experience whilst also taking the edge off the veteran's experience of going mad, it would be better to use a phenomenological understanding of the effects of war on the psyche as explicated by Lifton (1988. See section 2.6), than to use the diagnosis as found in the DSM III-R. Neil's response to my explanation of PTSD reflected both condescension and disbelief. He said that I made it sound so clinical, which a diagnosis does. What was important in this instance appeared to be both the confidence that I had in understanding the clinic picture, as well as the honesty to acknowledge that a clinical diagnosis is pitifully inadequate in the face of experience. This appeared containing enough because Neil moved from a disdain of the diagnosis into the brutality of experience.[1]

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[1] **I have a query in my mind, although nothing to substantiate it, about whether Neil began describing the brutal horror of his experiences in order to shock me, and show up any complacency I may have felt in believing that a diagnosis is sufficient to account for where he had been.**

The use of other texts on PTSD can be of value; however I would suggest that books such as Michael Herr's *"Dispatches"* will be of more use than any academic work. The difference being that the experience remains tangible and can be identified with, rather than explained away.

5.6.2 "DERESPONSIBILITISATION"

Again the process is semi-educational in that explanations are made and links are drawn to show how everyday events will remind him of traumatic events which will in turn trigger off the emotions associated with those past events. In showing how an article in a newspaper on "necklacing" reminds him very powerfully of the real necklacing he witnessed and the feeling evoked by that event, helps to contextualise the seemingly "inexplicable" catharsis in the University cafeteria. This is what Beck would call "deresponsibility" (Parson 1984) whereby the veteran is taught to accept explanations for his behaviour in terms of the environment from which he came rather than judging his actions along moral and self-condemnatory lines.

Neil struggled to accept these explanations and at times it was necessary to intervene very actively to deter him from acting on his impulses, as was the case when Neil wanted to physically assault his "irritating" friend who reminded him of a soldier whose casual attitude allowed somebody to die.

This process continued throughout the therapy, but at a more profound and embroidered level, becoming much more than a simple technique. At a much later stage in the therapy, Neil was shown how he bound himself to his traumatic past and how he refused to distinguish between somebody running down his university corridor and somebody charging towards his army bungalow to kick the door open and wake them for an emergency. To acknowledge the difference would have meant to feel the pain of the past and just how much he had been affected by it. It would have meant to stop getting so angry, not only at the world but also himself for seemingly being so different from everyone around him, and to confront the reality of his hurt. It meant a fundamental shift in attitude towards himself, where feeling hurt was not something to be despised, but was

an acceptable emotion under all the circumstances. It meant understanding himself and not criticising himself.

In order for Neil to grasp what he has been doing to himself required a confrontational yet simultaneously understanding intervention from myself where I pointed out in unambivalent terms how he was behaving, how it was affecting his relationship with his world, and what he had to do to change it. This intervention was very directive yet simultaneously understanding because it was grounded in a reality where the choice of recovery was made squarely Neil's responsibility. I acknowledged how difficult a process it was, yet for therapy to be effective, he had to make a similar acknowledgement, and be willing to try. By showing him that he could indeed control his feelings, if he chose to, therapy was important in getting him to work actively towards his own health, as well as, upon discovering that he could control the feelings, improving his self-esteem and allowing him a sense of being able to manage better in the world.

Finally, the process was graphically illustrated by the hydraulic drill episode (see section 4.10.16 **[Jasmine and Hydraulic Drills]**), where we were actively able to distinguish the emotions that were evoked in him, and work towards a more effective way of containing them. More important was to instill in him the recognition that the world was full of reminders of his experience, but that he was the one now capable of controlling his feelings, rather than the prior helplessness he felt when it seemed that the experience controlled him.

5.6.3 IRRATIONAL BELIEF SYSTEM

The value of the cognitive techniques is that they allow the veteran to focus on the present dimension of his life without succumbing to the potentially overwhelming anxiety of his combat experience. In so doing one encounters a myriad of problematic belief systems which still operate in civilian life. Recognition and management of these beliefs allows for a better understanding of the veteran's world, as well as a means of challenging and confronting how these beliefs contribute negatively to the veteran's civilian adaptation.

Initially Neil held steadfastly to his belief that if he cried, he would not be able to function, if he did not function, somebody would die.

Working through this belief required an acknowledgement that "everybody" had already died, and that now it was time to mourn their deaths. That it was OK to cry, that it was normal to cry, and finally that nobody had ever died from crying, that he wouldn't either, which meant he would not stop functioning.

A more entrenched belief was that he was a "nut" (see section 4.10.13 **[The Woman and the Nut]**) because of what he was feeling, and although this attitude was also constantly challenged, the revoking of the belief required a fundamental change from Neil in his attitude towards himself and his suffering. A shift from a punitive and self-condemnatory stance, to one of caring and understanding. These belief systems occurred in virtually every facet of Neil's life, including his perception of the world as being filled with uncaring, indifferent people; that he was entitled to behave the way he did because of what he had been through; basically culminating in a recognition that his perception of his own experiences as being filthy and unacceptable was a large component contributing to his sense of isolation.

The use of cognitive techniques in aiding Neil to regain control over his world and move towards a greater sense of reintegration proved invaluable in this instance.

5.7 THERAPEUTIC REQUIREMENTS

5.7.1 PREPARING TO LISTEN

The horrors Neil described are subjective to him alone. Whether all combatants with PTSD suffered a similar exposure is unlikely. Needless to say, a therapeutic capacity to endure and suffer alongside Neil was essential in effectively containing the impact such atrocities had on him.

Advice to any therapists who intend working with war veterans is that they should, as Parson (1988) put it, begin sharpening their personal instrumentation, as they can expect to encounter horrors on a scale not thought possible. Images of revulsion, disgust, grotesque discomfort, and immense pain and despair are some of the sensations experienced, it being difficult to prepare oneself for any single horror.

The first time that Neil did divulge the content of his experience, the horrors were innumerable, and of such unspeakable violence that any one of them could have served to have precipitated some kind of stress response reaction. Yet he recounted them with a certain impassivity, his voice indeed like a ticker-tape from Hell. As a mortician would label cadavers, by tying a string around their big toes, so it was that Neil needed to label his deaths, his experiences. That one individual should suffer so much seemed beyond cruelty. Parson (1988) described the therapeutic relationship as being the primary means by which the veteran regains touch with his stricken emotional world, and enhances the control needed to mature beyond it. Lifton (1988) sees the struggle to reconnect with the "great chain of being" as one of the most poignant and difficult aspects of the recovery process.

Of necessity this requires the therapist to remain in touch with his or her humanity and his or her own pain. The session being referred to (see 4.10.3 **[Deaths behind the nightmares]**) contains such a unique moment. The surfacing from the blood of Neil's pain and reminding him of the tape recorder switching off is a very simple gesture, as most human gestures are, yet it is this humanness that carried us forward to that most simple yet most profound human attribute - the ability to cry, and this is what Neil needed to do.

Accompanying the recognition of the pain, and the realisation of Neil's suffering there was an additional need for myself, as therapist, to have access to a space where I could also unload. The use of supervision in this respect proved invaluable in both providing me with a structure from which I could draw support as well as being a gauge upon which the intensity of the therapy could be measured. The difficulty of merely listening to such atrocities was vividly illustrated by the reaction of my class in the supervision session.

5.7.2 "PSYCHIC NUMBING"

The absence of any tears, any real feelings in the onslaught of human carnage as Neil described it reflects what Lifton (1988) refers to as "psychic numbing". It was as though Neil remained symbiotically fused with his experience, the deaths of the thousands represented his own death, to grieve for all of them was an impossible task. It was for the loss of himself that he had to grieve, the loss of his innocence and his own psychic death. To do that he had to separate himself from the "deaths". Separation is a loss. He needed to be allowed to grieve his losses without any further loss to himself.

What is significant in this instance is that Neil returned to a state of "psychic numbness" even after the trauma work, which involved massive waves of feeling. He felt contemptuous of the world of others, was dismissive towards his family, had no faith in relationships, nor any compassion for the feelings of others. Lifton describes this as basically "... the self being severed from its own history, from its grounding in such forms as compassion for others, communal involvement, and other ultimate values (1988)." The influx of feeling as seen in the "flooding" is the indicator of the humanness that remains beneath the numbing dislocation. It is the work of the therapist to remain in touch with the humanness and constantly serve as reminder to the veteran of his presence.

5.7.3 THERAPIST AS CONTAINER

Parson says that the therapist is required to become a "powerful fool-proof container" for the veteran's drive-dominated inner world (1988). Parson describes this as a process in his model of treatment, calling it the "Consolidation-Stabilisation" Phase (1984; 1988. See section 2.7.2.2). Basically what begins occurring is that the relationship between veteran and therapist becomes more real. As such the validity of the therapeutic frame begins to be tested. Wilson (1987) points out that the therapist must expect to be tested as the veteran is suspicious of all relationships, particularly one that seems to imply authority, and will test the limits in many ways including intimidation, acting out, non-attendance and the like. Subsequent to my discussion of the diagnosis of PTSD with Neil, he did not arrive for two sessions. I became very anxious, and at one point felt that he may have

attempted suicide. However, once having overcome, what I regard as my personal anxiety as a beginner therapist, reflected that it probably had to do with further rebuke of my persistence at reducing his condition to a set of clinical symptoms. Saretesky notes that "veteran's desire the 'perfect container' and are emotionally oblivious to the fact that the most they can realistically expect is the optimal functioning of the 'imperfect container' (1981)."

5.7.4 THERAPISTS RISKING THEMSELVES AS HUMANS

Parson says that the therapist's basic stance is one of continued openness with the veteran, "maintaining an empathic-introspective attitude, that is balanced by an observational attitude and a flexible approach. The therapist must be willing to risk himself and become aware of the potentially destructive countertransference impediments to the work (1984)." The therapist must be prepared to be real, and be willing to communicate that realness.

Perhaps the most extraordinary coincidental moments of the entire therapy occurred when I recognised the dream-figure of Jan Simons. In recognising the figure, I implicitly recognised the pain, and by so doing confirmed its realness. It was no accident that the following sessions were characterised by the massive upheaval of all the pain, so descriptively, undeniably present in the dream. Despite serving as a trigger for Neil's emotional release, this single incident had significant implications on the whole therapeutic process.

Up until this point, Neil's and my relationship could be defined as such: Neil was the brutalised protagonist while I was the concerned onlooker. My role thus far consisted of either containing the feelings evoked by the experience, or facilitating those feelings. The focus was that this was Neil's experience, Neil's alone. There could be no sharing. The very brutality of his world seeming to demand that I remain excluded from it. Whatever my feelings were they had no place in the room. War had no place for human beings.

However the profound poignancy of his dream, and my dramatic link with the dream-figure had significantly altered those roles. I became at once, fellow combatant, spurious ally, informed story-teller. For the first time it felt as though we were communicating. I could feel myself relating rather than just intervening. For a moment it seemed as though Neil could allow himself the feeling that he was not alone, that there was a possibility of a lasting relationship containing care and kindness emerging from the purulent backdrop of his immediate past. That session was the prelude to the real war to come. The therapy room became the battlefield, a real link between past and present, with myself as the medium.

By admitting my knowledge of the war, a real intimacy was achieved, a significant deepening of rapport resulted and provision was made for the emotional flood to come; simultaneously it laid the groundwork for incredible anger, resentment, suspicion and fear. I became an ambiguous mixture of that which he needed yet simultaneously loathed. I was someone who knew the pain, could understand, would listen to him, yet also, I was an enduring symbol of all those who he held directly responsible for his predicament: the officer, uncaring, unfeeling, contemptuous of Neil and his ilk.

5.7.5 THE TRAUMA WORK

Sessions ten and eleven (**Childdeath; A World of Death**) undoubtedly comprised the trauma work. In the space of two sessions Neil accessed with profound anguish some of the deepest moments of human suffering and despair. He touched on a vast spectrum of human emotions, many of which others do not experience in a lifetime. The moments represented true chaos in which he oscillated from extreme despair at the waste of human life, to virulent anger that he should be the one suffering so. These were almost psychotic moments in which his ears were filled with the screams of the dead, and he had to withdraw. There were moments of indescribable grief in which his entire being was racked by the suffering of humanity. His guilt and self-condemnation is overwhelming and I had to all but physically restrain him from injuring himself. And there were moments of pure lucidity, in which Neil understands all that he has been through.

Parson (1984) describes the trauma work as forming a definite phase in his model, something which is pre-planned and follows a particular process in recovering the buried memories and accessing the accompanying emotion. He uses a combination of hypnosis and guided imagery in reaching the experiences and then subsequently assimilating them.

The therapy with Neil contained no such preplanned structure. Nor were any specific techniques employed in precipitating the emotional flood, such as an approach/avoidance technique using systematic desensitisation/relaxation exercises combined with implosive type therapy, or any form of guided imagery. Certainly no hypnotic techniques were used.

It seemed inevitable that the emotional pain accompanying the brutal savagery of his experiences would have to form part of the therapy; that it would erupt in ceaseless waves seemed equally inevitable. That it was made possible for it to happen can be attributed primarily to the Jan Simons dream (see 4.10.8 [**Dreampain**]), where the profound depth and excess of emotional pain first announced itself in human form, in stark contrast to the broken, battered, "objectified" corpses that had so far haunted the room. The reality of the pain is given additional impetus by both my recognition of the dream-figure, and my understanding that the pain essentially resided within Neil.

Finally I must return ultimately to myself, for within my commitment to helping Neil, lay my courage to carry it out. I held the fundamental belief that the intensity of his pain, no matter the volume or the duration, was justified by the horrific nature of his experiences. That is was his right, as it would be anybody's who has suffered so, to feel the way he did, and grieve for as long as necessary, and I would be willing to stand by that right. In the same way, I stood by my right to mourn what it was I felt inside myself, once the session was completed. To be completely honest, one had to be completely human. There was no time for rules.

The moments at the end of session eleven (see 4.10.10 [**A World of Death**]) represented a resurgence of my anxiety as a beginner therapist. Such was the dramatic intensity of the session that I feared for Neil's safety over the weekend. I felt that I needed to see him to make sure that he was OK. Neil, I feel, interpreted this as me implying a weakness

about himself and his ability to look after himself. He was reluctant to accede to the suggestion and I amended the arrangement accordingly, arranging a time where I would be available if he needed it.

I believe this form of crisis intervention provided relief for both Neil and myself, whereby Neil could feel intact enough to leave the room, knowing that help was available if he needed it, whilst I experienced the relief of both providing the helping space, whilst simultaneously communicating my faith in Neil's own strength and resources.

A similar communication transpired prior to the July holiday, where telephone numbers of people who could help were provided, and he was encouraged to regard seeking help as a caring and responsible thing to do, and not as a weakness. However this was an issue, as already discussed, which Neil had ongoing difficulties and will not be further considered at present.

5.8 TRANSFERENCE RELATIONSHIP

The ambivalence mentioned in the previous section remained present throughout the rest of the treatment. Neil approached therapy with a mixture of resentment as well as reluctant dependency. Often his behaviour outside of therapy seemed to point to the fact that therapy was useless and not helping; he continued to get angry at, and feel isolated from the world; other people's behaviour evoked enormous rage in him; relationships continued to disappoint him. His family and friends were either oblivious to his suffering, or did not understand it, and when he did tell someone, like his girl friend, they reacted with horror and then shunned him. Implicit throughout was the communication that the therapeutic relationship was not working, but it was all he had. That effectively he was damned. Pointing out to him how his own attitude towards his suffering was a major contribution to his continued pain, he initially responded with remorse, becoming small and complacent in the room, yet later seemed to experience contempt and resentment at having to come at all, regarding therapy as punitive and persecutory. Fuelling this vacillation of attitudes was his deep-seated ambivalence towards myself, his therapist. Parson writes "... through the self-other mutuality of the therapeutic relationship, all other

self-other configurations in the veterans experience stemming from before, during and after the war are examined in both transference and non-transference spheres of the relationship (Parson 1988)." It must be pointed out that Parson is referring to ongoing therapy of some three-and-a-half years duration, whilst Neil's therapy constituted just over seven months. Nonetheless transference issues were distinctly present in Neil's and my relationship, and whilst it can be argued that they were not sufficiently resolved due to time constraints, their presence still had significant impact on the treatment process. Neil was shown how his expectation of rejection filled him with condescension and suspicion towards others, an attitude which he invariably communicated, which they in turn reacted to, leading them to tend to avoid him. In showing Neil how he needed to change his attitude towards himself, he came to experience greater self-control which improved his self-concept, which in turn allowed him to become more open in relating to others.

What needed to be separated and made quite distinct was the horrific nature of his experiences, from the impact such experiences would have had on him. His "girlfriend" played a vital role in making that distinction. She was angry and disappointed in Neil, not because of the experiences that he had shared with her, but because of the way he behaved towards her afterwards. This could be used to show how dramatically and literally Neil saw himself as being disgusting because what he had experienced was disgusting. The shifting of these attitudes was a vital aspect of the recovery process as it demanded that Neil acknowledge there could be a different reality to the distorted and hopeless vision he clung to - illustrating Lifton's point that "to be literally bound to a traumatic experience is to permit oneself no psychic vitality in relationship to the experience itself and to limit vitality in other areas of life as well (Lifton 1988)."

Another vital feature of the treatment was the discovery of Neil's way of relating to my being an officer. Whilst this did not come as a surprise to me, it did seem to prominently highlight how a tendency to cling to the experience in its most literal form leads to invariable limitation on all forms of subsequent relationships. An officer/soldier relationship is necessarily circumscribed by militaristic ceremony. By imposing such a structure on therapy, the most important consequence was that it kept Neil as a soldier, and therefore unable to move beyond his experience. My interpretation of the transference, my own

rejection of the notion of being an officer, allowed Neil to explore what it would be like to not have to relate in terms as dictated by his traumatic past. The outcome was a significant improvement in his social functioning, a deeper involvement in aspects of his life that were important to him, and a gradual resurgence of vitality and concern for not only his emotional wellbeing, but the wellbeing of others. The therapeutic relationship ultimately provided a different way of seeing himself and a different way of relating.

An understanding of the narcissistic vulnerabilities evoked by the impact of extreme trauma on the veteran's self is particularly useful in working through the transference and grasping how the therapeutic relationship provides the means for the organisation of a new psychic structure by the veteran; however this is a vast area of debate and will not be considered at present. Needless to say, such an understanding can only lead to a deeper and richer experience of the therapeutic relationship.

5.9 THE CHILD AS SYMBOL OF REBIRTH

Lifton writes that "one could define the traumatic syndrome as the state of being haunted by images that can neither be enacted nor cast aside. Suffering is associated with being stuck. Hence the indelible image is always associated with guilt, and in its most intense form, it takes the shape of an image of ultimate horror: a single image that condenses the totality of the destruction and trauma and evokes particularly intense feelings of pity and self-condemnation in the survivor (1988)." Neil would often chastise himself for having "let others die", or even accuse himself of having killed them. His guilt seemed not only irrational but also completely unfair. Certainly the most painful moment in the whole treatment occurred when he lamented the death of the child, the child who died in his arms; and perhaps the most brutal moment occurred when he smashed his fist into his own face, blaming himself for having caused the child's death. The contrast between the two experiences was marked.

The first experience evoked an entirely human reaction, the pain of all those who died becoming centred around this experience of a solitary child's death. There is nothing more vulnerable and in need of protection than a child, and there is little else that shows up the

barbaric nature and violence of war more than when a child is killed. Neil accessed this awareness in the most painful way, his grief a shout of the most profound despair. Simultaneously this experience gave rise to the most abusive and seemingly inexplicable guilt and self-condemnation.

In this instance what required recognision, understanding and containment was that there really was nothing that Neil could do. His feelings resulted from the tragic consequence of being placed in a situation where he was impotent and helpless. His immense guilt was a reaction against this experience of helplessness; the child in his arms was helpless and the child died. Helplessness is equivalent to death, so rather than acknowledge his helplessness he would condemn himself for living and blame himself for the child's death. Neil's fantasy was that if he were a doctor, or had somehow the skill to save the child it would have been different. Lifton refers to this as "failed enactment" whereby the veteran, whilst simultaneously experiencing the horror of the incident, also has an anticipatory plan of action to remedy the situation, and failing to do so, suffers the consequences for that failure indefinitely.

This profound experience of guilt is not something essentially resolvable. Guilt is integral to the human experience, as it is from the experience of guilt that one draws the necessary insights into the morality of our actions, how they affect ourselves and others. As such guilt is necessary ambiguous, and it is this aspect that facilitates a movement beyond the stuckness that characterises traumatic guilt. Lifton writes that "... it provides the possibility of finding some alternate enactment for the image that haunts one, of undergoing personal transformation around that image (Lifton; 1988)." Neil had to recognise not only how much he had suffered, but also how glad he was that he was alive. Perhaps the most uplifting moment in the whole treatment was when Neil "welcomed himself back" (see section 4.10.19**[Rebirth: A celebration]**). He allowed himself the pleasure of living again, bringing both relief and joy.

5.10 A SHORT NOTE ON NEIL'S ISOLATION

The final phase of Parson's model is what he describes as the Reintegration-Cohesion phase (see section 2.7.2.4), in which the earlier aspects of the veteran's psychic past is examined and their contribution towards his present development is considered. The phase basically deals with the progression of therapy in healing the narcissistic wounds that afflict all those who suffer a sense of incompleteness about their lives. It is a long process, lasting years. As already mentioned Neil's therapy lasted only months, by the time the last session arrived, Neil had told only two people about the impact of the war on himself, his "girlfriend" and myself. There lie difficult times ahead in dealing with the world as well as inevitable disillusionment at the realisation that the war is a part of his life that will never properly heal, and that he may even need to seek help again in the future. That he will be able to recognise these struggles I have no doubt, actively acting on the need to resolve them may take more time. Nevertheless, despite these difficulties, Neil has come a long way, and has shown that he is able to utilise his own understanding of his experiences and apply it to the human condition. Vulnerability is a facet of human experience that is often largely hidden. To suddenly come to an awareness of one's vulnerability can be both shocking and profoundly painful. Neil has a deep insight into that experience, and possibly with time and patience, that insight may mature more fully to enhance his whole life.

5.11 FINAL CONSIDERATIONS

In every therapeutic process there occurs a difference between the methodical, well-differentiated outline which the theory provides, and the direction of the organic flow of the actual therapy. Invariably, however there are points where the two converge and issues discussed in the theory become illuminated, and are deepened by their occurrence in practice.

In the initial phases of Neil's treatment, I had no particular theoretical model in mind, nor any specific strategies which I intended to employ. My understanding was simply that Neil had a particularly painful and brutal story to recount, and that he needed the time and the

space to do it. That some kind of emotional catharsis would occur seemed inevitable. The point that needs to be emphasised is the need of the patient for time and space. In this respect, the opening phase of Parson's model, the Stabilisation-Maintenance phase (see section 2.7.2.1) is very useful. He cautions against premature exploration of the internal impact of the actual trauma, and advocates instead an approach which focuses on stabilising the ego functions of the veteran. The value of such an approach is that it allows the veteran to gradually build up faith in the therapeutic environments, as well as instilling in him the realisation that there is ***no hurry to get better***. The therapeutic space is not a military environment in which one lives according to orders that need to be carried out immediately, and where one's life is dictated by rigid methods and routines, deviations from which, punishment or worse would follow. The communication is thus that the space is his or hers, and is solely for their benefit. In this respect I would caution against being too active and filling the therapeutic space with techniques and homework tasks as advocated by Parson. Instead the pace must be determined by the veteran, and one must be flexible and relatively unstructured in the utilisation of cognitive restructuring techniques.

Furthermore, Parson delineates between the Stabilisation-Maintenance phase (see section 2.7.2.1) and the Consolidation-Stabilisation phase (see section 2.7.2.2) as two separate processes, the first referring to the stabilisation of the veteran's ego, whilst the second, following on the first deals with the growing therapeutic relationship, emphasising the importance of the therapist being someone the veteran can relate to. I believe the separation to be an artificial one and would not distinguish between the two as clearly as Parson does. I feel that the vehicle upon which the treatment rests is in the relationship between therapist and patient, without which the first phase of implementing cognitive techniques could not be properly effective.

Parson adequately stresses the importance of the therapeutic relationship, highlighting how this relationship provides a vital means of understanding the way in which the veteran's relationship with himself or herself has changed.
This is the most vital aspect of the treatment and in this respect both Parson and especially Lifton prove invaluable sources in understanding PTSD. Lifton's (see section

2.6.1) constant emphasis on the impact of Death on the veteran's sense of self is essential in grasping the implications of massive trauma on the human psyche.

This was an aspect I came to understand only in the later stage of the therapy, and it shaped the direction the therapy was to take. Healing required more than the purging of the painful affect, it required also the integration of that which gave rise to these violent and destructive emotions.

An important point with regards to Lifton's theory, is that his work is a rich and eloquent metaphor on post traumatic stress disorder, and as such must not be taken literally. To simply provide a veteran with the insights offered by Lifton would amount to nothing less than a negation of the horror of the veteran's experience, much the same way as purely behavioural techniques seem to do, but probably less effective. Lifton offers no specific methods in working with post traumatic stress disorder, yet he provides an awareness which is profound and rich and from which the therapist can draw inspiration and then convey in the form of courage to the veteran.

In conclusion whilst no specific model was undertaken when working with Neil, indeed the objectives, the techniques, suggestions and goals of both Lifton and Parson were both included and achieved. There was extensive cognitive restructuring whilst engaging with the impact the traumatic experience had had on Neil's self, and the whole process was located within the ebb and flow and gradual growth of the therapeutic relationship.

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