Do Military Peacekeepers Want to Talk about Their Experiences? Perceived Psychological Support of UK Military Peacekeepers on Return from Deployment

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ABSTRACT

Background: Little is known about what support the United Kingdom (UK) armed forces require when they return from operations.

Aims: To investigate the perceived psychological support requirements for service personnel on peacekeeping deployments when they return home from operations and examine their views on the requirement for formal psychological debriefings.

Methods: A retrospective cohort study examined the perceived psychological needs of 1202 UK peacekeepers on return from deployment. Participants were sent a questionnaire asking about their perceived needs relating to peacekeeping deployments from April 1991 to October 2000.

Results: Results indicate that about two-thirds of peacekeepers spoke about their experiences. Most turned to informal networks, such as peers and family members, for support. Those who were highly distressed reported talking to medical and welfare services. Overall, speaking about experiences was associated with less psychological distress. Additionally, two thirds of the sample was in favour of a formalised psychological debriefing on return to the UK.

Conclusions: This study suggests that most peacekeepers do not require formalised interventions on homecoming and that more distressed personnel are already accessing formalised support mechanisms. Additionally social support from peers and family appears useful and the UK military should foster all appropriate possibilities for such support.

INTRODUCTION

Military personnel engaged in peacekeeping duties encounter numerous stressful situations and many of these stressors are very different to those encountered during conventional combat operations. Often peacekeepers are asked to operate under difficult and restrictive rules of engagement and have to deliver humanitarian aid amidst politically chaotic environments (1, 2). Research indicates that being subject to these stressors impacts upon well being, readiness and operational effectiveness (1). Studies have also

Greenberg, N. (2006) Do Military Peacekeepers Want to Talk about Their Experiences? Perceived Psychological Support of UK Military Peacekeepers on Return from Deployment. In *Human Dimensions in Military Operations – Military Leaders' Strategies for Addressing Stress and Psychological Support* (pp. 22-1 – 22-10). Meeting Proceedings RTO-MP-HFM-134, Paper 22. Neuilly-sur-Seine, France: RTO. Available from: http://www.rto.nato.int/abstracts.asp.

shown such stressors are associated with serious psychopathology including not only Post Traumatic Stress Disorder, (3) but also other psychiatric disorders such as alcohol problems, anxiety disorders and depression (4, 5).

In an attempt to mitigate some of the effects of these stressors, before 2000 the UK military conducted formal psychological debriefings for UK peacekeeping personnel who were exposed to traumatic events. This practice was stopped by the Surgeon General (the most senior UK military doctor) after emerging scientific evidence suggested that single session psychological debriefing is ineffective and may be harmful. This advice has been echoed by the UK Department of Health (6). Although the effectiveness of formalised debriefings following standard models has been questioned (7, 8) studies have shown a generally beneficial effect for peacekeepers who talk about their experiences on homecoming (9).

This paper examines the perceived psychological needs of UK peacekeepers on return to the UK, and whether these needs were met. The current study uses a sub sample of Peacekeepers drawn from a cohort that was originally examined in relation to the Gulf War of 1991.

METHODS

A questionnaire enquiring about Peacekeeping operations was sent out along with 3322 other questionnaires which were part of a series of follow up studies of the King's UK Gulf Cohort. Details of the original study can be found elsewhere (10, 11). The questionnaire aimed to explore the experiences of UK Peacekeepers who had been engaged on operation between April 1991 and Oct 2000.

Personnel were asked whether they had wanted to discuss their deployment experiences with anyone, whether they were able to do so and if so with whom Peacekeepers were also asked to comment on whether, looking back, they were in favour of a formal psychological debriefing following return from deployment. Peacekeepers were also asked to complete the GHQ-12 (General Health Questionnaire, 12 item version) (12) and the PCL-M (Post Traumatic Stress Disorder Checklist, Military version) (13).

ANALYSIS

Analysis of the results of the questionnaire was undertaken for the group who had returned questionnaires which reported at least one peacekeeping deployment during the study period. Chi Squared tests were used for categorical data and the independent samples T-test for continuous data. The Pearson Correlation coefficient was used where appropriate.

The main outcome variables (GHQ-12 and PCL-M) were calculated for each of the possible combinations of wanting to talk to someone and actually being able to talk to someone on return from deployment.[1] For each of the groups the outcome variable was compared to the rest of the sample group.

RESULTS

The overall response rate for the follow up study was 71%, (14). Of the respondents, 1202 of reported being involved with one or more peacekeeping operations. Although 3322 questionnaires were sent, it is unclear how many of those surveyed had actually been involved with peacekeeping operations. We know that 51% of those who sent back any information also included a valid peacekeeping questionnaire. If one

[1] The four groups were (1) wanting to talk and being able to, (2) wanting to talk and not being able to, (3) not wanting to talk but in fact talking to someone and (4) not wanting to talk and in fact not talking to anyone.

assumes that 51% of the original 3322 that were sampled had been involved with any peacekeeping duty, then the valid response rate for peacekeepers would be 1202/1694=71%.

GENERAL CHARACTERISTICS

The sample was composed of 84% (n=1008) men and 16% (n=190) women. 72% (n=862) were married, 80% (n=973) were still serving and the mean age was 36 (range 23-60). Many Peacekeepers had been on more than one deployment (range 1-7), although 83% of them had been on less than three deployments and only one percent had been on more than five, during the study period.

DID PEACEKEEPERS TALK TO ANYONE ABOUT THEIR EXPERIENCES?

On returning from deployment 525 (44%) of people wanted to discuss their experiences with someone. There was a weak association between not being married and wanting to discuss their experience (χ^2=5.99, d.f=2, p=0.05) but no association with age (t=0.12, d.f.=1174, p=0.90), gender (χ^2=5.43, d.f=2, p=0.07), number of deployments (χ^2=6.4, d.f=10, p=0.78), GHQ-12 score (t=-0.19, d.f.=1119, p=0.85) or PCL-M score (t=0.45, d.f.= 1170, p=0.66) and wanting to speak to someone about the peacekeeping experiences.

Approximately two thirds (n=760, 63%) reported speaking to someone about their experiences. There was no association between age (t=-0.88, d.f=1096, p=0.38), marital status (χ^2=0.4, d.f=1, p=0.84) or the number of deployments (χ^2=3.0, d.f=5, p=0.69) between those who spoke about their experiences and those who didn't. Females spoke about their experiences more than men (χ^2=23.1, d.f=1, p<0.001). Those who spoke about their experiences had lower scores on both the GHQ-12 (Mean score 13.3 v 16.6, t=-8.7. d.f.= 1045, p<0.001, CI -3.9,-2.5) and the PCL-M (Mean score 24.4 v 34.8, t=-13.1, d.f.=1092, p<0.001, CI-11.9, -2.4).

There were no differences in terms of psychological distress between those who wished to talk about their experiences and those who did not. However stratifying by those who did talk about their experience reveals significant differences, namely that those who did talk had significantly lower GHQ-12 and PCL-M scores than those the two groups who did not, regardless of whether they had an initial desire to talk to someone.

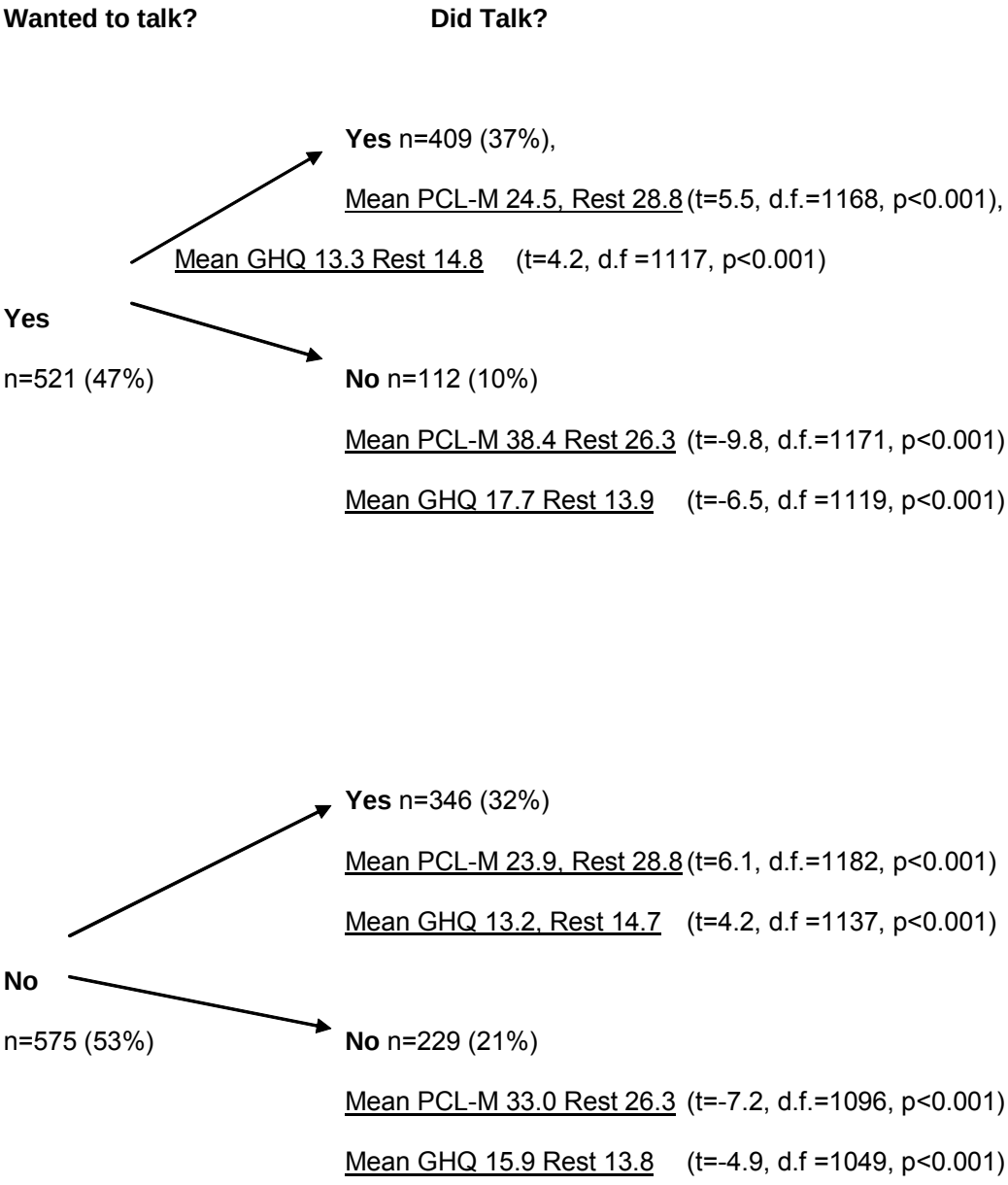

Figure 1: Interaction of wanting to talk and actually talking to someone on return from deployment.

WHO DID PEACEKEEPERS TALK TO ABOUT THEIR EXPERIENCES?

Table 1 shows who peacekeepers talked to about their experiences. Of the 760 who talked to someone about their experiences, 95% spoke to their spouse or partner, 98% their peers who were on the same deployment and only 8% spoke to medical and welfare services about their experiences.

Table 1: Who did peacekeepers speak to about their experiences?

Who did Peacekeepers talk to about their experiences?	n	%
To spouse or partner	724	95
To another family member	580	76
To civilian friends or peer group	395	52
To military friends or peer group on the same deployment	741	98
To military friends or peer group not on the same deployment	453	60
To the chain of command	112	15
To medical services	62	8
To welfare services	57	8

Those who spoke to their spouse or partner were more likely to be married (χ^2=74.1, d.f=1, p<0.001), male (χ^2=4.1, d.f=1, p=0.04) and older (t=-3.7, d.f.=1196, p<0.000). Female peacekeepers were more likely to have spoken to other family members than male peacekeepers (χ^2=9.2, d.f=1, p=0.002). Older peacekeepers were more likely to have spoken to their military peers (from the same deployment and from the military generally) and to the chain of command. There was no association with the number of deployments (Table 2).

Table 2: Characteristics of those who talked to others compared to those who did not

Group Spoken to:	Gender	Marital Status	Number of Deployments	Age
Spouse or partner	M>F (χ^2=74.1, d.f=1, p<0.001)	M>S (χ^2=74.1, d.f=1, p<0.001)	NS (χ^2=6.3, d.f=5, p=0.28)	Older>Younger (t=-3.7, d.f.=1196, p<0.000)
Another family member	F>M (χ^2=9.2, d.f=1, p=0.002)	NS (χ^2=0.58, d.f=1, p=0.45)	NS (χ^2=9.68, d.f=5, p=0.09)	NS (t=1.3, d.f.=1196, p=0.18)
Civilian friends or peer group	NS (χ^2=1.98, d.f=1, p=0.16)	NS (χ^2=0.98, d.f=1, p=0.33)	NS (χ^2=4.82, d.f=5, p=0.44)	NS (t=-1.5, d.f.=1196, p=0.12)
Military friends/peer group on the same deployment	NS (χ^2=0.61, d.f=1, p=0.44)	NS (χ^2=0.367, d.f=1, p=0.55)	NS (χ^2=5.1, d.f=5, p=0.41)	Older>Younger (t=-3.0, d.f.=1196, p=0.003)
Military friends/peer group not on the same deployment	NS (χ^2=2.7, d.f=1, p=0.10)	NS (χ^2=2.1, d.f=1, p=0.15)	NS (χ^2=6.44, d.f=5, p=0.27)	Older>Younger (t=-3.95, d.f.=1196, p<0.000)

Group Spoken to:	Gender	Marital Status	Number of Deployments	Age
The chain of command	NS (χ^2=0.11, d.f=1, p=0.74)	NS (χ^2=1.1, d.f=1, p=0.30)	NS (χ^2=9.1, d.f=5, p=0.10)	Older>Younger (t=-2.9, d.f.=1196, p=0.004)
Medical services	NS (χ^2=0.17, d.f=1, p=0.68)	NS (χ^2=1.7, d.f=1, p=0.19)	NS (χ^2=1.6, d.f=5, p=0.86)	NS (t=-0.7, d.f.=1196, p=0.54)
Welfare services	NS (χ^2=0.00, d.f=1, p=0.99)	NS (χ^2=1.37, d.f=1, p=0.24)	NS (χ^2=3.2, d.f=5, p=0.67)	NS (t=0.5, d.f.=1196, p=0.62)

There were significant associations between speaking to most groups of people and having a lower GHQ-12 and PCL-M score. This was not the case for those who spoke to medical services who had higher PCL-M scores and higher GHQ-12 scores than those who did not. There was no significant association between speaking to welfare services and GHQ-12 scores, although there was a significant difference in terms of PCL-M score (Table 3).

Table 3: Psychometric Outcomes after speaking to different groups

Group		GHQ-12		PCL-M	
Spouse or partner	Did talk	13.9	*t*=2.4, p=0.02*	25.9	*t*=5.0, p<0.001*
	Did Not	14.8		29.7	
Another family member	Did talk	13.7	*t*=3.6, p<0.001*	25.1	*t*=6.0, p=<0.001*
	Did Not	14.8		29.5	
Civilian friends or peer group	Did talk	13.6	*t*=2.8, p=0.05*	24.7	*t*=5.2, p<0.001*
	Did Not	14.6		28.8	
Military friends or peer group on the same deployment	Did talk	13.7	*t*=4.1, p<0.001*	25.7	*t*=6.0, p<0.001*
	Did Not	15.1		30.2	
Military friends or peer group not on the same deployment	Did talk	13.4	*t*=4.2, p<0.001*	24.6	*t*=6.1, p<0.001*
	Did Not	14.8		29.1	
The chain of command	Did talk	13.2	*t*=2.0, p=0.04*	24.4	*t*=2.6, p=0.01*
	Did Not	14.4		27.7	
Medical services	Did talk	16.1	*t*=-2.6, p=0.01*	32.6	*t*=-3.2, p=0.001*
	Did Not	14.2		27.1	
Welfare services	Did talk	15.3	*t*=-1.44, p=0.14	31.9	*t*=-2.7, p=0.007*
	Did Not	14.2		27.2	

AGE AND PSYCHOMETRIC DATA

Analysis of GHQ-12, PCL-M and age showed that the PCL-M and GHQ-12 scores were significantly correlated (Pearson's r =0.60, $p< 0.01$, 2-tailed) but there was no correlation with age and either GHQ-12 (r = 0.16) or PCL-M (r = -0.13).

FORMAL PSYCHOLOGICAL DEBRIEFING

With regard to a formal psychological debriefing on return, 67% (n=763) were in favour. Those who were in favour were younger (35.3 v 36.3, t=-2.2, d.f.=1125, p=0.027), had higher GHQ-12 scores (14.8 v 13.2, , t=4.5, d.f.=1077, p<0.001), higher PCL-M scores , (29.7 v 23.1, t=8.1 d.f.=1123, p<0.001) and more likely not have spoke to someone about their experiences (χ^2=24.5, d.f.=2, p<0.001). There was no association between gender (χ^2=2.1, d.f.=2, p=0.349), number of deployments (χ^2=7.2, d.f.=10, p=0.706) or marital status(χ^2=0.44, d.f.=2, p=0.803) and being in favour of a formal psychological debriefing.

DISCUSSION

The study clearly shows that whilst only about half of those surveyed wanted to speak about their experiences with others, nearly two thirds of people eventually did so. It is likely that personnel who had returned from deployment would have been encouraged to speak about their deployment by their usual social groups (family, friends and colleagues) and indeed these are the people who were mostly commonly spoken to. This study also found a clear association between speaking about peacekeeping experiences and lower distress levels (as indicated by having a lower GHQ-12 and PCL-M score) which suggests that the age old dictum "it's good to talk" may indeed be a true.

LIMITATIONS OF THIS STUDY

This study was undertaken in 2001 and examined peacekeeping operations back to 1991. The results have to be interpreted with the possibility of recall bias in mind.

Likewise, we cannot determine the issue of causality as there is no reliable way of clarifying whether the psychological distress levels found, as indicated by the GHQ-12 and PCL-M, were as a result of having spoken about their experiences. The results found can, though, be taken as being valid indicators of association. Future prospective studies are required to examine whether the distress levels examined in this study are in fact caused by peacekeeping deployments rather than merely associated with them. This will require having access to baseline data before service personnel are sent on operations, as now happens in the US armed forces.

MAIN FINDINGS

The results show that whether or not people wanted to speak to someone about their experiences, those who actually did so were less psychologically distressed than those who did not. Cognitive theory postulates that post traumatic stress symptoms (which are common after distressing events) may not resolve if those who have been exposed to critical events are unable to "process" what has happened to them (15). Unlike formalized single session psychological debriefings, which have been found to be unhelpful, support from informal social networks is likely to be ongoing and is unlikely to strongly encourage the expression of emotion as happens in psychological debriefings. Rather, such conversations are likely to be based on simple recounting of the events and to be supportive. Such interactions are likely to facilitate the processing and as such reduce traumatic distress. Other studies have also found that positive homecomings (associated with talking about the event) are linked with better psychological

adaptation in peacekeepers (4). This hypothesis is supported by the additional finding that the group with the highest levels of distress was the group who wanted to speak to someone but were unable to, perhaps because they lacked the assistance in processing which is provided by talking about their experiences.

The results also show that older peacekeepers were more likely to make use of both social networks and military networks (those who had been deployed with them and the chain of command) which might be explained by those that had found informally discussing their experiences helpful once were more likely to do so in the future. Importantly though, there was no direct correlation between age and measures of psychological distress, perhaps indicating that those who do make use of such formal networks early on during their career, do not manage learn to do so with experience.

Another finding was that female peacekeepers had an increased propensity to talk about peacekeeping experiences and were more likely to make use of other family members than their spouses. Men, on the other hand, were more likely to speak to their spouses and partners. This may reflect that, in general, women are better listeners than men and thus both male and female Peacekeepers are more likely to speak to a female listener.

Of significant interest is that whilst for most subjects, there was a significant association between talking about their experiences and having lower GHQ-12 and PCL-M scores, this was not the case for those who spoke to medical and welfare services (not significant in the case of GHQ-12 and talking to welfare services). It is perhaps reassuring that although most people made use of informal networks (family and peers) the more distressed people sought help from medical and welfare services. Of course, one can not exclude the possibility that it is as a result of having talked to medical and welfare services that their distress levels are higher. Other studies have shown that early psychological intervention in the form of psychological debriefing can lead to increases in distress levels (7) and it may be that talking to medical and welfare services increases levels of distress in a similar fashion. However, this explanation seems unlikely and it seems more plausible that the most distressed people were more likely to seek help.

Also of interest is the finding that those who did not speak to anybody (perhaps because of opportunity or lack of social skills) were more in favour of a formal psychological debriefing on return from deployment. It is understandable that the more distressed a Peacekeeper the more likely they are to be in favour of a formal psychological debriefing as this probably represents a belief that talking about their experiences would lead to a reduction in their symptoms. This is in keeping with the other finding that the most distressed group were those who wanted to talk about their experience but were unable to. Older peacekeepers were less likely to be in favour of a formal psychological debriefing which might represent an “old school” approach of not talking about distress, not uncommon in older service personnel and often described as the “stiff upper lip” approach to stress. Additionally, the results also show that older Peacekeepers are more likely to make use of social networks and the chain of command and thus may not feel that any formalized procedure is required.

CONCLUSION

This study has found that talking about peacekeeping experiences is associated with reporting lower distress levels, with most people talking making use of informal networks. The study adds to the evidence that formal psychological debriefings and medical/welfare interventions are not required by all. Some years ago the vogue was for “one size fits all” debriefings for people who had been in stressful situations. Thankfully the fashion may be passing, encouraged by the resounding lack of evidence for debriefing (7) and the possibility that it may do harm than good (8). More recent formulations suggest restricting formalized interventions to higher risk, visibly distressed groups (16) and the majority of service personnel appear to be making use of common sense solutions using of informal networks of friends and peers as the preferred source of ventilation with the minority of highly distressed individuals making use of professionals.

Within the UK military, over the past decade, there has been a trend for personnel to view their military service less as a way of life and more as an occupation. Additionally it is known that being in the military is a risk factor for divorce and nationally the divorce rate has been reported to be rising. Consequently the spirit of community and the accessibility of informal networks which has been one of the hallmarks of military life is less than strong than was the case previously. The results of this paper suggest that the UK military should do all they can to promote a sense of community and facilitate stable interpersonal relationships in order to maintain the informal networks which this study has shown appear to be beneficial.

REFERENCES:

[1] Orsillo S, L Roemer Litz BT, Ehlich P, Friedman MJ. Psychiatric symptomatology associated with contemporary peace keeping: an examination of post mission functioning among peacekeepers in Somalia. J Trauma Stress 1998;11:611-625.

[2] Halverson R. Determinants of Soldier Support for Operation Uphold Democracy. Armed Forces & Society 1996;23:81-96.

[3] Litz BT, Gray M, Bryant R, Adler A. Early intervention for trauma: current status and future directions. Clinical Psychology: Science and Practice 2002;9:112-134.

[4] Asmundson GJ, Stein MB, McCreary DR. Posttraumatic stress disorder symptoms influence health status of deployed peacekeepers and non-deployed military personnel. J Nerv Ment Dis. 2002 Dec;190(12):807-15.

[5] Wong A, Escobar M, Lesage A, Loyer M, Vanier C, Sakinofsky I. Are UN peacekeepers at risk for suicide? Suicide Life Threat Behav. 2001 Spring;31(1):103-12.

[6] Treatment Choice in Psychological Therapies and Counselling: evidence based clinical guideline. Department of Health, February 2001.

[7] Rose S, Bisson J, Wessely S. Psychological debriefing for preventing post traumatic stress disorder (PTSD) (Cochrane Review). In: *The Cochrane Library,* Issue 1 2003. Oxford: Update Software.

[8] Van Emmerik AA, Kamphuis JH, Hulsbosch AM, Emmelkamp PM. Single session debriefing after psychological trauma: a meta-analysis. *Lancet*. 2002;360(9335):766-71.

[9] Bolton E, Litz B, Glenn D, Orsillo S, Roemer L. The Impact of the Homecoming reception on the adaptation of peacekeepers following deployment. Military Psychology 14(3), 241-251. 2002.

[10] Unwin C, Blatchley N, Coker W, Ferry S, Hotopf M, Hull L *et al*. The health of United Kingdom Servicemen who served in the Persian Gulf War. *Lancet*. 1999;353:169-178.

[11] Greenberg N, Iversen A, Unwin C, Hull L, Wessely S. Screening for Depleted Uranium in the United Kingdom Armed Forces – Who wants it and why? Submitted 2003.

[12] Goldberg, D. The Detection of Psychiatric Illness by Questionnaire. London, Oxford University Press, 1972.

[13] Davidson JR, Book SW, Colket JT, Tupler LA, Roth S, David D *et al.* Assessment of a new self-rating scale for post-traumatic stress disorder. Psychol Med. 1997;27(1):153-60.

[14] Ehlers A, Clark DM. A cognitive model of posttraumatic stress disorder. Behav Res Ther. 2000;38(4):319-45.

[15] Litz B, S Orsillo, Friedman M, Ehlich P, Batres A. Posttraumatic stress disorder associated with peacekeeping duty in Somalia for US military personnel. Am J Psychiatry. 1997;154:178-184.