

Engaging with military trauma in former conscripts: Dilemmas and opportunities

The struggle of man against power is the struggle of memory against forgetting.
The book of laughter and forgetting. Milan Kundera.

Introduction

I am a general practitioner in Johannesburg. I work in private practice but am attached to the Wits department of Family Medicine. I provide teaching services as a field tutor, and I hold an honorary Wits appointment at the Wits Donald Gordon Medical Centre.

I was conscripted into the South African Defence Force (SADF) in 1985 and 1986 after I had qualified as a doctor. After six months of military training I was deployed to various places by the army as a medical officer. I spent three and a half months on the Border, and was exposed repeatedly to direct danger in the combat zone and also to the terrible casualties of war. In this I was privileged by my education and profession because many school-leaving conscripts drafted after high school spent a full 18 months on the Border. For 22 years I completely buried all memory of this time, although my experiences had given me a hatred for the policies of the Apartheid state and the lengths to which it was prepared to go to maintain itself. I came back to civilian life with the determination to put all of the experience behind me, to make it as if it had never happened.

Paradoxically I also came out with a deep drive to assist the victims of detention and torture by the security forces. Ironically my first readings into Post Traumatic Disorder (PTSD) were to enable me to better understand and assist these patients. When I started to get flashbacks from my time in the SADF, and the time on the Border this started a process which saw me reflecting and trying to understand the nature of PTSD on my own account:

I wrote a master's level Research Report on data from a cohort of former conscripts who had matriculated from my own high school over the 15 years of active warfare on the border¹. I later co-wrote an article detailing my major finding which was published in the African Journal of Psychiatry².

Systematic literature searches revealed that this is the only published article in a medical journal on PTSD in conscripts from the South African Border War. I have only found one research report funded by Atlantic Philosophies on the prevalence of PTSD in former ANC and APLA cadres³. This is striking. The phenomenon has been referred to as 'official amnesia' reinforced by war veterans' self-imposed silence' by Professor Gary Baines⁴, but it seems to me to amount to a tacit national amnesia project. This silence has implications for healing and moving on not only for the ex-combatants from both the former liberation and security forces, but also for our descendants.

I began the research as a kind of logotherapy for myself. But I have moved on from that. I have come to see the research as central to support and interventions with traumatised patients. I also believe that it is important to challenge the silences, to

document the horrors and the horrible long term outcomes of war. I would like to write clearly against war. I have come to realise that the war has affected not just my generation, but my daughters as well, so I also write for the healing of my descendants and their peers. I believe it has the potential to contribute to a neglected aspect of reconciliation.

Structural issues

What do conscripts really think today?

Conscripts are in the view of some, a hangover from the past, the relic of a defeated army and ideology. There is almost no scholarly data available on what opinions the silent majority of conscripts hold. We have some idea what is being said on internet chat rooms and websites such as ~~armytalk~~ set up by veterans. But one researcher for the End Conscription Campaign (ECC) pointed out that the total number of people on the internet chat rooms is in the region of 6500 to 7500, well short of the 600 000-odd conscripts in the cohort. And there is no way of knowing just how many of those who express some very intemperate opinions are actually former conscripts. A number of former conscripts joined the ECC, and we have some idea what they thought of their time in the SADF, but again there has been no scholarly attempt to determine the precise numbers of these.

What is the state of conscript mental health?

I have already noted that my tiny study is the only attempt to answer this question, and then only in the narrow confines of the definition of PTSD. In the light of the lack of data regarding the mental health of our former conscripts and also of the former liberation fighters I think it is relevant and important to look at the literature from the extensive bank of research into the Vietnam veterans.

Parallels between the Vietnam War and the South African Border War are many and were implicitly understood by conscripts even during the Border War⁵. My own study showed a prevalence of PTSD in a conscript cohort comparable to that of the enormous and seminal National Vietnam Veterans Readjustment Study (NVVRS).⁶ Many of the indices measured in my study showed remarkable correspondence with the NVVRS data.

Key conclusions of the study indicate that the condition is extremely long lasting and prone to relapses over time⁶. A number of high-quality studies reflect the same truth^{7-9 10}. Studies from other wars show identical trends: these are studies of Israeli conscripts from the Lebanon War¹¹ and WW II veterans¹². Former conscripts and liberation army fighters can be expected to have to live with the fallout for the rest of their lives.

Resources

Funding for the care of both former conscripts and former liberation cadres is lacking. The military hospitals have been providing care and medication for sufferers from severe PTSD from the former SADF since the 1980s. This care has been dependent on their meeting criteria for being 100% permanently disabled by PTSD and for convincing an unnerving panel of assessors at 1 Mil. For *these* men there is provision for appropriate medication by the outpatient clinics, although there is no

preparedness to liaise with medical and allied medical professionals outside the military and no access to counselling or therapy.

For the former liberation fighters who were not absorbed into the new South African National Defence Force (SANDF) there was no provision until 2007 when the Mkhonto we Sizwe Military Veterans Association (MKMVA) received recognition and funding as a payback for their support of the successful presidential aspirations of President Zuma. The memory of their service has perhaps dulled but whatever the reason funding has dried up while a large percentage of the money set aside for MK veterans has reportedly been stolen by office holders¹³.

A Military Veterans Act enacted in 2011 set up the South African National Military Veterans Association (SANMVA) and provides access to healthcare, subsidised public transport, education, skills and job training and burial support, among other things, for those who served on both sides of liberation conflicts from 1960. It is only since *this* date that former freedom fighters *and* former SADF combatants have access to medical cover at 1 Mil and other military hospitals based on an income assessment. According to Military Veterans Deputy Minister Kebby Maphatsoe the current basic veteran's grant is R3200 per month¹⁴. As of writing at least two of my patients who applied for benefits have yet to receive acknowledgement from the ministry.

In this setting any healing intervention is dependent on the private resources of the individual: access to medical funding, the income and education to access the available therapists and information, the quality of his support network, and his personal resilience.

Mutual support is the only real resource for many former conscripts and one such resource *is* the internet which functions to provide platforms for advice on matters like PTSD as much as to validate their identities as war veterans¹⁵. Unfortunately the value of this resource is arguably diminished because some members of these groups still adhere to Apartheid's ideology.

For few years between 2000 and 2004 there was an attempt to set up mutual self-help groups modelled on the Alcoholics Anonymous 12-step programme under an organisation called the South African Veterans Association (SAVA). The success of this initiative was dependent largely on the charisma and stamina of the founders, two ex-parachute battalion conscripts¹⁶ and it failed because it became exhausting for the group leaders and it was felt that some of the ex-combatants needed expert professional therapy.¹⁷

Repeat trauma

The problem is compounded by the exposure of conscripts to repeat trauma in the form of the endemic violence in South Africa¹⁸. To this is added a constant barrage of violent images in the news¹⁹, in films and in video games and other media. Repeated exposure to these violent memes has been shown to aggravate the effect of the initial trauma²⁰

Stigma of seeking help

The stigma of having a mental illness is a profound drawback and has been cited as an important reason why former soldiers avoid seeking psychological help²¹.

Perhaps the only group that has succeeded in overcoming this perception is the Vietnam veterans. It appears to me important that we re-phrase this disorder, or group of disorders as a normal response to an extreme event.

Theoretical issues

Debates around the nature of PTSD

Within medical discourse there are evolving and conflicting understandings of the nature of PTSD. While these need to be examined, they do not reflect the ways in which I view my patients and their struggles. The medical language is clinical, distancing, inadequate and reductionist. I use these constructs where they serve my patients, but I retain a sense of each person's unique humanity.

The paradigm shift in moving from a stigmatised understanding of psychological and mental health problems was a long time in coming. During WW I the diagnosis of ~~Battle Fatigue~~ or ~~Shell Shock~~ became an accepted term in psychiatry and known to be the result of prolonged exposure to combat. Remarkably little was written for more than twenty years when the psychological injuries of WW II soldiers demanded treatment. But it was only in 1980 that the Diagnostic and Statistical Manual (DSM) III included the diagnosis of PTSD. Since then the diagnosis has been refined and re-worked categorised as a mood disorder. A number of diagnostic instruments have been established over the years based on a succession of manuals notably the DSM III and the DSM IV TR. In 2013 the DSM 5 has placed the diagnosis in its own chapter entitled ~~Trauma and stress-related disorders~~

However even within the medical world there are controversies around the diagnosis and treatment of PTSD. An alternative set of diagnostic criteria has been published in the World Health Organisation (WHO) International Classification of Disease version 10 (ICD-10). There has been criticism of the DSM's approach, most notably from the National Institutes of Mental Health (NIMH).

The NIMH regards the DSM conceptualization of mental illness as an unscientific collection of descriptive ~~word pictures~~ based on clusters of clinical symptoms without reference to biological markers of disease. This implies that many treatments are based on ~~whatever works~~ and reasons for the success and failure of treatment are not clear. In addition ~~mortality~~ has not decreased for any mental illness, prevalence rates are similarly unchanged, there are no clinical tests for diagnosis, and this means that detection of disorders is delayed well beyond generally accepted onset of pathology, and there are no well-developed preventive interventions²².

The NIMH initiated the Research Domain Criteria (RDoC) unit in 2009 to guide an entirely new approach to mental health research based on developing behaviour-based scoring systems allied to neuroimaging, genetic and epigenetic markers. It will be some time before it influences interventions for assessment and healing.

Significant mental health issues outside of the PTSD label

But PTSD is not the only outcome experienced by returning soldiers. A further 11.1% of male veterans in the NVVRS had partial PTSD. In addition, ~~interviews~~ conducted with the spouses or partners of Vietnam theatre veterans with and without PTSD revealed that PTSD has a substantial negative impact not only on the veterans own

lives but also on the lives of spouses, children and others living with such veterans⁶
pxvii-xviii, Research in former liberation fighters in the South African context bears this
out^{3 23 24}. This means that for a clinician the problem of medical and health outcomes
involves a much larger cohort than the prevalence statistics for PTSD suggest.

The society that soldiers return to often finds it difficult to accept them back. One reason is that returning soldiers had put their education and their lives on hold to go and fight. The men who return are not the same as the ones who left. Many are difficult men, emotionally distant, shunning former friends, prone to fits of rage, using alcohol and other drugs to sleep, or even to escape into oblivion. While many came back with a sense of increased discipline and determined to throw themselves in study or work to forget the military past, a high percentage no longer had the internal balance to be able to study. In many cases marriages and relationships broke up, not once, but many times.

Demobilisation, disarming and re-integration program

After all wars the state sets up a demobilisation, disarming and re-integration program (DDR). For all the ex-combatants the various governments have been quick to attend to the first two, to remove the danger to political stability, but have done little to see to the last. For research regarding this process in South Africa see the work of Gear, Mogapi and Naidoo^{24 25 26}

Spirituality

One of the proximate experiences which set the scene for PTSD is nearness to death and a deep, inescapable knowledge of one's own mortality. This usually involves responses of intense fear, helplessness or horror and meaninglessness. This awareness inevitably initiates a process of searching for meaning. Soldiers often come to a point where they have rejected religious beliefs they were raised with, and are deeply offended and enraged by attempts to corral them back into platitudes of established religion which have often become empty after experiences of combat and war. But they often need to search quite deliberately for something that makes meaning of their experiences for them. I have found it helpful to reframe spirituality in non-religious terms.

There are many definitions of spirituality in the literature. Astrow et al defined it as ~~the~~ the search for transcendent meaning+ which can be expressed in religious practice or expressed ~~exclusively~~ exclusively in ~~õ~~ relationship to nature, music, the arts, a set of philosophical beliefs, or relationships with friends and family²⁷ Canda and Furman defined spirituality as referring to ~~a~~ a universal quality of human beings and their cultures related to the quest for meaning, purpose, morality, transcendence, well-being, and profound relationships with ourselves, others and ultimate reality.^{28,p95}

Traumatized soldiers need to rediscover some form of faith on a journey of recovery: a faith that includes ~~centres~~ centres of value; images of power; and master stories (Fowler quoted by Sacco 1995^{29,p110}). This understanding of faith provides both a goal and a template for getting there. For example a centre of value may be breaking the silence around the trauma of conscription. An image of power might be interconnectedness and shared story-telling. A master story might be Odysseus in Homer's epic.

Moral injury

Another aspect of spirituality that deserves attention is an injured morality. Litz et al introduce their article on moral injury with the explanatory words: Service members are confronted with numerous moral and ethical challenges in war. They may act in ways that transgress deeply held moral beliefs or they may experience conflict about the unethical behaviors of others. Warriors may also bear witness to intense human suffering and cruelty that shakes their core beliefs about humanity³⁰. Another study noted the presence of moral repair.³¹ Further attention needs to be paid to ways of encompassing this.

Traumatic memory: denial, repression, dissociation

There is a wide literature regarding the problems with our memory of traumatic events. I mention some points which have particular reference to the problems with traumatic memory. These cause difficulties for the traumatised person, because having an altered memory of events, he or she can never learn from them.

Goleman³² quotes Freud: the essence of repression lies simply in the function of rejecting and keeping something out of consciousness. This implies keeping items out of awareness, items that evoke psychological pain^{32,p112}. He goes on to note that Painful moments or dangerous urges are repressed in order to ease the burden of mental anguish. But the tactic is only half successful: the pains so defended against skew attention and exert a warp on personality. The subtle menace of repression is the silence: the passing of a pain out of awareness sends out no warning signals; the sound of repression is a thought evaporating.^{32,p113}

Leslie Epstein, a journalist researching a book about the Holocaust became aware that he felt guilty about the callousness and distance he felt from the terrible material: What I noticed first was a lack of responsiveness not so much to the horrors of the past but to those occurring around me. [many disasters listed] what I did was take a series of notes. The world was stale, flat it was not the calamities of the day that rolled off my ducks back like water, it was all manner of pleasures as well (Epstein quoted by Goleman). Goleman comments: There is a price, though, for striking such a bargain. What's more, it doesn't work so well and the repressed fear and loathing leak out in disguise, blemishing innocent thoughts^{32,p113-5}

According to Freud the penalty for repression is repetition. Painful experiences not consciously dealt with are, unconsciously, repeated. [and] attentional schemas shape the deep structure of personality^{32,p113-5p146}. It therefore is important to understand that with repression there is a full declarative memory sequence which the unconscious shields us from, but with therapy one can learn to access fully.

Lenore Terr's case studies of traumatised patients illustrate the deep destruction of memory which is called dissociation³³. Dissociation is a kind of self-hypnosis, a willing of oneself away, and so there is no narrative memory. There are images: images that may be in the form of sound, smell, position or spatial sense, which are powerfully informed with emotions such as misery, despair, fear and wishing to die. There may also be a history of behaviours which alert the therapist to a dissociated subtext. These are linked to implicit (embodied, non-verbal) memory, particularly if the trauma was repeated often. There are also behaviours observed during the therapeutic interview which reflect back to the trauma. A dissociated memory can never be fully retrieved to form a coherent narrative.

Masculinity and aggression

Boys, (particularly those of us raised in the militarised South Africa of the 70s and 80s) are moulded and encouraged to be heterosexual, aggressive, authoritative and courageous men. Competing and dominating, winning, are admired qualities. In this context trauma as a loss of control over oneself can be seen as a failure in masculinity, a failure to conform to one's self-conception and one's expectations and assumptions about one's relationship with the world.³⁴ The consequences of this insight are far-reaching. In order to heal, former conscripts must re-formulate a new type of masculinity.

The masculinity we learn can be augmented in the crucible of combat and the military environment to uncontrolled aggression. The exercise of violence and the abuse of strength or obsessively seeking exposure to danger can become appetitive³⁵. This has profound implications for healing from the war.

Mainstream interventions

The treatment of the returning soldier is a highly complex and still contested terrain. The Veterans Affairs hospitals and infrastructure in the USA have provided most of the evidence for what works and what does not, but their efforts to hone on *one* and only one protocol I think is doomed. The psychological and spiritual damage that returning soldiers carry back with them; whether it qualifies as PTSD or partial PTSD or simply as a pervasive sadness and distress is deeply complex. Judith Lewis Herman writes *in general, the diagnostic categories of the existing psychiatric canon are simply not designed for survivors of extreme situations and do not fit them well. The persistent anxiety, phobia, and panic of survivors are not the same as ordinary anxiety disorders. The somatic symptoms of survivors are not ordinary psychosomatic disorders. Their depression is not the same as ordinary depression. And the degradation of their identity and relational life is not the same as ordinary personality disorder*^{36,p118}

Psychotherapy

This is a contentious terrain, with a huge body of published data which has yielded a host of important insights. Although I proceed to list the most effective therapies, which are seldom available in South Africa, I feel that the most success is achieved by therapists who are eclectic and versatile and client-centred in their approach. The conscript and the liberation fighter who left to fight carried with him his own unique baggage of traumas and strengths and these *must* influence the approach. The conditions caused by combat and by the warping of nature inseparable from the military mind-set will also be modified by the inevitable stresses and trauma of return to civilian life. It is Herman again who points the way most succinctly in the second chapter of her book.

She says: *Recovery unfolds in three stages. The central task of the first stage is the establishment of safety, a shift from unpredictable danger to reliable safety. The central task of the second stage is remembrance and mourning, moving from dissociated trauma to acknowledged memory.*

In the second stage of recovery the survivor tells the story of the trauma. [He] tells it completely, in depth and in detail. This work of reconstruction actually transforms the memory so that it can be integrated into the survivor's life story.

The central task of the third stage is reconnection with ordinary life, moving from stigmatised isolation to restored social connection. She examines processes of re-education, learning to fight, reconciling with oneself and reconnecting with others.³⁶

The academic and research literature is confusing and contradictory but has been moving toward the following consensus:

Trauma focussed Cognitive Behaviour Therapy (CBT), Eye movement desensitisation and reprogramming (EMDR) and to a lesser extent Stress Management therapy are the most supported by evidence-based research.^{37 38} EMDR involves focusing on the traumatic memory while simultaneously focusing on an external stimulus such as the rhythmically moving finger of the therapist. This reduces the emotional distress associated with the traumatic memory and reduces associated negative cognitions. However Albright and Thyer have recently cautioned that the adoption of EMDR as the second most supported treatment is premature. They note that while there are good studies evaluating EMDR for PTSD linked to rape, disaster exposure and civilian trauma, it is not yet supported for combat or military PTSD by the same evidence-based criteria.³⁹

There is less evidence for psychodynamic and hypnotherapy-based interventions.⁴⁰ I feel that this is an overstatement: there are going to be occasions when the unique needs of the client demand treatment using the different lens of these treatment modes.

Logotherapy

Psychiatrist and WWII concentration camp survivor Viktor Frankel developed a form of therapy known as logotherapy, or healing through meaning. This is usually regarded as an adjunct to the above therapies, but has the advantage that the locus of control remains in the hands of the traumatised former conscript. Frankl believed that people, at their core, are motivated by a need to find meaning in life. Logotherapy is future-oriented, focuses on personal strengths and places responsibility for change on the patient. It harnesses the human potential to transform suffering into human achievement and guilt into meaningful action. Employing specific techniques, such as self-distancing (learning to gain distance from and observe the self), paradoxical intention (wishing for or doing that which is feared), Socratic dialogue (interviewing designed to elicit the patient's own wisdom), and dereflection (redirecting attention from the self toward other people or meaningful goals), logotherapy promotes the adoption of a radically optimistic view of human potential and the ability to transcend the self through pursuit of meaning that is specific to one's own life.⁴¹

Pharmacotherapy

Drugs such as anti-depressants play a role in stabilising symptoms such as insomnia, anxiety, impetuosity and aggressiveness. They have invariably had a limited effect on improving the symptomatology of PTSD. At present paroxetine or duloxetine have the strongest empirical support for depression and anxiety, risperidone for aggression and impetuosity, and trazodone for insomnia.

Expanded interventions

These are modalities which share the characteristic of being inexpensive. They have little backing in terms of randomised controlled clinical trials. Perhaps rather than having a proven efficacy they come from a long tradition of inherited practical wisdom. They are also accessible to sufferers from the various levels of trauma-related stress and the stresses of living in a society characterised by endemic on-going violence.

Daily aerobic exercise

I advise my patients to exercise daily for at least a half hour. There is interesting theory but not much valid science behind this: Stress causes a range of hormonal events triggered by the release of hormones such as cortisol and the catecholamines such as adrenaline. Substrates including fats are released into the blood for energy as the body gears up for fight or flight. Exercise uses these up and further toxic substrates are sweated out. Studies do show that exercise decreases anxiety. A recent review article has confirmed objective improvement in outcome for PTSD.⁴²

Wilderness journeys

There is an account in the literature of the outcome of an ecotherapy approach funded by a Non-Governmental Organisation used for a cohort of former Self Defence Units and Self Protection Units. This was the National Peace Accord Trust founded in 1994. Eco-therapy aims to help individuals understand and create meaning from the emotional and psychological difficulties they are experiencing by forming a relationship with the natural world. This enables participants to make better sense of their inner emotions and life experiences. Those who have developed ecotherapy believe that a wilderness area, in its natural state, facilitates the experience of healing. Eco-therapy stresses the importance of the relationship between the human psyche and the natural environment. The wilderness frames the challenge of overcoming trauma. Eco-therapy is premised on five psycho-therapeutic principles:

- ~ the wilderness is healing
- ~ trauma is stored in the body
- ~ eco-therapy helps shift social beliefs that shape behaviour
- ~ eco-therapy incorporates local African culture and ritual; and
- ~ eco-therapy provides the best results when you spend time preparing the participants before the trail and debriefing them when they return²³

Alasdair Little and Wilhelm Verwoerd have been conducting interventions they describe as Journeys through Conflict with a number of former enemy groups.

Massage and Body-Mind interventions

As a clinician I have to find interventions which are accessible to sufferers who have not the resources to access psychotherapy. These must be inexpensive and within the reach of most former conscripts. They include body stress release, dance, Yoga, Tai chi, and massage. There are practitioners in most cities and many small towns and their charges are modest. Many of these interventions can be learned and practiced at home without further costs. There is not much quality academic literature regarding these interventions for military trauma nor will there be: there is no funding for his kind of research, it will not yield the profits that developing a drug or surgical appliance can do. Nonetheless, there is some work in the field reported in the literature.^{42 43}

Future themes

Trans-generational transmission of trauma

There is an established literature on this subject. There has been research into the children of Holocaust survivors, the children of WW II and Korean War veterans, and the children of Vietnam War veterans. There is no doubt that the legacy of the trauma is transmitted down the generations. This happens even if, perhaps especially if, we stay silent. Our children need to hear these stories in order to understand how this country has come to be, at once marvellous and fractured, open-hearted and violent. We hope that if we work on ourselves today, we can limit the damage to our children and grandchildren.

Resilience and Post traumatic growth

Resilience means the ability to bounce back and is essentially an evolving construct. Resilience is not static, it can be worked on and enhanced. It changes over time.

Studies into resilience have been commissioned by the military in an effort to discern which recruits are more prone to PTSD at the outset and to reduce the psychological damage afterward. They have failed to learn from their own research: Correctable issues such as scheduling a finite short period of deployment to the combat zone, and keeping the units of men who trained together and know and trust each other together, both during and after deployment have been ignored in the Afghan and Iraq theatres of war.

For therapists and clinicians the studies of resilience have generated insights into factors that promote resilience and factors that reduce it. Trauma therapy has to make use of these insights in modifying cognitions, actions and reactions.

Post traumatic growth refers to positive changes reported by veterans as a response to trauma. Outcomes reported include being more optimistic, being better able to distinguish between what was important in life and what was trivial, developing a rich inner life, being able to be more flexible and able to relinquish the need to control.

A related area of study is the study of coping. In the military situation problem-focussed strategies are linked to better health outcomes: keeping busy, maintaining personal hygiene, working hard, stretching the envelope. Emotion-focussed coping is associated with poorer outcomes. These are coping strategies such as wishful thinking, denial and withdrawal. In the therapeutic situation veterans can be assisted to recognise poor coping strategies and consciously replace them with better ones.

Reconciliation

Throughout this document I have referred in tandem to the issues affecting the conscript cohort and the returned freedom fighters. I think that this is important. To understand the trauma and the strengths of both and to provide spaces for their stories to be told and become part of our national discourse is essential to not repeating our divisive and violent history. In previous presentations to groups consisting of former combatants from the liberation struggle and from the ECC I have been astonished and encouraged by the sense of mutuality, warmth and understanding that emerged afterwards.

During the CAR debacle it was also heart-warming to see that former conscript and ex-permanent force parabrats came to the fore to denounce the way their black successors had been treated and to provide support in terms of money and logistical support to the families.

Closing remarks

In this paper I have traversed a range of dilemmas in the field of working with the military trauma of conscripts and looked at some opportunities that may arise from them. For me, psychologist and former conscript Roger Brooke summarised my thoughts most succinctly by posing the following questions. As yet they have no answers, but they summarise the core of our dilemma, and point to the opportunity that is fast vanishing:

1) How many South African soldiers on both sides of the conflict from the 1970s and 80s suffer from combat trauma? Do we have carefully researched numbers?

2) How many are in need of redemption ..? More and more veterans have been travelling to Angola to visit old battlegrounds and, it seems, to pay their respects and to seek a certain peace.

3) Is there any possibility of recognition and respect, even redemption, across the lines of former enemies? Some white veterans simply feel the enemy won, and their bitterness has not shifted at all, but there are instances at an individual level where reconciliation has happened. I know one paratrooper who became a close friend with a work colleague who had been on opposite sides of the same operations in the bush war. Their sense of shared experience far outweighed their history of having tried to kill each other. They drank a beer to each other for having both survived.

4) How many veterans feel betrayed by our politicians, both then and now? The sense of betrayal might be a surprisingly shared experience across great ideological differences: white Afrikaner professional soldiers who feel their leaders sold out, and/or who feel unappreciated for their continued support for the military in the new South Africa; national servicemen who feel that their sacrifice and continued psychological distress were meaningless; former Angolan 32 Battalion soldiers who swore allegiance to South Africa, and who were promised in return, the benefits of South African military retirees; Umkhonto we Sizwe fighters who politically won the war in South Africa, yet who may feel their political leaders are abandoning them and their communities. There needs to be some cultural room for the narratives of sacrifice and betrayal so that lessons may be learned.

5) Can our current political leaders follow the example set by Nelson Mandela and other statesmen, which is to honour those soldiers who fought on the wrong side of history, but who were nevertheless defending South Africa in the terms they understood? That is to say, how can we recognise and honour those veterans who were confused by the old Nationalist propaganda, which deliberately and cynically conflated defence of South Africa with defence of Afrikaner Nationalism and apartheid?

6) Can we as a society find room in our cultural and political discourse for the lessons learned by our old soldiers across the political spectrum? ⁴⁴

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