Dialectic of War Trauma

Maciej Zbyszewski

Abstract

The paper refers to the theoretical and clinical analysis of work with homogeneous groups on the example of war veterans group therapy. In particular, the specificity of psychological content developed by veterans referring to traumatic experiences related to the uniqueness of the war is explored. The conflicts and needs of people who live in a chronic state of separation from contact with civil society are subject to analysis. Such phenomena as the durability of traumatic memories and the isolation and loss of of common values are examined.

Keywords: homogeneous group, war veterans, mourning, reintegration

It was 08 August 1918. The Battle of Amiens had just begun. Two British soldiers sheltered themselves in a shell crater. Suddenly one of them, a young twenty-year-old captain, realised that his companion's chest was torn and his left lung was gone. Gusts of steam billowed from the horrible void in the soldier's body as he kept asking the vomiting captain with a desperate voice:

''Mother, Mother, write to my mother, sir, won't you? You'll remember her address, sir, won't you?"
''Oh for Christ's sake shut up'', shouted Bion, revolted and terrified.
''Write to my mother, sir, you will write to my mother, won't you?''
''Yes, for Christ's sake shut up.''
(Souter, 2009)

After this terrifying event the soldier was transported to a place for the wounded where he soon passed away. His commander lived but was left with an acute feeling that part of his self had died and remained forever on the battlefield. The British Army captain was Wilfried Ruprecht Bion.

74 years later Ronnie Janoff-Bullman (1992), a psychologist dealing in PTSD, coined a "theory of shattered assumptions" to explain the onset, development and persistence of post-traumatic stress symptoms. According to this theory, a traumatic experience shatters the victim's assumptions that the world is benevolent, predictable and meaningful and that the self is worthy. Destruction of these views leads to a state of disintegration manifested in the feeling of mental catastrophe, with the world no longer perceived as a safe, just and benevolent place.

Bion's understanding of his experience related to the events of 8 August and their psychic consequences seems to show several analogies with the construct of mental catastrophe as described by Janoff Bulman. Commenting on Bion's reminiscences, Souter (2009) describes them as follows: In the course of the traumatic event Bion

exhibited a strong reaction to stress, being forced to protect his mind by rejecting his companion's projection (symbolic vomiting) in order to ensure his own physical survival. To survive his companion's death and terrible demands Bion had to eliminate the part of his self that was capable of accompanying the other man in the face of his annihilating projections, thus becoming a zombie or machine. In other words, the refusal to admit the feelings related to horror and fear of death incapacitated his ability to love, entrapping him in hatred of self and the world, in which madness was intermingled with sanity (Souter, 2009). Thus, as a result of trauma he lost the ability to be a container.

This experience led Bion to formulate some very significant conclusions on the nature and consequences of trauma. Bion believes that a person in extremity needs the sympathetic presence of another mind that would "modify the baneful force of emotion" related to a frightening experience, making the fear of death tolerable. Rejecting communication – like in Bion's war experience – brings "nameless dread." The ability to think when faced with horror and suffering makes psychic survival possible. Bion continues to say that psychological isolation equals emotional torture because "intermind experiences are the basis of normal human function and an absolute requirement *in extremis*." In this way, being human means being open to the "intensity of psychic experience", like a simple gesture of a soldier asking his captain to write a letter to his mother. This openness requires heroism and courage. As Bion's story shows, courage in life-or-death combat may be something altogether different than the courage to take another person's suffering. The twenty-year-old Bion showed immense bravery when he jumped on top of a tank under enemy fire, and yet he wasn't able to muster enough psychic courage when faced with the horrible plight of a comrade-in-arms.

However, it seems that Bion's most original war-related discovery was that the relationship between soldiers being in constant danger has something in common with the relationship between mother and child – namely, extreme emotional dependence. It is significant that, on the brink of death, Bion's companion called his mother, expressing the desire of presence of another human being. In both these relationships one's survival depends on the other person's acts.

This concept is Bion's undeniable contribution to understanding the relationship between mother and child. As concerns war, it seems that Bion's discovery can also be employed to understand characteristic clinical phenomena that appear in work with soldiers who experienced war trauma. These phenomena may seem strange to a therapist who starts working with war trauma. They include a strong intimate bond between soldiers, united in the experience of combat, and the so-called survivor guilt (persistent feelings of guilt after witnessing a comrade-in-arms being wounded).

Before we consider these phenomena in detail let us reflect on the nature of war experience. In clinical practice, veterans' memories are characterised by lack of verbal narrative and context. Sometimes these reminiscences are perceived as series

of images without context. For war in its very nature carries the burden of strangeness, as these words of a soldier show:

For the common soldier . . . war has the feel – the spiritual texture – of a great ghostly fog, thick and permanent. There is no clarity. Everything swirls. The old rules are no longer binding, the old truths are no longer true. Right spills over into wrong. Order blends into chaos, love into hate, ugliness into beauty, law into anarchy, civility into savagery. The vapors suck you in. You can't tell where you are, or why you're there, and the only certainty is overwhelming ambiguity. In war you lose your sense of the definite, hence your sense of truth itself, and therefore it's safe to say that in a true war story nothing is ever absolutely true (Judith Herman,1997)

Bion (2015) too mentions this specific strangeness of war experience, writing about "*hideous*" closeness, with dead and living, animal and man, food and excrements all mixed together. Physiology-laden reminiscences of Afghanistan mission soldiers serve as an excellent illustration of this concept.

Due to social processes this strangeness remains isolated from common experience (unless of course war *is* a common experience), and participants of combat are assigned a special status of individuals knowledgeable in the mystery of war. Such soldiers often feel that no civilian – woman or child in particular – can understand their experience of being confronted with evil and death. They view civilians with a mixture of idealisation and contempt: ordinary humans being both innocent and unaware. Themselves, they perceive as higher, but at the same time defiled, persons; those who broke the killing taboo (Herman, 1997).

These processes are reflected in therapy, particularly in emotions aroused in contact with a veteran, like helplessness and mute terror, but also feeling special to be in the presence of mysterious knowledge, inaccessible to ordinary mortals. Also, it seems that veterans' frequent reaction "*You weren't in Afghanistan, you're not going to understand*" can be seen not only as a sign of resistance but also as the actual untranslatability of war experience into words or impaired verbalisation following a traumatic event.

However, war trauma is, above all else, the collapse of existing internal order due to intermingling contradictory experiences. Soldiers' war stories tell us that feelings of mental catastrophe can happen to victims and perpetrators of violence alike. Often the mere perspective of witness can lead to trauma, like in the moving story of a veteran who experienced breakdown when confronted with living conditions of locals, especially children. But the core nature of war trauma is psychic chaos and undermining of existing beliefs, brought about by intermingled experiences of victim, perpetrator and witness in the face of a spiral of violence.

Relating their life-or-death events, veterans also speak of a state of frenzy, driven by aggressive and sadistic impulses (inaccessible to consciousness in most everyday situations) whose scale can also be a terrifying experience. Having become aware of these impulses, particularly when they have been a driving force behind destructive

actions, one feels like crossing a line beyond which there is no return. The following quote from a veteran may illustrate this point:

And then I saw them die. They weren't people to me, just targets to eliminate, as many as I could. And when you shoot a man he doesn't die like in the movies – it's painful agony. Sometimes I wanted to finish them off. What I saw made me think: "Am I really on the good side? I'm an occupier and they're defending their country." Back from action, it would take me a week to recover. I saw other soldiers act in frenzy, as if they were on drugs.

Soldiers in combat share the experience of constant danger of death mixed with the experience of violating the rules of the civilised world, made all the more surreal by the intensity of events. In these circumstances it's crucial to retain the feeling of safety, which only a group can guarantee. As a result, group members develop very strong bonds based on extreme dependence, with the survival of an individual soldier inseparably tied to the survival of the group. This is why:

In fighting men, the sense of safety is invested in the small combat group. Clinging together under prolonged conditions of danger, the combat group develops a shared fantasy that their mutual loyalty and devotion can protect them from harm. They come to fear separation from one another more than they fear death (Herman, 1997).

Veteran stories often contain references to special rules or rituals, adhered to in particular combat groups. One of the most common has it that the number of soldiers going to action must equal the number of soldiers who return, whether alive or in a body bag. In the experience of a combat group, leaving a dead companion on the battlefield is a very traumatic and bond-destructive event.

The sense of a specific intimate bond is a recurring theme in soldiers' accounts, nostalgically expressed by the phrase "*We ate from one plate*." Veterans frequently give the impression that they feel closer and better understood amongst their companions rather than in the relationships with their wives or partners. Emergence of bonds is related to the needs of safety and coherence, but it can also serve as major gratification. This is especially dangerous in the case of soldiers whose life stories are marked by attachment trauma – the experience of closeness with comrades-in-arms can function as reparation but, on the other hand, can make them long to go on a mission again. This often makes adapting to the everyday life more difficult.

As a result of the extreme emotional dependency between individual and group, which Bion compared to the mother-child relationship, a combat unit undergoes a sort of fusion on the battlefield. Ranks and insignia formally still exist but are annulled in daily dealings. The sense of hierarchy and distance, present in barracks, disappears. However, this situation may lead to an internal conflict between group loyalty (expressed in declared readiness to give up one's life for a colleague) and individual will to survive, often kept unconscious.

Specific intimate bonds created on the battlefield are reflected in therapy culture, especially in homogeneous groups consisting solely of veterans. In such groups

members usually, within a short time, develop a strong sense of loyalty, which helps them to achieve mutual understanding and open themselves to therapeutic processing of trauma. And although veterans frequently complain about symptom increase following the start of therapy, they also mention a kind of euphoria of finding themselves in the experiences of others.

Thanks to the sense of fellowship they can fairly quickly delve in their war past and bereavement. In these groups emotional temperature soars high during sessions and the overwhelming intensity of traumatic memories triggers strong feelings of terror and helplessness. Some therapists (Herman, 1997) speak of traumatic transference, characterised by intensity and lack of distance incomparable to feelings that appear in ordinary therapeutic experience. Working with this kind of transference, the most important aspect is the capacity to contain traumatic memories. Veterans find it very difficult to trust the therapist before they are convinced that she or he is able to withstand the intense images of war.

Additionally, mutual loyalty translates to observance of the rules of therapy. Veteran-only groups surprisingly quickly internalise set-out norms and take the setting very seriously. Perhaps one of the reasons is perceiving the therapist as a commander and associating rules with orders.

Nevertheless, this kind of approach to the setting is conducive to trust, openness and empathy, but also makes it easier for patients to encourage one another to take up the challenge of facing one's own trauma in the course of therapy. When a patient reconstructs his story, its details almost always trigger personal associations in the listeners. Combat mission participants are very tolerant towards one another, even though during sessions they often bring up memories that contradict the stereotypical image of soldier (a strong and fearless commando), such as losing control of bodily functions under stress. This phenomenon is best illustrated by words of the oldest veteran in a group of 12, who thus summed up another patient's account: *"There ain't no man tough enough to help it..."*

Slightly different processes take place in heterogeneous groups that contain, alongside veterans, patients who have no army connections and suffer from other disorders than PTSD. This is a chance for veterans to overcome the social isolation of their experience and eventually rebuild the sense of social belonging, destroyed by trauma. In such groups, veterans can assume the perspective of their families, for whom a husband's or son's participation in a war mission is a taxing experience on its own. For instance, the presence of a veteran and his deceased companion's mother in one group can bring intense feelings.

On the other hand, a strong intimate bond between veterans in a heterogeneous group can be very destructive for therapeutic process. This was the case with a group in which one member, a person of Islamic descent, triggered associations with the feeling of danger. Veterans' mutual loyalty quickly turned into collective hostility towards this man, which made therapy work impossible.

The existence of strong intimate bonds between veterans coincides with a frequent phenomenon in therapeutic practice – survivor guilt. Losing a group member with whom one shared a relationship based on extreme emotional dependence is a traumatic experience that triggers uncontainable feelings of helplessness, resentment and sorrow. In response, feelings of guilt appear, manifested by obsessive thoughts on alternative ways of action in a traumatic situation. As Herman (1997) aptly comments:

Guilt may be understood as an attempt to draw some useful lesson from disaster and to regain some sense of power and control. To imagine that one could have done better may be more tolerable than to face the reality of utter helplessness. Feelings of guilt are especially severe when the survivor has been a witness to the suffering or death of other people. To be spared oneself, in the knowledge that others have met a worse fate, creates a severe burden of conscience. Survivors of disaster and war are haunted by images of the dying whom they could not rescue. They feel guilty for not risking their lives to save others, or for failing to fulfil the request of a dying person.

On the one hand, the mechanism of persistent feelings of guilt has its foundation in personality and earlier traumas (unnecessarily war-related). On the other, it fits in the logic of conflict, associated with the specific character of war trauma, where feelings of guilt and fantasies of giving up one's life for a colleague block the joy of survival. This is a situation when under the conscious attitude expressed by the phrase "*I would give up my life for him"* an unconscious fantasy is hidden: "*I'm happy that it wasn't me*." The difficulty to accept consciously this "*terrible*" fantasy often makes survivor guilt the most problematic symptom to work through. Frequently a veteran who in the course of therapy recovers the ability to communicate his feelings retains a distorted perception of reality, manifested by magical thinking about his influence. The following clinical illustration may serve as an example:

The patient – a participant of an Afghanistan mission – was a thirty-year-old officer from a nuclear family (parents in a good relationship, 4 brothers). "*As a child he would get into trouble and always get away with it*". His lifeline was fairly smooth, the patient had graduated from a technical university and married shortly after studies. Before the mission he hadn't used psychiatric or psychological help. He hadn't experienced any serious traumas either, although there had been a taboo in his family about his uncle's suicide over a love affair. This is how he characterised himself: "*What am I like? Mean, inquisitive, technical mind. Black was black, white was white. I try to explain things clearly. Combination of inquisitiveness and meanness. I like sticking to rules*."

He went on the first mission for financial reasons. With the second one, "*he jumped in himself, because he felt like it*." It was on the second mission that the traumatic event happened. Soldiers were spending their usual time in the smoking room when a rocket attack started. Acting on instinct, the patient dashed towards the bunker, disregarding

the fact that he was leaving his subordinates in the smoking room. The attack left several people seriously wounded, one heavily.
Back at home, he returned to work. After six months he developed symptoms of post-traumatic stress. This is how he described his state:
We were on the firing ground... Somebody played the Afghanistan alarm sound on his mobile... I totally went apart. My friend saw that – he's my friend now, we were just colleagues back then. All I remember is I just kept sitting and didn't care about anything around me, chain-smoking cigarettes... I didn't care about anything... Hard to say... I don't know how long I went on like that... helplessness. I don't think I was in this kind of state before.
My hobby died... Cars. I liked getting my hands dirty working on a car. I'm still thinking if I should take it up again. I don't have any dreams... Small plans at the moment, I would say. My focus is on my wife, my son... Going on holiday at last. But I've always liked to have something definite – date, place, things to do.
I've reached my targets. Having a family, a home. But I also feel there's something missing... having a wife, a son. Family is a long-term thing. One part of me is technical, the other – emotional. I think I want to focus on the technical part now.
During therapy the patient was absent-minded. There was almost no eye contact. Utterances were broken, with long pauses and intervals of suspension, when he would sigh with his gaze fixed on the floor. Asked where his thoughts were, he would reply *"miles away*." Speaking, he would often break out into crying.
In hospital environment the patient took part in both group therapy (including veterans and civilians) and individual therapy (twice a week). Within a fairly short period of time his symptoms reduced, making it possible for him to function normally on a daily basis. However, his group therapy activity had two facets. Throughout most of the time he exhibited a good grasp of reality, whether commenting on utterances of others or giving accounts of his life. This would change dramatically when he started speaking about his traumatic event, whereupon the magical belief in his influence surfaced while he wallowed in his suffering. Simultaneously, he communicated with other group members from the position of a very strict superego, playing the role of an "accuser" and confronting them with negligence or departure from rules. Despite several therapeutic stays the patient's feelings of guilt tended to remain on the same level. His greatest therapeutic achievement was accepting his will to save his life at the moment of the rocket attack.
It seems that regardless of an analysis of patient's personality structure – which can certainly facilitate understanding the persistence of symptoms – realising the meaning of, and inherent conflict within, relationships between soldiers on the battlefield helps to face destructive consequences of trauma.

References

Bion, Wilfried, R. (2015). *War Memoirs 1917-1919*. ed. Francesca Bion. London: Karnac.

Janoff-Bulman, Ronnie (1992). *Shattered Assumptions: Towards a New Psychology of Trauma*. New York: Free Press.

Herman, Judith (1997). *Trauma and Recovery*. New York: Basic Books.

Souter, Kay, M. (2009) *The War Memoirs: Some origins of W.R. Bion*. International Journal of Psychoanalysis 90: 795 – 808.

Maciej Zbyszewski: Institute of Group Analysis "Rasztów"; Cardinal Stefan Wyszyński University in Warsaw

Email: maciekzbyszewski@yahoo.com