PSYCHIATRIC MORBIDITY IN PAKISTANI PEACEKEEPERS AND THEIR PERCEPTION ABOUT DEPLOYMENT IN LIBERIA

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ABSTRACT

Objective: To identify the Psychiatric morbidity among personnel deployed in Liberia and to explore their perception about the deployment.

Study Design: Descriptive study

Place and Duration of Study: The study was carried out at in the United Nations Peace Keeping Mission in Liberia from December 2007 to December 2008.

Subjects and Method: Sources of stress, positive and negative perception of the deployment were recorded on a semi structured proforma along with demographic characteristics of subjects. The General Health Questionnaire-28 was administered to identify case-ness.

Results: One hundred seventy two non – commissioned officers participated in this study. All of them were males. Their ages ranged from 23 to 51 years with the mean age of 30, 2 years (SD =6.3). The most common sources of stress for all personnel were the lack of recreations (46.5%, 57.1% respectively).This was more so for singles. Almost half of married personnel rated separation from home and family to be the source of maximum stress. Approximately eighty three percent (50% +32.56%) had positive perception of the deployment on comparison to nearly sixty-four percent (50% + 13.59%) who had negative perception. Married personnel had more likely than singles to have negative perception of the deployment (70% vs. 54%).11% (n=19) of studied personnel scored high on GHQ who were later subjected to present state examination and diagnosed using ICD-10. About 25% (n=5) were diagnosed to be suffering from depressive episode mild with somatic features (F32.1) 50% (n=9) were diagnosed having Anxiety disorders. About 25% (n=5) had emotional and behavioural disorder associated with use of Medicine (Mefoloquine).

Conclusion: Lack of recreational facilities, separation from family and risk of getting infectious disease were common stressors. Financial advantage and professional grooming were positive perceptions. Depressive episode mild with somatic features and anxiety disorders were main psychiatric morbidities.

Keywords: Post Traumatic Stress Disorder (PTSD), Behavioural disorder, Anxiety disorders

INTRODUCTION

Peacekeeping missions set up new and different challenge to combat- trained soldiers. Although UN forces have traditionally fulfilled humanitarian roles and are not usually, engaged in active fighting, the nature of the conflict may nevertheless be highly stressful for many soldiers. The most frequently reported stressors included experiencing local unrest; encountering people suffering severe illness, starvation or mutilation; being bothered by incidents involving children; the quality of life of the local people; and feeling that one's freedom was restricted[1] Post-traumatic stress disorder and other psychiatric sequels after peacekeeping deployments have been associated with war stressors, frustration with peacekeeping tasks, and life events after the deployment[2] .PTSD was 8% among US soldiers served in Somalia and 15.2% among Vietnam War veterans[3].

The mental health of the peacekeepers themselves, which may have a negative impact on mission success, has received little attention[3] Psychiatric disorders occurring in peacekeeping workers have been recognized for long time[5]. Peacekeeper's stress syndrome is now formally recognized as a unique problem of UN peacekeeping[6] A variety of other psychiatric diagnoses or specific psychological conditions have also been reported as acute stress disorder, PTSD, conversion reaction, posttraumatic depression, alcoholism and drug abuse, somatization disorder and survivor's guilt syndrome'[3].

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Military deployments are generally thought about as negative events with potentially risky consequences. However, there is variation among soldiers and their family members relative to the beneficial or harmful outcome of deployments[7]. The positive or negative perceptions of the deployment experience may be linked to positive changes in the soldiers' personal experiences, their social relationships[2]

Psychological well-being was evaluated using the 28-item version of the General Health Questionnaire (GHQ), which was originally developed in the 1970s by Goldberg and Hillier as an instrument for identifying individuals with minor psychiatric disorders[8,9]. The aim of this study was to identify the Psychiatric morbidity among personnel deployed in Liberia and to explore their perception about the deployment Knowledge of such perceptions may facilitate a more comprehensive picture of deployment environment for soldiers and assist in not only devising selection procedure, screening protocols before deployment, maintenance of mental health during deployment and assessment protocols and structuring of interventions for soldiers and their families on repatriation.

SUBJECTS AND METHOD

This was a descriptive study based on data collected from the non-commissioned officers of the 5th Pakistani peacekeeping mission to Liberia, which was deployed from December 2007 until December 2008. This includes 72 personnel serving at PAK MED V and 100 in PAK CON V. One hundred seventy two took part in this survey. Individuals participated voluntarily and gave informed consent. The General Health Questionnaire (GHQ-28) was administered to identify general mental health and case-ness.

The deployed personnel were asked to identify sources of stress and satisfaction "respectively" perceived during deployment. These responses were reviewed and then classified to six common sources, each was given a score as represented in (Table-1), Sources of satisfaction (Table-2) and Perceived impact of deployment (Table-3) and GHQ Case-ness (V) categories.

RESULTS

Of the 172 soldiers, 109 were married and 63 were single. The majority (46.5%) reported having secondary school education. Approximately 42% were in the rank group of Sepoy. The ages of responders ranged from 23 to 51 years with the mean age of 30.2 years.

Table-1 showed the common sources of stress among personnel in Liberia. The most common overall sources of stress were lack of recreations (46.5%), separation from home and family (39.5%) and perceived risk of infectious disease (27%). The same applied for single soldiers (57%, 23.8%, and 20.6% respectively). For married soldiers, separation from home and family (48.6%).lack of recreations, and perceived risk of infectious disease (40%, 31% respectively)

The most frequently cited source of satisfaction for all personnel was "Financial Advantage" (Table-2). Single soldiers, more often than married soldiers, reported both "Financial Advantage" (86% and 56%) and "Professional grooming" comment (21% and 16%). A few personnel reported satisfaction in the form of being more valued in the family and helping the Liberian people.

Table-3 illustrat the details of Perceived impact of deployment. Among these deployed personnel, almost 83% (n=142) reported positive impact of the deployment (50% + 32.56%) on comparison about 64% (n=110) of negative impact (50% + 13.59%). Both positive and negative consequences of the deployment were described by 50% (n = 86). Nevertheless, only positive consequences of the deployment were stated by 32.6% (n = 56) and only negative consequences were presented by 14% (n = 24). Singles were more likely than married ones to report positive consequences of the deployment (87% vs. 80%). On the contrary, married more likely to describe negative consequences [70% (52.3% + 17.43%) vs. 54% (46.03% + 7.94%)

It was found that 11% (n=19) of studied personnel scored high on GHQ who were later subjected to present state examination and

diagnosed using ICD-10. About 25% (n=5) were diagnosed to be suffering from depressive episode mild with somatic features (F32.1) 50% (n=9) were diagnosed having Anxiety disorders. About 25% (n=5) had Unspecified organic or symptomatic mental disorder (F 09) associated with use of Medicine (Mefoloquine).

Factors determining the distinguishing features of a PKO include the degree of enforcement, length of mission, amount of chaos, acceptance by the local people and attacks from the local force[3]. Bartone PT[12] has identified five dimensions of psychological stress for peacekeepers during the deployment

Table-1: Sources of stress among Pakistani Peacekeepers in Liberia.

Source of stress	Total N=172	Single n=63	Married n=109
Lack of recreations	80(46.5%)	36(57.1%)	44(40.4%)*
Away from home	68 (39.5%)	15 (23.8%)	53(48.6%) **
Risk of infectious diseases	47 (27.34%)	13(20.6%)	34 (31.2%)*
Language Difficulties with other nationalities	35(20.35%)	12(19.05%)	23(21.10 %)
Risk of secondary traumatization	30 (17.44%)	11(17.46%)	19 (17.43%)
Risk of violence by local people	26(15.1%)	9(14.29%)	17(15.6%)

A comparison of single and married soldiers: * - p<0.05, ** - p<0.001

Table-2: Sources of satisfaction

Category	Total (N=172)	Single a (n= 63)	Married a(n=109)
Financial advantage	115 (66.86%)	54 (85.71%)	61 (55.96%) **
Professional Grooming	30 (17.44%)	13 (20.63%)	17 (15.60%) *
More valued in the family	23 (13.37%)	2 (3.17%)	21 (19.27%) **
Helped the people of Liberia	16(9.3%)	5(7.9%)	11(10%)
Travel to another culture	14 (8.14%)	6(9.5%)	8(7.3%)

A comparison of single and married solders: * - p <0.05; ** - p< 0.001)

Table-3: Perceived impact of Deployment.

Consequences of Deployment	Positive impact	Negative impact	Total (N=172)	Single Solder (n=63)	Married Solder (n=109)
Only positive	Yes	No	56 (32.56%)	26 (41.27%)	30 (27.52%)
Only negative	No	Yes	24 (13.95%)	5 (7.94%)	19 (17.43%)
Both positive and negative	Yes	Yes	86 (50.00%)	29 (46.03%)	57 (52.3%)
Neither positive nor negative	No	No	6 (3.49%)	3 (4.76%)	3 (2.75%)

DISCUSSION

It is speculated that this study was carried out in a low –intensity conflict area, where the Pakistani troops did not engage in active fighting. In fact, we did not have a long-standing follow-up design since this is a brief cross sectional mental health assessment. Moreover, it is considered the Pakistani military has become very well prepared to conduct peacekeeping and peace enforcement operations, including preparing, educating, and supporting soldiers with respect to these unique demand and roles[10, 11].

period of the PKO: isolation (separation from home and family), ambiguity (role confusion), powerlessness (compassion fatigue and secondary traumatic stress), boredom (repetitive, monotonous routine and lack of recreations) and threat/danger (attack by civilians, local troops and the risk of spread of infectious diseases).

This study demonstrated the same range of stressors among the Pakistani troops in Liberia. Separation from home and family is a common source of stress, which may be increased by uncertainty about return dates, poor

communication home leading to both physical and psychological isolation[3] Danger may come from the risk of spread of infectious diseases such as Malaria, Lassa fever and AIDS. Overall, existing studies suggest that while peacekeepers exposed to a range of stressors, which appear to impact upon their mental health, the incidence of reported psychiatric disorders, such as PTSD, is low among UN soldiers[13,14]. On the contrary this study focused on peace keeping forces deployed on low intensity conflict area and not exposed to active war and its traumatic experiences therefore did not include Acute stress disorders and PTSD. The presence of 11% psychiatric morbidity in a peace keeping force deployed in a low intensity conflict area is significant feature in terms of problems faced by these personnel.

These statistics revealed that both positive and negative impact might result from any military peacekeeping deployment. Significantly, a considerable number of deployed soldiers (83%) reported at least some positive impact of deployment on comparison to 14% who reported only negative impact.

Table-3 shows the perceived deployment effect on soldiers whether they are single or married. Regarding negative impact, Single soldiers were more likely to report issues related to lack of recreations whereas married soldiers confirmed that missing their families was the most negative impact. Accordingly, these deployments have a differential impact upon soldiers, whether they are married or single. Therefore it is recommended that future studies should be focused on identifying the reciprocal factors in families as well.

This study is based on self-report data. Additionally, the categorization of the positive and negative perception was inferred from the soldiers' comments using the semi-structured interview. Moreover, it was impossible to obtain data from a non-deployed control group.

All the participants were males. However, other studies 15 revealed that the deployment effect in women is similar to that described in men. There was also a weak relationship between increased depression and female gender[15].

The redeployment effect was not examined in this study. Such experiences might confound with effects of trauma experience during military duty[1].

One weakness of this study is that 11% psychiatric morbidity may not be the result of stressors of deployment and may be pre-existing pathology. Another possibility of presence of personality disorder in the troops proning them to psychiatric illness. Other studies[16] confirmed that personality disorders seemed to contribute to poor mental health 1 year after returning home from a mission abroad. However mental health screening before troop deployment is not supported by current evidence as it is repeatedly failed to predict psychological vulnerability[17,18] Previous studies[19] confirmed that fear of stigma resulted in less than half of U.S. combat infantry personnel who developed mental health problems sought psychiatric treatment. The main deterrents were fear of being seen as weak and of being treated differently by officers[20].

The UN has worked on these problems since 1994 to provide stress management, press on training and enhance readiness of mission personnel, provided by the UN Staff Counsellor's Office[3]. These conclusions emphasize the need for a thorough understanding by research of the factors, which influence the psychological adjustment of military personnel who were deployed on peacekeeping duties. Keeping in view the perceptions and impact on personnel, new strategies should be evolved including pre and post deployment assessment, family interventions and interventions to reduce sources of stress such as lack of recreation and communication with family members and proper education and counselling regarding prevention of endemic diseases of mission area. Mental health professionals should be included in medical contingent sent of UN missions to address these psychiatric morbidities and stressors.

CONCLUSION

We can conclude that lack of recreational facilities, separation from family and risk of getting infections disease were common stressors. Financial advantages and professional grooming were positive perceptions. Depressive episodes with somatic features and anxiety disorders were main psychiatric morbidities.

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