COLLEGE OF MEDICINE AND HEALTH SCIENCES

SCHOOL OF MEDICINE & PHARMACY

DEPARTMENT OF CLINICAL PSYCHOLOGY

MSc, Clin. Psych. & Therapeutics

HUYE CAMPUS

BATTALLION STRESS MANAGEMENT STRATEGIC PLAN IN OPERATIONAL AREAS, ROLE OF CLINICAL PSYCHOLOGIST. CASE OF RWANBATT 37 IN SUDAN.

Dissertation submitted in partial of the requirement for the award of Masters Degree in Clinical Psychology and Therapeutics

PRESENTED BY NZABAMWITA MUSAGARA Euphrem

Superviser: Dr Simeon SEBATUKURA

Huye, May 2017

DECLARATION BY THE CANDIDATE

1.I, NZABAMWITA MUSAGARA Euphrem, do here declare that this dissertation titled “Battallion stressmanagement strategic plan in operational areas,role of clinical psychologist.Case of Rwanbatt37 in SUDAN ” is my original work.

1. I have not presented the same work for the award of any other degree or to any other university.
2. I also declare that sources of information utilized in this work have been acknowledged in the reference list.
3. I have not allowed, and will not allow anyone to copy my work with the intention of passing it off their own work. In additional, no part of this research should be produced without the prior written permission of the author and/ or the University of Rwanda.

NAME OF THE CANDIDATE
…….. Signature:…… Date……
Student number:UR/ 215033607

DECLARATION BY THE SUPERVISOR
This research proposal has been submitted with my approval as the University Supervisor.
NAME OF THE SUPERVISOR
…… Signature:…….. Date……
Department of Clinical Psychology
School of Medicine and Pharmacy
College of Medicine and Health Sciences
University of Rwanda

DEDICATIONS

To my wife ANNONCIATA UWANYIRIGIRA and all my children
To my late father, mother and brothers

To my comrades and friends with whom we share the professional life.

ACKNOWLEDGEMENTS

This work is the joint effort of several people who deserve our sincere thanks.

My thanks are addressed to the University of Rwanda, School of Medicine and Pharmacy particularly the staff of Clinical Psychology Department who facilitated the progress of our course through teaching and guidance.

My deep gratitude goes especially to Dr. Simeon SEBATUKARA , who has agreed to supervise this work despite his many obligations. His advice, guidance and corrections have led to the culmination of this work.

Many thanks to RDF which granted me the permission and the scolarship to join the course as I wished since many years in order to perform better my duty of military Psychologist .

Thank you to the leadership of Rwanbatt 37 in Sudan , the leadership of Rwanda Military Hospital , all officers and men of Rwanbatt 37, all my clients in level one clinic who facilitated and allowed me to collect necessary data used in this research.

I can't forget to thank from the bottom of my heart Dr Jean MUTABARUKA
for his helpful advises. He always answered kindly my calls and provided me necessary academic informations at the right time.

Many thanks to all my family members, relatives, and close friends, mainly my wife,
Annonciata UWANYIRIGIRA , Dr Viator NYARUBUYE , Stanislas SEZIKEYE's familly, Late Father Ignace SAMURENZI and J.Pierre RURANGWA for their Encouragement and support of all kinds throughout my hard way of looking for
Knowledge.

Thanks to all people whom I might have forgotten and who deserve my gratitude.

Euphrem NZABAMWITA MUSAGARA

INSPIRATION

« Combat and operational stress is not only a medical problem but
It's also a command problem, both in terms of numbers of soldiers lost from duty
and reduced performance on duty » (Col L.NEALE COSBY at al, 1981, /www.us.army).
Thus, military psychologists in collaboration with all the chain of command have to conjugate their efforts together in order to minimize stress effects on soldiers by psychotherapeutic treatement and other preventive measures.The corporalism is full of frustrations, better give all your ears to your subordinate in order to help him find his own proper solution to his own stressfull problems

NZABAMWITA MUSAGARA Euphrem

ABREVIATIONS AND ACCRONYMS

APA: American Psychological Association

LAS: Local Adaptation Syndrome

ASD: Acute Stress Disorder

ASR: Acute stress Reaction

Bn: Battallion

CARAES: Caritate aegrum Service

CISD: Critical Incident Stress Debriefing

CISM: Critical Incidence Stress Management

CONTICO: Contingent Commander

COSR: Combat Operational Stress Reaction

COYCOMD: Compagny commander

CSR: Critical Stress Reaction/Combat Stress Reaction

DSM: Diagnostic and Statistical Manual of Mental Disorders

FARG : Fond d'assistence pour les rescapés du genocide

GAS: General Adaptation Syndrome

GHD: Historical Group Debriefing

GHQ: General Headquaters

ICD-10: International Classification of Deases&Related Health

M.P: Military Police.

Med: Medical

Medics: Medical staff meaning somaticians only (Doctors and nurses).

MSD: Multiple Stress Debriefing

PD: Psychological Debriefing

PIE: Proximity, Immediacy, Expectency

PTE: Potentially Traumatic Event

Pte: Private

PTSD: Post Traumatic Stress Disorder

RCP: Regimental Clinical Psychologist

RDF: Rwanda Defence Forces

RMH: Rwanda Military Hospital

RMO: Regimental Medical Officer

RWANBATT: Rwanda Battallion

S1: Administration officer

S2: Security officer

S3: Officer in charge of operation

S4: Logistic officer

S5: Political Officer

SGT: Sergeant

T.V: Television

UCMJ: Uniform Code of Military Justice

UNAMID: United Nation Mission in Darfur

USA: United States of America

WHO: World Health Organisation

XO: Battalion Commander

ABSTRACT

A military deployment has three different phases. Each phase is punctuated by It's own stressors. The military training , exercise , rehearsals,manoeuvers and other psycho educative exercises aim to shape the personality of the soldiers to develop endurance skills which would increase soldiers' resiliency towards multiple potentially stressors encountered during different circumstances of their military carrier include peace keeping mission. Despite those exercises building resiliency , some soldiers consult the level one hospital with different symptoms, some of them are transferred in the Military Hospital with physical and/ or psychological exhaustion symptoms from military training, other are referred from military operations include peace keeping mission in Soudan**.**

A deployment is a military duty away from home, it may be short or long according to the circumstance and need. It 's always a moment of strong emotions which can very from adaptative to maladaptative coping mechanisms in response to stressors of separation with family according to family- social role of each soldier. A military deployment usually has different phases and each one has his own potentially stressful factors which needs adaptation from every soldiers. No one can escape from the stressful factors of deployment; in case of maladjustment to stressors some individuals can develop negative behavioral changes and low moral which can endanger themselves, their comrades, the military cohesion, decrease the man power and have a negative impact on the global success of operations. During a military operation it 's usually a rule to help soldiers to prepare themselves physically and psychologically through rehearsals ,exercises and instructions. The effect of meeting in one camping site for preparation is good for mutual socialization etc…

For all these reasons, a psychological screening must be always incorporated in medical screening during the pre-deployment phase, and a psychological accompaniment appears to be useful through out all phases of deployment. The chain of command usually has to support all initiatives related to stress management strategies according to the circumstances. The stress management becomes a task of every body and the psychologist becomes an officer from the chain of command and from the medical team who can explain the new behavioral symptoms of a soldier affected psychologically.

All the chain of command has the power to help and cure emotional casualties in collaborations with psychologists. Is there any specific approach related to military emotional causalities or psychological treatment ?No ,Even if it exist the good collaboration of the Battalion psychologist, the whole battalion medical team and the chain of command remain the corner

stone in the therapeutic process of emotional casualties. This collaboration leads them to understand the behavioral change of the client and get common understanding of the way to help soldiers experiencing stress and trauma symptoms to find solution to his fearful problems.

In this research the phenomena of behavioral change related to psychological trauma and stressful events from military operations and peacekeeping operations in particular are examined (The pressure of preparation including rehearsals, personal needs, resocializing , evaluating the sense of belonging, sense of cohesion, adaptability of each one in his new unity, problem solving process analysis, the reaction and behavior on medical results through pre and post test counseling).

Secondly, It tries to analyze the effective stress management strategic plan of Rwanbatt37 deployed in Soudan (Darfur) in 2013 and the way each soldier perceive and live the military operations as his own experience, mobilizing all his resources in order to adapt himself and develop coping mechanism in order to give the best of his contribution to the success of his battalion or contingent, committed for working hard to succeed the assigned mission.

Thirdly, it tries to analyze and appreciate ideally the complementarity effort of the chain of command include the medical team in terms of global medical treatment and problem solving for each particular case related to stress management ,psychological trauma and stress prevention. Despite the efforts of Rwandan contingent in terms of stress prevention some cases needed special care and treatment. Those cases are considered as designated patients of the whole system and calls the attention of the leadership to reinforce and organize much better the psychological care of soldiers during military operations and peacekeeping mission in particular.

The method used was the participant observation associated to a retrospective analysis of findings after mission in Soudan, all those two first methods were sustained by the documentation from clinical cases observed and remarks from general soldier´ behavioral monitoring from the chain of command on terrain during the three different phases of Rwanbatt37 deployment in Soudan .

The result of this analysis allows us to conclude that the majority of Rwanbatt37 soldiers' adapted well in mission area despite the only case of Suicide case without any other loss which was the most fearful case encountered. Among mental diseases relative to acute stress; Depression, PTSD and other somatization symptoms are found among the majority of cases hospitalized at least once in level one hospital. Light amnesia, anger and some cognitive-behavior symptoms are experienced in some cases but considered as normal. The most of symptoms disappear when soldiers arrive home.

Due to stigma associated to mental disorder in Rwanda, some soldiers consult a clinical psychologist after experiencing acute symptoms or on demand of an administrative or judicial leader.

KEYWORDS

Stress , Battalion Stress management , PTSD ,War trauma , Military operations , Military cohesion , Military briefing , Military debriefing , Military Psychologist , Psychological debriefing , Peacekeeping mission , peacekeeping operations , Military deployment ,Military training ,resiliency

TABLE OF CONTENTS

CHAP I. GENERAL INTRODUCTION

Any military operation include peacekeeping mission involve soldiers trained and shaped by the training preparing for deployment. As a soldier, a potential deployment away from home or far from the family may be a constant reality. A deployment is never easy but proper preparation can help minimize stress and anxiety of soldiers being deployed far away from their families. The way leaders view, approach and manage the effects of war and operational stress can maximize somehow his manpower and influence greatly his success. Operational and combat stress has been always one of commander's programs.

A good commander must always appreciate the magnitude of a potentially stressful event as it affects somehow individuals exposed. Every soldier has his own frustrations, his own personality, and his own resiliency and lives his frustrations in singularity; that's why the psychological accompaniment from the chain of command is always precious so that every one may be helped to get adequate solution to his most frightening problem.

It's a reality that combat and operational stress can affect every one engaged in full military operations. No soldier or family member can remain unchanged. It can be viewed as a continuum of possible outcomes that each person can experience with a range from positive growth behaviors to negative and sometimes mental confusion influencing disruptive reactions.

Effective leadership shapes the experience that they and their Soldiers go through in an effort to successfully transition units and individuals, build resilience and promote posttraumatic growth, or increased functioning and positive change after enduring trauma. Combat and operational stress control do not take away the experiences faced while engaged in military operations, effective leadership, unity operational stress control team and psychological care attempts to mitigate those experiences so that Soldiers and units remain combat-effective and ultimately provide the support and meaning that will allow Soldiers to maintain the quality of life to which they are entitled. Postcombat and operational stress describes the range of possible outcomes along a continuum of stress reactions that are experienced weeks or even years after combat and operational stress exposure. Postcombat and operational stress includes adaptive resolution to the stressors of combat operations, mild adjustment reactions, and the more severe negative symptoms that are often associated with posttraumatic

stress disorder (PTSD). Leaders must understand this continuum and know the difference between adaptation, adjustment, and PTSD. Most Soldiers adapt, but some will struggle with Combat operational stress reactions and, if unresolved, result in a diagnosis of PTSD. Based to the history of the war of liberation of 1994 and peace keeping operations todays, it's necessary to reinforce the psychological care of soldiers in terms of stress control , PTSD screening , counseling , guidance and daily behavior monitoring .This could have a positive impact on their military discipline , will increase their military productivity , moral , health and mental health in particular . During the war of liberation there were few trained army psychologists in Rwandan army; todays the number of military psychologists is increasing with continuous shot training granted by the institution and their contribution is well appreciated. Despite this effort we notice today's some soldiers condemned by military court for desertion behavior, indiscipline case, misconduct behavior, drunkedness and other dangerous crime and sentenced sometimes between one month or more or condemned to pass the rest of their life in jail.

Sometimes all those crimes are in relationship with cumulative stress all over their military carrier and indeed stressfull is the prison life too. All this cumulative stress sometimes has negative effects on global functioning, discipline, negative behavioral change and mental health in particular. If we observe in Rwandan military unities some of those cases are sometimes found , despite the Unity disciplinary measures and advise , those who experience symptoms of poor mental health are transferred to hospital for treatment but other many symptoms of psychological distress are interpreted in a criminal manner or indiscipline Some times or social conflicts between two persons simply. Many symptoms usually are recognized later after a behavioral incident in many cases such as in case of suicide attempt and other criminal acts. The military lawyer and military Psychologists must learn a proper way to work together in the reconciliation of these two different disciplines in order to rehabilitate well soldiers incriminated, and those victims of psychological disorders.

Psychological aspect of soldiers incriminated may be taken in consideration by the courts in order to facilitate the lawyers to understand the crime scene properly and the general behavior of crime suspects include the source of motivation of his crazy shamefull and unlowfull behavior .

I.1. Starting question

Todays the army has more clinical psychologists and other trained mental health providers who provide mental health care to their colleagues in need.

1. How do they do it in operations and peace support operations in particular?
2. Is there any preestablished strategic plan specific for psychological interventions which can facilitate the Battallion Psycologist in peacekeeping mission?
3. What is the role of Clinical Psychologist among the chain of command, among the medical team and among the entire troop?
4. What are the tools used by Psychologists to help their clients?
5. How do Psychologists interact with the chain of command and the medical team on terrain?
6. What are the specific professional challenges they meet in operations and in their clinical work?

There is a need to show the specific contribution of a psychologist in different military operation phases and peacekeeping mission operation in particular, the role of leadership in general interms of combat and operational stress control include the role of a battalion army psychologist.

According to my own observation through out this research; The deployment of Rwanbatt contingent (37Bn) in its area of operation (Darfur Soudan) began in January 2013. The end of mission rotation started in October for the first Bns and closed in December 2013.

All soldiers were totally prepared and motivated both military, physically and psychologically; every one wished to go in mission with the first trip and were given enough time to prepare even their families for separation until the last day of moving according to the schedule. The pre-deployment phase took 6 months of military rehearses exercises and socialization between soldiers because some of them meet from different military unities.

Psychologically what is the feeling of those soldiers medically screened unfit or not healthier enough to go in mission? How is their global care after separation with other soldiers who were screened healthier enough to participate in peace keeping operations during predeployment phase? Is their psychological aspect tacken in consideration properly?

7. Don't they need special psychological accompagnement on addition to medical care?
8. How do soldiers adapt themselves to multiple stressors during deployment phase?

I.2. Problem statement

A military deployment has three different phases (pre-deployment, deployment, post-deployment phase). Each phase is puntuated by his own stressors.The military training ,exercises,rehearsals,maneuvers and other psychoeducative exercises aim to shape the personality of the soldiers in order to develop knowledge and endurance skills which would increase their resiliency towards multiple stressors potentially encountered during different circumstances of their military carrier include peace keeping mission. Despite those exercises building resiliency , some soldiers consult the level one clinic , some of them are transferred in the Military Hospital with physical and/ or psychological exhaustion or somatic disease related to physical and psychological exhaustion symptoms related to military training , others are reffered from military operations include peace keeping mission in Sudan etc…

A deployment is a military duty away from home, it may be short or long according to the circumstance and need. It's always a moment of strong emotions which can vary from adaptative to maladaptative coping mechanisms in response to stressors of separation with family according to familly- social role. A military deployment usually has different phases and each one has his own potentially stressfull factors which needs adaptation from every soldiers. No one can escape from the stressfull factors of new deployment ; In case of maladjustement to stressors some individuals can develop negative behavioral changes and low moral which can endanger themselves, their comrades,the military cohesion,decrease the man power and have a negative impact on the global success of operations . let us remember that an unmoralised soldier is predisposed to diseases of all kinds due to his poor mechanism of coping against potential stress factors.

During a military operation it 's usually a rule to help soldiers to prepare themselves physically and psychologically through rehearses, exercises and instructions.The effect of meeting in one camping site for preparation is good for mutual socialization etc…

For all these reasons, a psychological screening must be always incorporated in medical screening during the pre-deployment phase, and a psychological

accompaniment appears to be usefull throughout all phases of deployment. The chain of command usually have to support all initiatives related to stress management strategies according to the circumstances.The stress management becomes a task of every body and the psychologist becomes an officer from the chain of command who can explain the new behavioral symptoms of a soldier affected psychologically.

All the chain of command has the power to help and cure emotional casualities in collaborations with psychologists.

Is there any specific approach related to military emotional casualities psychological treatement? Even if it exists the good collaboration of the battallion psychologist,the medical team and the chain of command remain the corner stone in the therapeutic process of emotional casualties.This collaboration leads them to understand the behavioral change of the client and get common unstanding of the way to help him find solution to his problems.

In this research the phenomena of behavioral change related to stressfull events from operations and peacekeeping operations in particular are examined (The pressure of preparation including rehearsals, personal needs, resocializing, evaluating the sense of belonging, sens of cohesion, adaptability of each one in his new unity, problem solving process analysis, the reaction and behavior on medical results through pre and post test counseling).

Secondly, It tries to analyse the effective stress management strategic plan of the battalion and the way each soldier perceives and lives the military operations as his own experience, mobilizing all his resources in order to adapt himself and develop coping mechanism in order to give the best of his contribution to the success of his Unity committed for working hard to succeed the assigned mission.

Thirdly, to appreciate the complementarity effort of the chain of command in terms of problem solving for each particular case related with stress management and stress prevention. Despite the efforts of Rwandan contingent in terms of stress prevention, some cases needed special care and treatement.

I.3. Study significance

The result will help the planners, policy makers but almost unexperienced military psychologists to understand the stress management strategic intervention plan in operational areas and the role of a battalion psychologist in three different phases of

deployment, and the ways he must collaborate with all the chain of command in terms of stress prevention and stress management on terrain.

The study is relevant because its result will help each member of the battalion almost the chain of command and the medical team to understand a collaborative approach in terms of stress prevention and stress management and the role of a battalion psychologist in mission areas without role confusion between a Doctor and a Clinical Psychologist.

It will show the importance of self control behavior of each member of the battallion in order to protect the sense of cohesion of your battalion which is the key to fulfill efficiently the global military tasks and military mission in general.

The result will explain, the role of command and control and daily behavior monitoring among soldiers in mission areas and the role of Clinical Psychologist in a military force in collaboration with the chain of command.

The result will also explaine, the procedure of identifying a designated patient in a military formation for quick intervention and help in a battalion in mission area in order to help the client to recover as soon as possible.

The result will show also the role of anti stress activities and campaigns in terms of stress coping mechanism of a battalion in mission area and reinforcement of the sens of military cohesion in particular.

I.4 RESEACH HYPOTHESIS

I.4.1.General hypothesis

1. An effective collaboration between the battalion chain of command and the battalion psychologist would facilitate an effective care of emotional casualities and stressmanagement procedures in operational areas.

2. Leisure activities and psychoeducation are effective tools for stressmanagement in military operational areas include peacekeeping mission.

I.4.2.Specific Hypotheses

The specific hypothesis in this research is the following:

1. The sensitization of the battalion chain of command about stress in operational areas can facilitate effectively the care of emotional casualties and stress management procedures in peacekeeping mission areas.

2. The collaboration between the chain of command and the battalion psychologist can facilitate to minimize negative effects of stress among soldiers in peacekeeping areas and facilitate the management of related behavior.

3. The promotion of leisure activities in operational areas can facilitate stress prevention and contribute to good health of soldiers in operational or peacekeeping areas.

4. psycho-education through leisure activities in peacekeeping areas can facilitate stress management and psychological relaxation.

I.5.Research objectives

A/General objective

1. To analyse the stress management strategic plan in peacekeeping mission.

2. To identify the best approach of stress management and stress prevention which marches with Rwandan culture and RDF doctrine.

3. To highlight the role of a battallion Clinical Psychologist among the battalion medical team, the chain of command, and among all troops.

C/ Specific Objectives

1.To identify the role of each member in the battalion in terms of stress management.

2. To identify different kind of stressors that can probably disturb the mental homeostasis of a soldiers.

3. Describe, analyse, assess and schematize a required approach which can facilitate the military psychological care in operational areas according to the military structure of the chain of command and the principle of mutual complementarity and cooperation of soldiers.

4. To suggest recommendations to the leadership, and other military psychologists who would work in the future as battalion psychologist in operational areas, in the country or in peacekeeping mission.

CHAP II. LITERATURE REVIEW

II.1.Definition of key concepts

In this study, the following key concepts and expressions will be defined:

1. Stress

Stress is viewed as a common denominator of all adaptative reactions in the body and complete freedom from stress is death (Selye, 1974).

In his first publication on stress in Nature Selye (1936, p.32) defines stress as non specific response of the body to any demand made on it. Following criticisms for being too vague, confusing, and ambiguous, he offered the following operational definition:

Stress is ‹‹ a state manifested by a specific syndrome which consists of all the nonspecifically induced changes within the biological system ›› (Selye, 1976b, p.64).

He proposed that such changes were measurable and occur at both the system and the local level,The entire stress process at the system level including the threat and the individual's reaction to it , he called it Adaptation syndrome(GAS).

The regional response (localized inflammation where microbe enterred the body) he termed it local adaptation syndrome (LAS). The GAS and LAS are seen as closely coordinated, with the GAS acting back up (Selye, 1976a).In physic the word stress means any force that tends to cause a change in material. Stress is a pressure imposed on mechanical structure. A state of extreme tension on the body which is required together all its defenses so as to overcome this situation. Any response from the body which is a result of demands exerted on it. In other words, it's the body's response to physiological aggression as well as emotions which necessitates an adaptation of both the body and mind. (Hans Selye cited by Den GUANGHUI (2010).

CROCQ (1986; 1996; 1999), inspired by Selye defines stress as the « immediate alertness reaction which is, biological, physiological and psychological, mobilization and defense of the individual facing aggression or threat ».

Crocq (1999) added: « it is transient or short time reaction , It's useful, prior saving and generally result in the selection and execution of an adequate solution.It is conducted in an exceptional psychological tension and ends by the relaxation of this tension , with mixed feeling of relief but with physical and mental exhaustion .It is not pathological , but bears overwelming symptoms . However, if stress is too intense,

repeated at short intervals or prolonged excessively, it becomes a pathological reaction and inadequate from exceeded sress ».

«The confrontation with the death threat, the danger of death, will determine the reaction of stress and anxiety, sometimes very high, but not necessarily psychological trauma. The meeting with the real death the most of time corresponds to psychological trauma» (Lebigot, and al 1999.p.17).

For military and their families, stress is an everyday occurrence, whether married to a service member, experiencing move to new location, raising children, dealing with a new deployment, experiencing a serious illness or death of family member, shortly the nature of military duty and socio- family management is not usually easy. Life in the military can create an endless list of potential stress. Some of these stressors can be anticipated while others need an individual effort of adaptation.

Stress is an integral fact of life; and its elimination completely is impossible. Claude Bernard (1865/1961) noted that the maintenance of life is critically dependent on keeping our internal milieu constant in the face of changing environment.Cannon (1929) called this ‘’ homeostasis’’. Selye(1956) used the term « stress » to represent the effects of anything that seriously threatens homeostasis .The perceived threat to the organism is reffered to as ‘’the stressor’’ and the response to the stressor is called « stress response » , although stress response evolved as adaptative processes,Selye confirmed that severe , prolonged stress responses might lead to tissue damage and disease.

2. Stress in military environment

The word ‘’ Stress’’ firstly refers to stimuli in the environment (physical and psychological) which impinge upon the organism (Baltone 1980).

Secondly the word ’’ stress ‘’refers to the physical and psychological response of the organism to such stimuli or stressors (Baltone 1998:114).

3. Potentially traumatic event

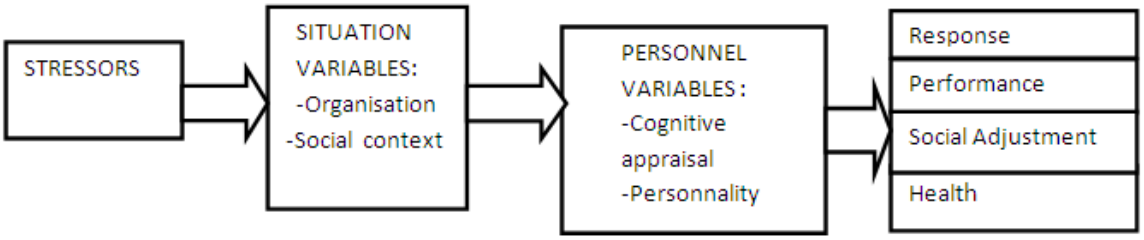
Units and Soldiers deploy and execute military missions which continuously expose them to military-specific stressors. The effects of these stressors are experienced prior to, during, and after conducting military operations and missions. Sometimes these stressors are related to a significant or multiple PTEs. A PTE is an event which causes an individual or group to experience intense feelings of terror, horror, helplessness,

and/or hopelessness. It is an event that is perceived and experienced as a threat to one's safety or to the stability of one's world. Units and Soldiers are exposed to or experience PTEs during both combat and operational military missions (Gen Dennis Reinner, 2009:P.1-3)

4. Military psychology

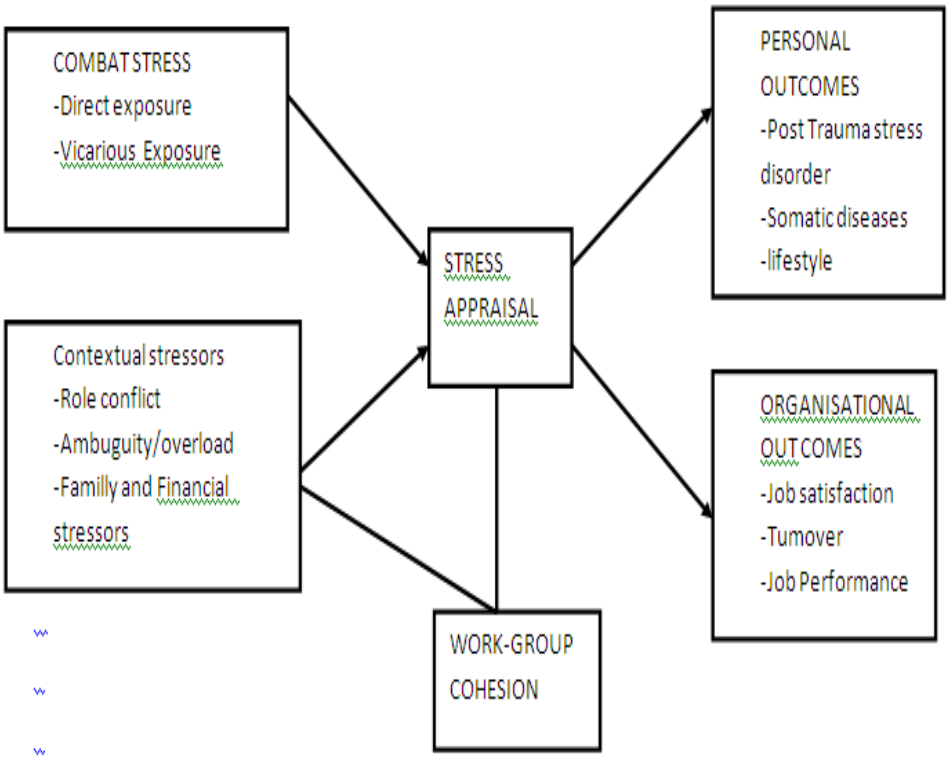
Military Psychology is the application of research technics and principals of psychology to the resolution of problems to either optimize the behavioral capabilities of one's own military forces or minimize the enemy's behavioral capabilities to conduct war.(Walters, 1968). It's the application of psychological principals to military environment regardless of who is involved or where the work is conducted (Cronin, 1998).

5 .Schematic representation of process that takes place between stressors from environment and response of organism



This schematic representation shows the pathway of stressors (stimuli) in the environment to the responses of the organism (Adapted from Baltone, 1998:116).

6. Model of peacekeepers' stress



Lamerson and Kellow (1996).

Lamerson and Kelloway (1996) developed a conceptual model of the stressors inherent in peacekeeping deployments. Those researchers included this model in their current research on South Africa first peacekeeping experience in DRC in 2001 because of its functionality. It was hypothesised that the stressors that members experience may have a destructive effect on their morale and on the cohesion of the force, and that it could lead to alcohol and drug abuse (Baltone, 2000). This model suggests that both combat stressors (e.g. witnessing death of others, hostage taking) as well as contextual stressors (e.g. increased levels of marital, family and financial stress) play an important role in the development of peacekeeping stress. The model recognises to a limited extent personal vulnerabilities, which may result in individuals' adverse reactions to peacekeeping stressors. The model also takes cognisance of moderators (e.g. cohesion) that affect the relationship between exposure to the stressors and the subsequent experience of stress. Lammerson and Kelloway (1996) furthermore posit that all three forms of strain reaction are likely to be outcomes of peacekeeping stress and that the strain experienced by peacekeeping soldiers will have detrimental consequences for the employing organization. Initially,

the first peacekeeping missions in a new area can apear as an immence learning platform for soldiers. Reasons include, firstly, the fact that peacekeeping operations require a different role of soldiers than that for which they were trained during basic training; secondly, that the peacekeeping environment is much less controllable and predictable than the conventional warfare environment.Despite certain generic similarities, every peacekeeping mission is unique in character. Thus, since a study of the various stressors within the peacekeeping environment encompasses a variety of variables that may differ from area of deployment, phase of deployment, type of mission and individual predispositions, it's imperative to identify the stressors

« …In the stress the subject is facing the threat, defensively mobilizes resources and manages to maintain on the outside of his psychic apparatus of any image real, as he usually does .... In trauma, a real image of the death will make refraction in the psyche and embed it as an internal foreign boddy (Freud).....A subject involved in an exceptionally serious event is confronted with the question of death… the psychic traumatism can have serious repercussions, be visible immediately, because it often mingle of stress reactions, if more choking it prepares a difficult tomorrow of the subject…». (De Clercq and al, 1994, p 91-101)

7. Health

The health is a state of complete physical, mental and social well being and not merely the absence of disease or infirmit (WHO).Secondly, It's defined as « the state of an organism when it functions optimally without evidence of disease or abnormality » (medilexicontion's medical dictionary). Thirdly It's defined as « a state characterized by anatomic , physiologic , and psychological integrity, ability to perform personally valued family,work , and community role; ability to deal with physical, biological, psychological and social stress; feeling of well being, and freedom from the risk of disease and untimely death » .

8. Mental health

The mental health is defined as « a state of well being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively, and is able to make a contribution to her or his community» (WHO).

9. Psychological resilience

Psychological resilience is an individual's tendency to cope with stress and adversity. It's understood as a process, and not a trait of an individual (www.Psychology about.com).

10. Military / Unity cohesion

Unit cohesion is a military concept, defined by one former United States Chief of staff in the early 1980s as "the bonding together of soldiers in such a way as to sustain their will and commitment to each other, the unit, and mission accomplishment, despite combat or mission stress". Teamwork is the collaboration or coordinated efforts of a group of soldiers towards common goals or objectives .Cohesion on the other hand, is both more abstract and more basic. Cohesion means a bonding together of an organization or unit members in such a way as to sustain their will and commitment to each other, the group, and the mission cohesion binds an organization together and enables it to function as unified integrated unit. Cohesion allows teamwork to occur under difficult conditions. Sigmund Freud wrote about what happenes to a military unit when its cohesion breaks down: panic arises; none of the orders given by superior are no longer listened to (www. usacac.army.mil/CAC2/Military review/archives/English). According to my own view, military cohesion is understood as the sense of belonging to the same army,one military unity ,obeying to one order given by the same leader belonging to the same army,working uniformly in team work,in interdependence, in complementary together as one.

11. Exploration of combat and operational stress

Psychic disorders from the war have been very formerly described and studied mainly in military medicine; they facilitated to discover originally traumatic pathology. In terms of epidemiology, It's almost an experimental population, among many studies some are already very old,their methodology is few comparable between them.The presence of symptoms offer a great variability according to the time,the nature of facts of the war themselves,but almost according to the past facts of the war and psychological symptoms experienced by soldiers,the most of studies are realised in a retrospective way many years after the war.The population of Vietnam is one of the examples, this population of combattant is the most studied population .In an american journal(Farlane,1996) 35 epidemiologic studies were done,the proportion

of post traumatic stress disorder varie from 2 to 7% , those differences are explained by the time between the objectivation of troubles and their evaluation.The most serious study was the Vietnam veteran readjustement study realised by Kulk and Coll (1990), in which they found 15% of post traumatic stress disorders and 11% of partiel symptoms among Vietnam veterans. Some studies (Orsillo, 1996) stressed on the important comorbidity(anxious troubles,major depression)presented by those veterans .Combat and operational stress reactions refer to the adverse reactions personnel may experience when exposed to combat or combat-like situations. Other names that have been used in the past to describe this reaction include *shell shock, Soldier's heart, battle fatigue*, and *battle exhaustion.*Combat and operational stress control falls under the force health protection mission and must not beoverlooked or minimized.

It is important for Soldiers and leaders to understand that the effects of combat and operational stress are experienced by all Soldiers in full spectrum operations. Recognizing and managing the effects of combat and operational stress is equally important during routine training missions as it is during combat. It is the leaders that have the greatest impact in successfully implementing a COSC program. Leaders must create conditions where their Soldiers can talk about and make sense of their experiences. They prepare Soldiers before combat by training them, talking to them, sharing experiences, and making sure they understand the rules of engagement and the factors that lead to combat and operational stress. The medical personnel include Clinical psychologist are usually integrated into training and predeployment exercises with units preparing to deploy not only for medical and psychological screening but some are staff attached to the unity going for deployment. Once in theater, leaders usually reinforce the mission's purpose, importance of communicating stress,and involve even religious congregations by encouraging them to be available to the troops Leaders are aware that the more the troops know about normal reactions to extremely abnormal experiences, the more resilient they will be at dealing with the stress of combat and other military operations. Leaders know and can estimate their influence on the morale and well-being of Soldiers under their command. Historically, COSR have significantly decreased in Rwandan army due to the deployment of clinical psychologist officers in battalions going in mission. In today's operational environment, leaders can expect to retain and have returned to duty over 99 percent of the Soldiers who experienced some symptoms of COSR while in mission Combat

and operational stress control has become a tactical consideration that is not minimized in Rwanda army and the leadership is supporting the continuous capacity building of military psychologists and other mental health practitioners in the army

11.1. Operational stressors (www.train.arm.mil) retrived 0n May 12, 2013

- ✓ Personal injury.
- ✓ Falling into the enemy's ambush.
- ✓ Witnessing the death of an individual.
- ✓ Death of another unit member.
- ✓ Exposure to extreme geographical

  Environments such as desert heat, cold, dusts, rains, dangerous insects, and other dangerous obstacles.
- ✓ Separation from significant support systems such as Family separation.
- ✓ Exposure to significant injuries over multiple missions such as witnessing the death of several Unit members over the course of many military missions.

Brief: Living always in an unpredictable security area.

11.2. Observing and recognizing reaction to combat and operational stress

The stress reaction may be signaled by changes in behavior and discernable by the client himself, or close comrade or his direct leader such as his section commander or his platoon commander.Without self report, it can be difficult to observe stress related changes. The leaders and medical personnel depend to the information from the soldier or his comrades for early recognition of combat operational stress reaction in order to provide appropriate help. Severe stress reaction may prevent individual from performing his duties or create a concern for personnel safety or the safety of others.

11.3.Mild stress reaction symptoms

PHYSICAL	EMOTIONAL
Trembling Jumpiness Cold sweats,dry mouth,insomnia,punping heart Nosea,vomiting or diarrhea,fatigue Difficult thinking,speaking,and communicating	Anxiet,indecisiveness, irritability,complaining Forgetfulness,inability to concentrat, nightmares,easily startled by noise,movment,light Tears,crying,anger,loss of confidence in self and others.

11.4. Severe stress reaction symptoms

PHYSICAL	EMOTIONAL
Constantly moves around Flinches at sudden sound or movement Shakes ,trembles Can not use some part of the body (arm, hand,or leg) for no apparent physical reason(Kind of paralysis). Inability to see,hear,feel Physically exhausted,cries easily Freeze under fire,socialy withdrown	Talk rapidly and or inappropriately argumentative, act recklessly. Indifferent to danger, memory loss, Stutters severly or can not speack at all (mutism or aphony). Insomnia,severe nightmares, hallucination,dellurium Apathetic,hysterical outbusts,strange behavior

The most common stress reactions include

- ✓ Fatigue
- ✓ Slow reaction time.
- ✓ Difficulty sorting out priorities.
- ✓ Difficulty starting routine tasks.
- ✓ Excessive concern with seemingly minor issues.
- ✓ Indecision and difficulty focusing attention as evidenced by a tendency to do familiar tasks and preoccupation with familiar details. These reactions may reach a point where the person becomes very passive or wanders aimlessly. Loss of initiative with fatigue and exhaustion.

1. Muscular tension due to stress

Often increases strain on the scalp and spine (backache) and often leads to headaches, pain, and cramps.

The inability to relax because of prolonged muscular tension wastes energy and leads to fatigue and exhaustion. Muscles must relax periodically to enable free blood flow, waste product flushing, and nutrient replenishment.

1.Shaking and tremors

During incoming rounds, the individual may experience mild shaking. This symptom appears and disappears rapidly and is considered a normal physiological reaction to conditions of great danger.

A common postbattle reaction, marked or violent shaking can be incapacitating if it occurs during the action. If shaking persists long after the precipitating stimulus ceases or if there was no stimulus, the individual should be checked by medical personnel.

It is normal to experience either mild or heavy sweating (perspiration) or sensations of chilliness under combat stress.

2. Digestive and urinary systems reactivation

Nausea (*butterflies in the stomach*) is a common stress feeling. Vomiting may occur as a result of an extreme experience like that of a firefight, shelling, or in anticipation of danger.

Appetite loss may result as a reaction to stress. It becomes a significant problem if rapid weight loss occurs or the person does not eat a sufficiently balanced diet to keep his muscles and brain supplied for sustained operations.

3. Acute abdominal pain (*knotted stomach*, heartburn) may occur during combat. Persistent

and severe abdominal pain is a disruptive reaction and may indicate a medical condition.

Frequent urination may occur, especially at night.

During extremely dangerous moments, the inability to control bowel and/or bladder functions (incontinence) may occur. Incontinence is embarrassing, but it is not abnormal under these circumstances.

4. Circulatory and respiratory systems

Rapid heartbeat (heart palpitations), a sense of pressure in the chest, occasional skipped beats, and sometimes chest pains are common with anxiety or fear. Very irregular heartbeats need to be checked by medical personnel.

Hyperventilation is identified by rapid respiration, shortness of breath, dizziness, and a sense of choking. It is often accompanied with tingling and cramping of fingers and toes.Simple solutions are increased exercise and breathing with a paper bag over the nose and mouth or breathing slowly using abdominal muscles (called abdominal breathing).Faintness and giddiness reactions occur in tandem with generalized muscular weakness, lack of energy, physical fatigue, and extreme stress. Brief rest should be arranged, if possible.

5. Sleep disturbance

Sometimes a Soldier who has experienced intense battle conditions cannot fall asleep even when the situation permits or when he does fall asleep, he frequently wakes up and has difficulty getting back to sleep (refer to Chapter 4 for a complete discussion on sleep deprivation).

Terror dreams, battle dreams, and nightmares of all kinds cause difficulty in staying asleep. Sleep disturbances in the form of dreams are part of the coping process. This process of working through combat experiences is a means of increasing the level of tolerance of combat stress. The individual may have battle-related nightmares or dreamshat a close relative (such as a spouse or parent) or another person important in his life has been killed in the battle. As time passes, the nightmares tend to occur with less intensity and less frequency. In some cases, a Soldier, even when awake, may experience the memory of the stressful incident as if it were recurring (called a *flashback*). This is usually triggered by a smell, sound, or sight, and is not harmful as long as the Soldier realizes it is only a memory and does not react inappropriately or feel overwhelmed. However, if it happens frequently or is very distressing, help should be sought from the chaplain or medical personnel.

When a person is asleep, the sleep is not restful sleep if the person is constantly being halfwakened by noise, movement, or other stimuli. Heavy snoring often indicates poor quality sleep. The individual wakes up as tired as when he went to sleep. Finding a more comfortable position, away from distractions, can help.

Individuals exhibiting a need for excessive sleep may be exhibiting symptoms of combat stress; however, excessive sleep is also a sign of substance abuse or depression. (Persistent insomnia is a more common indicator of possible depression) .

6. Visual and hearing problems and partial paralysis

Stress-related blindness, deafness, loss of other sensations, and partial paralysis are not truephysical injuries, but physical symptoms that unconsciously enable the individual to escape or avoid a seemingly intolerably stressful situation. These symptoms can quickly improve with reassurance and encouragement from comrades, unit medical personnel, or physician.If they persist, the physician must examine the Soldier to be sure there is not a physical cause; for example, laser hazards (such as laser range finders) can cause temporary or partial blindness and nearby explosions can cause ear damage. Individuals with these physical conditions are unaware of the

causative relationship with their inability to cope with stress. These cases are genuinely concerned with their physical symptoms and want to get better. They are willing to discuss them and do not mind being examined. This is contrary to malingerers faking a physical illness, who are often reluctant to talk, or who over-dramatize their disability and refuse an examination.

Visual problems include blurred vision, double vision, difficulty in focusing, or total

7.blindness

Hearing problems include the inability to hear orders and/or nearby conversations or complete deafness occurs. Paralysis or loss of sensation is usually confined to one arm or leg. Prickling sensations or rigidity of the larger joints occur. However, temporary complete immobility (with normal breathing and reflexes) can occur. If these reactions do not recover quickly with immediate reassurance, care must be taken in moving the casualty to medical treatment facility for an evaluation to avoid making a possible nerve or spinal cord injury worse.

8. Bodily arousal

Not all emotional reactions to stress are necessarily negative. For example, the body may become aroused to a higher degree of awareness and sensitivity.

9. Threat

In response to threat, the brain sends out chemicals arousing the various body systems. The body is ready to fight or take flight.

The alerting systems of the experienced combat soldier become finely tuned, so that he may ignore loud stimuli that pose no danger (such as the firing of nearby friendly artillery). However, he may be awake from sleep at the sound of an enemy mortar being fired and take cover before the round hits.

The senses of vision and smell can also become very sensitive to warning stimuli. The Soldier may instantly focus and be ready to react.

10. Hyperalert

This refers to being distracted by any external stimuli that might signal danger and overreacting to things that are, in fact, safe. The hyperalert Soldier is not truly in tune with his environment, but is on a hair trigger.

The hyperalert Soldier is likely to overreact and consequences can range from firing at an innocent noise to designating an innocent target as hostile, or misinterpreting reassuring information as threats, and reacting without adequate critical thinking.

11. Startle reactions

This is part of an increased sensitivity to minor external stimuli (on-guard reactions). Leaping, jumping, cringing, jerking, or other forms of involuntary self-protective motor responses to sudden noises are noted. The noises are not necessarily very loud. Sudden noise, movement, and light cause startle reactions; for example, unexpectedmovement of an animal (or person) precipitates weapon firing.

12. Anxiety

Fear of death, pain, and injury causes anxiety reactions. After witnessing the loss of a comrade in combat, a Soldier may lose self-confidence and feel overly vulnerable or incapable.The death of a comrade leads to serious loss of emotional support. Feelings of *survivor guilt* are common.The survivors each brood silently, second-guessing what they think they might have done differently to prevent the loss. While the Soldier feels glad he survived, he also feels guilty about having such feelings. Understanding support and open grieving shared within the Unit can help alleviate this.

13. Irritability

Mild irritable reactions range from angry looks to a few sharp words, but can progress to more serious acts of violence. Mild irritability is exhibited by sharp, verbal overreaction to normal, everyday comments or incidents; flare-ups involving profanity; and crying in response to relatively slight frustrations.

Severe irritability includes sporadic and unpredictable explosions of aggressive behavior (violence) which can occur with little or no provocation. For example, a Soldier tries to pick a fight with another Soldier. The provocation may be a noise (such as the closing of a window, an accidental bumping, or just normal verbal interaction).

14. Short attention span

Persons under pressure have short attention spans.

Soldier finds it difficult to concentrate.

Soldier has difficulty following orders.

Soldier does not easily understand what others are saying.

Soldier has difficulty following directions, aiding others, or performing unfamiliar tasks.

15. Depression

Soldier responds to stress with protective defensive reactions against painful perceptions.

Emotional dulling or numbing of normal responsiveness is a result.

The reactions are easily observed changes from the individual's usual self.

16. Low energy level

Decreased effectiveness on the job, decreased ability to think clearly, excessive sleeping or

Difficulty falling asleep and chronic tiredness can occur.

Emotions such as pride, shame, hope, grief, and gratitude no longer matter to the person.

17. Social withdrawal

The Soldier is less talkative than usual and shows limited response to jokes or cries.

He is unable to enjoy relaxation and companionship, even when the tactical situation permits.

18. Change in outward appearance

If the Soldier is in a depressed mood, he may be observed to exhibit very little body movement and to have an almost expressionless mask-like face.

The Soldier may present disheveled in appearance, with reduced personal hygiene, and with little military bearing.

19. Substance abuse

Some Soldiers may attempt to use substances such as alcohol or drugs as a means of escaping combat and operational stress.

The use of substances in a combat area makes some Soldiers less capable of functioning on the job. These Soldiers are less able to adapt to the tremendous demands placed on them in combat.

20. Loss of adaptability

Less common reactions include uncontrolled emotional outbursts such as crying, yelling, or laughing.

Some Soldiers may become withdrawn, silent, and try to isolate themselves.

Uncontrolled reactions can appear singly or in combination with a number of other symptoms. In this state, the individual may become restless, unable to keep still, and move aimlessly about.

The Soldier may feel rage or fear which he demonstrates by aggressive acts, angry outbursts or irritability.

21. Disruptive reactions

Soldiers with disruptive combat operational stress cannot function on the job.

In some cases, stress produces signs and symptoms often associated with head injuries. For example, the person may appear dazed and may wander around aimlessly. He may appear confused and disoriented and exhibit either a complete or partial memory loss.

Soldiers exhibiting this behavior should be removed from duties until the cause for this behavior can be determined.These Soldiers may compromise their own safety in a desperate attempt to escape the danger that has overwhelmed them.

An individual Soldier may panic and become confused. The term *panic run* refers to a person rushing about without self-control. In combat, such a Soldier can easily compromise his safety and could possibly get killed. His mental ability becomes impaired to the degree that he cannot think clearly or follow simple commands. He stands up in a firefight because his judgment is clouded and he cannot understand the likely consequencesof his behavior. He loses his ability to move and seems paralyzed. A person in panic is virtually out of control and needs to be protected from himself. More than one person may be needed to exert control over the individual experiencing panic. However, it is also important to avoid threatening actions, such as striking him. They may compromise the safety of others if panic is not quelled early, it can easily spread to others. Although the more serious or warning behaviors described in the preceding paragraphs usually diminish with help from comrades and small unit leaders and time, some do not. Soldiers can improve when their basic needs are met and they are given the opportunity to express their thoughts. If a Soldier's signs and symptoms do not improve within 1 to 2 days or when symptoms endanger the Soldier, special psychotherapeutic care is needed from a battallian psychologist

11.5. Stress behavior in full spectrum operation

Combat and operational stress behavior is the term that is used to describe the full spectrum of combat and operational stress that Soldiers are exposed to throughout their military experience. Soldiers especially leaders must learn to recognize the symptoms and take steps to prevent or reduce the disruptive effects of combat and operational stress. Combat and operational stress is a reality of all military missions. It

is important to understand that combat and operational experiences affect all Soldiers and reflect all activities that Soldiers are exposed to throughout the length of their military service whether it is a complete career or a single enlistment.Combat and operational stress can occur during missions in both deployed soldiers even if each onefeels the deployment realities in his own way but the life in deployment remains one for both soldiers. Combat stressors include singular incidents that have the potential to significantly impact the unit or Soldiers experiencing them, may come from a range of possible sources while performing military missions. Operational stressors may include multiple combat stressors or prolonged exposures due to continued operations in hostile environments. Combat and operational stressors have a combined effect that results in COSRs.

11.6. Potentially traumatic event

Units and Soldiers deploy and execute military missions which continuously can expose them to military-specific stressors. The effects of these stressors are experienced prior to, during, and after conducting military operations and missions. Sometimes these stressors are related to a significant or multiple PTEs. A PTE is an event which causes an individual or group to experience intense feelings of terror, horror, helplessness, and/or hopelessness. It is an event that is perceived and experienced as a threat to one's safety or to the stability of one's world. Units and Soldiers can be exposed to or experience PTEs during both combat and operational military missions (www.train.army.mil) retrived on july 15,2013.

11.7. Combat and operational stress behavior

Combat and operational stress behaviors cover the range of reactions found in full spectrum operations. It covers the range of reactions from adaptive to maladaptive behaviors**.** Stressors, when combined with effective leadership and strong peer relationships, often lead to adaptive stress reactions which enhance individual and unit performance. Many reactions look like symptoms of mental illness such as panic, extreme anxiety, depression, and hallucinations), but they are only transientreactions to the traumatic stress of combat and the cumulative stresses of military operations. Some individuals may have behavioral disorders that existed prior to deployment or disorders that were first present during deployment and may need clinical intervention beyond the interventions for COSR. The COSR casualties are Soldiers who become

combat ineffective due to unresolved negative COSRs. Misconduct stress behavior is a form of COSR and most likely to occur in poorly trained soldier, undisciplined units. Even so, highly trained, highly cohesive units, and individuals under extreme combat and operational stress may also engage in misconduct Sometimes .Generally in case of poor behavioral monitoring and control of soldiers, misconduct stress behaviors range from minor breacks of unit orders or regulations to serious violations of the Uniform Code of Military Justice (UCMJ) and of the Law of Land Warfare. Once serious misconduct has occurred, Soldiers must be punished to prevent further erosion of discipline. Combat stress,even with heroic combat performance, cannot justify criminal misconduct and does not remove responsibility from anyone who commits such an act.(www.train.army.mil) retrived July15.2013.

11.8. Post combat and operational stress

Postcombat and operational stress describes a range of possible outcomes along the continuum of stress reactions which may be experienced weeks or even years after combat and operational stress exposure. Postcombat and operational stress includes the adaptive resolution to the stressors of combat operations, mild COSR, and the more severe symptoms that are often associated with PTSD. Leaders, Soldiers, and health care providers must understand this continuum and know the difference between adaptation, COSR, and PTSD in order to help who ever are affected.

11.9. Combat and operational stress reaction and post traumatic stress disorder

Leaders must understand the difference between COSR and PTSD. Combat and operational stress reaction is not the same as PTSD. Combat and operational stress reaction represents the broad group of physical, mental, and emotional signs that result from combat and operational stress exposure which includes :

- ✓ Combat and operational stress reaction which is considered a subclinical diagnosis with a high recovery rate if provided appropriate attention and time.
- ✓ Posttraumatic stress disorder which is an anxiety disorder associated with serious traumatic events and characterized by such symptoms as survivor guilt, reliving the trauma in dreams, numbness and lack of involvement with reality, or recurrent thoughts and images. Posttraumatic stress disorder is a clinical diagnosis as defined by the *Diagnostic and Statistical Manual of Mental Disorders* and the *International Statistical Classification of Diseases and Related Health Problems (ICD-10) in*

Occupational Health. Combat and operational stress reaction and PTSD may share some common symptoms, however, COSR is recognizable immediately or shortly after exposure to traumatic events and captures any recognizable reaction resulting from exposure to that event or series of events. Posttraumatic stress disorder is different from COSR because of its specific chronological requirements and symptom markers that must be satisfied in order to diagnose. Posttraumatic stress disorder is only diagnosable by a trained and credentialed health care provider. (www.train.army.mil) retrived on July15, 2013.

12. Exploration of psychological trauma and psychological debriefing

The well known wars in Burundi, DRC and Sudan for example caused high levels of trauma for involved. Dhladhla (2008, p .68) did research on ex-combatants and wrote: "participation in war or armed conflict is a recognised pathogenic stressor which often results in the soldiers psychological dysfunction", if the trauma is not treated. Bruwer and Van Dyk (2005) wrote that in peacekeeping operations in Africa, soldiers often experienced the following stressors as traumatic: separation from the family, isolation and frustration during the operation, harsh environmental conditions, child soldiers and causalities of the population like pregnant women. These are some exemples illustrating the extent to which trauma in Africa has the potential to destroy the mental health of people, their future, relationships and reason for existence.

This part will look at Psychological Debriefing (PD), as an intervention, after a traumatic event or a traumatic phase of life with the aim of preventing psychological complications, healing pain and creating future orientation. Trauma and some common consequences of trauma will be discussed so that one can understand why PD can play an important role after traumatic events.This paper will also focus on the different models of PD, the role of PD during military operations, as well as in traumatic circumstances in countries in Africa. A proposed PD model for military forces in Africa, as well as for the civilian populations will be discussed.

12.1. What is trauma

In order to understand PD one must first understand trauma. According to Perry (2006, p.1), "trauma is a psychologically distressing event that is outside the range of usual human experience". He continues to say that trauma often involves a sense of fear, terror and helplessness, and that trauma is an experience that induces an

abnormally intense and prolonged stress response (Perry, 2006). In some circumstances it can destroy the health levels of a community, for example, after a disaster.Trauma can also be seen as the influx of violent and urgent events which exceeds the defensive capacity of the person, such that the person can not master these events through normal adjustment processes (Crocq, & Crocq, 1987). Trauma is most often the result of a critical incident (rape), series of incidents (disasters) or a situation like war.Lewis (2001) writes a critical incident is described as any unplanned, unexpected or unpleasant situation faced that causes individuals to experience unusually strong emotional reactions and which have the potential interfere with their ability to function either immediately or later.War is an ongoing destructive process, where the population and soldiers experience trauma,losses, helplessness, feel out of control, struggle with feelings of anger, hate, resentment and sadness. The underlying assumption of PD is that reactions due to trauma are normal expected reactions being experienced by a normal person in response to an abnormally challenging situation (Lewis, 2001).

12.2 Consequence of trauma

Trauma affects every part of a person's being, their thoughts, emotions, behaviour and physical reactions. Trauma also refers to overwhelming, uncontrollable experiences that psychologically impact on victims by creating in them feelings of helplessness, vulnerability, loss of safety and loss of control. These traumatic results can result in psychological disorders such as Post Traumatic Stress Disorder ''Acute Stress Disorder'' and ''Combat Stress Reaction'' in military perations (www.train.army.mil retrieved on July15,2013).

12.3. Post traumatic stress disorder

Prior to 1980 there was no formal diagnosis for Post Traumatic Stress Disorder (PTSD). People who showed symptomatic behaviour as a result of a traumatic event were described as having a character defect (Carll, 2007). PTSD was firs recognised as a psychiatric disorder in the third edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-III) (McNally, Bryant, & Ehlers, 2003).PTSD is a psychiatric disorder that can occur in soldiers and other people who have experienced or witnessed life-threatening events such as natural disasters, terrorist incidents, war or violent personal assaults. People suffering from

PTSD often re-live the experience through nightmares or flashbacks of the incident. They may also have difficulty sleeping and can feel detached from their environment. PTSD can lead to the development of other related disorders such as depression (American Psychiatric Association (APA), 2005).

People who suffer from a traumatic event may have a range of different reactions including anger, self-blame, fear and anxiety. The question, however, is what qualifies as a traumatic event? According to the DSM (APA, 2005), to qualify as being exposed to trauma, an individual no longer needs to be a direct victim.

As long as the person is confronted with a situation that involves threat to the physical integrity of that person or others and experiences the emotions of fear, horror or helplessness, then the experience counts as exposure to a PTSD-qualifying stressor (APA, 2005). Usually, PTSD will appear within three months of the traumatic incident, but it may at times only appear later (Baumann, 1998). According to Baumann (1998) factors that influence the vulnerability of the individual to the development of PTSD include the following:

- ✓ Psychological difficulties present before the traumatic event.
- ✓ The trauma is severe and/or persisting.
- ✓ The age of the person.
- ✓ Absence of a social support system.
- ✓ Previous exposure to trauma.
- ✓ Lack of safety in their environment.
- ✓ The trauma was initiated by people rather than nature.

The more factors that are present, the more likely it will be that the person will be vulnerable to trauma. PTSD symptoms are grouped into three categories:

1) Intrusion or the re-experiencing of the event,

2) Avoidance of associated stimuli and emotional numbing and

3) Hyperarousal (Baumann, 1998).

Intrusion is when people complain that memories of the traumatic incident come back to them unexpectedly. These flashbacks of the events intrude into their lives and cause discomfort. These sudden, vivid memories will normally be accompanied by strong painful emotions associated with the traumatic event. These flashbacks can sometimes be so strong that the person feels that he/she is experiencing the traumatic event all over again (APA, 2005).

Avoidance symptoms tend to affect relationships with others. The person may try to avoid close emotional ties with family, colleagues and friends. At first, the person may feel numb and only complete routine, mechanical activities. Then, when re-living the traumatic event, the individual may alternate between a flood of emotions caused by the flashbacks of the events and an inability to feel or express emotions at all. A person with PTSD may try to avoid situations that are reminders of the original traumatic event (Baumann, 1998). PTSD can cause individuals to act as if they are constantly threatened by the trauma that caused their disorder. This hyperarousal can cause them to become suddenly irritable or explosive, even when unprovoked. They may have trouble concentrating or remembering current information and, because of terrifying nightmares, may develop insomnia. Many people with PTSD also attempt to rid themselves of painful flashbacks, loneliness and anxiety by abusing alcohol or other drugs to help them dull or forget the pain and trauma temporarily. This tendency can lead to further problems in their personal lives (Baumann, 1998).

12.4. Acute stress disorder

The definition of Acute Stress Disorder (ASD) requires that the individual has experienced or witnessed an event that has been threatening to either him/herself or another person and that the person's response to this event must involve fear helplessness or horror (Bryant, & Harvey, 2002). The symptom cluster that distinguishes ASD from PTSD is the emphasis on dissociative symptoms.

A person must display at least three of the following symptoms in order to satisfy the criteria:

1) A subjective sense of numbing or detachment,

2) Reduced awareness of his/her surroundings,

3) Derealisation,

4) Depersonalisation and dissociative amnesia (Bryant, & Harvey, 2002).

Numbing refers to a detachment from expected emotional reactions. The individual tends to show no emotions regarding the traumatic event. Reduced awareness of his/her surrounding refers to the person being less aware of what is happening around him/her during the traumatic event or immediately after it. Derealisation is when the person perceives his/her environment to be unreal or dreamlike. Depersonalisation refers to the sense that one's body is detached or a person is seeing himself or herself

from another's perspective. Dissociative amnesia refers to the person's inability to recall specific parts of the traumatic event (Bryant & Harvey, 2002).

The only other significant difference between ASD and PTSD is the time frame given for diagnosis. The time frame for ASD requires that the symptoms be present two days after the event and not persist for more than one month. Persons suffering from ASD will receive treatment much earlier due to this time period (Bryant & Harvey, 2002).

12.5. Combat stress reaction

Combat Stress Reaction (CSR) is also known as battle fatigue, shell shock and combat neurosis.Generally, CSR is characterised by a reduction in the person's capacity to function as a soldier and the subjective experience of overwhelming distress and inescapable anxiety (Freedy, &Hobfoll, 1995). According to Noy (1987), CSR consists of three stages:

1) Immediate,
2) Acute and
3) Chronic.

The immediate stage is characterised by anxiety, hyperactivity and panic after,for example, an artillery bombardment. Intense emotional turmoil, in the form of rage, crying and terror or extreme unresponsiveness can be observed. These extreme reactions can start suddenly at a breaking point or they can gradually build up to a point. During this stage, it may still be possible to prevent the disorder with psychological debriefing from developing to the next stage. During the acute stage, the soldier may try to use defense mechanisms like repression, dissociation or denial.

PD alone will no longer be effective during this stage. The soldier will need more treatment then PD, which can include removal from the battlefield, sometimes hospitalised with medication and a more detailed long term treatment approaches (Nathan, 2005). During the chronic phase functional efficiency is reduced and the soldier will suffer from exaggerated startle response, explosive anger, disruptive sleep and persistent battle dreams. This phase is very similar to PTSD and may persist indefinitely (Noy, 1987). Normally, the soldier also needs more than PD.The principle indicators of CSR include:

1) Strong enough emotions that interfere with task accomplishments,

2) Tension that is out of the control of the soldier and that does not decrease during times of relief,
3) Distress that is significantly more intense than that of other soldiers that are experiencing the same conditions and behaviour that is different to that of the soldier's normal behavior (Freedy,Hobfoll, 1995). If this disorder is left untreated it can ultimately lead to the development of PTSD (Noy, 1987).

12.6. Trauma experienced during military operations and disaster

Although each war and each deployment is different, there are however some fundamental aspects that are the same. Freedy and Hobfoll (1995) discuss some dimensions of war–zone stress. The biggest stressor for any soldier is the possibility that he/she may lose his/her life or he/she may lose a close friend. Other stressors that can lead to PTSD and CSR include demands on physical and emotional resources, levels of combat exposure, witnessing abusive violence, participation in abusive violence and subjective or perceived threats.

Demands on emotional resources can take the form of threats of personal injury or engaging in hostile destructive activities whereas demands on physical resources can take the form of inadequate supply of food, water and shelter as well as physical exertion. Levels of combat exposure can take many forms for example being on the receiving end of a fire fight, firing a weapon at an enemy and being exposed to wounded, dying or dead people (Freedy, & Hobfoll, 1995).

During peacekeeping missions, soldiers are not often actively involved in fire fights and are exposed to situations where they witness the aftermath of brutal attacks on civilians or the attack itself and they are not allowed to intervene. This can creat feelings of powerlessness and also contribute to PTSD and CSR (Freedy, & Hobfoll, 1995). During disasters in Africa like the flood in Mozambique, the drought in Ethiopia, bomb blasts inUganda or with personal disasters like rape, communities or individuals can experience shock, overwhelmed by emotions, can feel traumatised and helpless without a vision for the future. Such a situation can destroy the community's health and can be characterised by the anxiety, depression, anger and conflict. This chapter on psychological debriefing wants to empower community health workers, social workers, community leaders, military leaders and psychologists to help with PD.

12.7. Psychological debriefing

PD has been defined as « a brief, short-term intervention aimed at mitigating long-term distress and preventing the emergence of post traumatic stress » (Devilly, Gist, & Cotton, 2006, p.318).

PD has also been defined as a "planned structured group activity, organised to review in detail the facts, thoughts, impressions and reactions following a critical incident" (Dyregrov, 1997, p.589). PD is implemented within three days after a traumatic event and is predominantly done in terms of group interventions facilitated by trained peers or mental health professionals (Foy, Eriksson, & Trice, 2001). PD is a single session, semi-structured crises intervention designed to reduce unwanted psychological problems following a traumatic event by promoting emotional processing through the ventilation and normalisation of reaction (Bisson, McFarlane, & Rose, 2000). However, it must be made clear that PD is not psychotherapy or counselling, but only an intervention (Van Dyk, 2000).

12.7. 1.The aim of psychological debriefing

PD aims to prevent the development of abnormal stress responses and tries to promote normal stress responses (Deahl, 2000). Furthermore, PD aims to prevent the after effects of trauma, such as PTSD and CSR, stimulate group cohesion, normalise reactions, accelerate normal recovery, stimulate emotional ventilation and promote a cognitive grip on the situation (Dyregrov, 1997).

Van Dyk (1999) writes that after the emotions are debriefed it is most important to empower or better still, "ego-power" the victim. The ego represents the centre of our decisions, plans, actions and reactions. If the ego is developed, it is well able to deal with many difficult situations and master the future in a more competent way, instead of getting under severe pressure of anxiety. PD is also used as a screening function to determine whether or not a person who experienced trauma should be referred for treatment or not (Arendt & Elklit, 2001).

12.7.2..A Brief history of psychological debriefing

PD dates as far back as World War I. During this war, a model that was based on three principles, namely proximity, immediacy and expectancy (PIE) was utilised. The focus of this model was to treat soldiers close to the battlefield (proximity) as soon as possible (immediacy) with a strong prospect that they would return to the

battlefield for active duty (expectancy).During World War II, Brigadier General Samuel Marshall was the chief historian of the US Army. He coincidentally discovered that during the collection of his data for his records, which consisted primarily of group discussions with troops, that these discussions influenced troops'emotions for the better (Mirzamani, 2006). This was known as Historical Group Debriefing (HGD) (Adler, Castro, & McGurk, 2009). In the early 1980's Mitchell developed a model named critical incident stress management (CISM) for the emergency medical services in the United States of America (USA). Part of the CISM programme was a model called critical incident stress debriefing (CISD). A lot of attention has since been placed on this one aspect of CISM because it was believed that CISD can be used to prevent the development of PTSD. Then, in 1989, a Norwegian psychologist by the name of Dyregrov adopted the term PD but maintained that PD and CISD were essentially the same thing. Ever since, the two terms have become interchangeable and serve the same meaning (Regel, 2007). The past couple of year's different models on PD were developed. Following is a discussion of those models.

Mitchell's model

Mitchell developed one of the first PD models in 1983. His original model consisted of a"comprehensive, systematic and integrated multi-component crises intervention package (Regel, 2007, p.411). This package was developed for the use of individual as well as group interventions. This model was known as the CISM model (Regel, 2007). The CISM model comprised of many elements including pre-crisis education, assessment, defusing, CISD and specialist follow up (Regel, 2007).

For the purpose of this thesis, only CISD will be discussed as it is the element that has received the most focus during the past few years.

Critical incidence debriefing

CISD is a structured approach that consists of seven phases. These phases include the following:

1. The introductory phase,
2. The fact phase,
3. The thoughts phase,
4. The reaction phase,

5. The symptom assessment phase,
6. The information phase and
7. The re-entry phase (Devilly, & Cotton, 2003).

During the introductory phase, the participants are introduced to the CISD model and its components. They are also informed that confidentiality applies to the entire session and that they should feel free to say whatever they want. It is also emphasised that they will not be forced to say more than they want to, but they are encouraged to participate in the discussions. One of the most important parts of the introduction is to make it clear to the participants that PD is not counselling or psychotherapy, but a discussion of psychological elements (Mirzamani, 2006).

During the fact phase, the aim is to establish the facts of the particular incident. This is done by asking specific questions, for example, 'Where were you deployed?' and 'What happened when you made contact with the enemy?' During this stage their emotions will also come to the fore. These emotions are openly acknowledged and judged as normal reactions to the traumatic event (Rose, & Tehrani, 2002).

During the third phase, the participants' initial thoughts regarding the event are discussed. Here participants are encouraged to discuss the personal meaning the event has for them (Rose, &Tehrani, 2002). During the fourth phase, which is the reaction phase, the participants discuss the emotional, physical and behavioural reactions that result from the traumatic event. This phase usually takes the majority of the session and is the deepest phase of the PD session. The facilitator will ask questions such as 'What is the worst part of this event for you?' During this phase, participants are urged to speak freely and openly about their fears and emotions associated with the event.The fifth phase is the symptom assessment phase. During this phase the facilitator will look for physical, emotional, cognitive or behavioural symptoms of PTSD and other psychological disorders associated with traumatic events (Mirzamani, 2006). The next phase of the intervention is the information and teaching phase. During this phase general information is given regarding the stress reaction and the normal nature of these reactions. The facilitator gives specific advice regarding the reactions the individuals can expect as a result of the stressor (Mirzamani, 2006).

The facilitator also gives the participants advice regarding alcohol consumption, relationships and other relevant factors (Rose, & Tehrani, 2002). The last phase of this model consists of the re-entry phase. During this phase, all the issues that were

discussed are summarised and further attention is given to certain issues if needed (Mirzamani, 2006). It is also during this phase that referral information is provided for future follow ups (Devilly, & Cotton, 2003). Individuals who show symptoms of PTSD or other psychological disorders associated with trauma must be refered to qualified professionals so that they can receive help as soon as possible (Rose, &Tehrani, 2002).

Dyregov's model

Dyregrov based his PD model on the work of Mitchell, although there are some differences between the two models (Mirzamani, 2006). For the purpose of this thesis, only the differences will be discussed seeing that the models are relatively similar. There are three main differences between the two models. Firstly, where Mitchell's model starts the discussion with clients where the traumatic event started, Dyregrov starts his discussion of the event at what happened before the event occurred. He does this by asking questions such as 'How did you find out about this event?' (Rose, & Tehrani, 2002).Secondly, Dyregrov also focused on the cognitive decision making process of the individual during the event. This is done by asking questions such as 'Why did you decide to do that?' It is suggested that these questions reduce the tendency of individuals to blame themselves for what has happened. A third difference between the two models is that Dyregrov also focused on sensory information by asking questions such as 'What did you hear, smell, taste and see?' Dyregrov's model placed more emphasis on the reaction and responses of the individuals than Mitchell's model does and it is therefore suggested to be safer for the participants (Rose, & Tehrani, 2002).

The controversy on PD as illustrated by Van Wyk and Edwards (2005) is that "debriefing" is a military term referring to interviews in which critical incidents are examined by those involved in them and those in authority. Everly and Mitchell (2000) wrote critical incident stress debriefing (CISD) refers to one form or model of group crisis intervention, sometimes generally referred to as group psychological debriefing (PD). CiGrang, Peterson and Schobity (2005) wrote that there are a number of factors that have made PD especially appealing to a military population. PD deemphasizes psychotherapy and pathology, while emphasising normalization of reactions and returning members of the military to duty. The authors are aware of the

academic discussion on the advantages and disadvantages of PD, but this is not the focus of this thesis.

The authors want to use the advantages of PD, but agree with Edwards, Sakasa and Van Wyk (2005), Petronko (2005) and Nathan (2005) that once off PD session is not the most effective method to deal with PTSD. PD will be part of the proposed model with the function that members can get psychological closure after a traumatic event. Further it can be used as psychological triage by clinical psychologists on members who are psychologically fit to go back to the operational environment (Dhladhla & Van Dyk, 2009).

Raphael's model

Raphael starts the debriefing process by focusing on factors prior to the traumatic event.However, her focus was more on the training and preparation the individuals received prior to the incident. Her model also suggested some areas that may be useful during the intervention. According to Rose and Tehrani (2002), these include the following:

- ✓ The stressors that the person experiences personally, such as death and survivor conflict.
- ✓ Frustrations that may increase the stressors. For example, inadequate skills, training or equipment that could have helped prevent the incident.
- ✓ Special relationships with friends and colleagues who experienced the same incident.

It is suggested that these topics are discussed in a systematic manner to ensure that the participants can work through the emotions that may be evoked. Raphael's model makes use of more straight forward questions such as 'Was your life directly in danger?' This model also focuses on positive aspects of the incident by asking questions such as 'Do you feel good about something you did?' Raphael also suggested that the participants analyse the feelings of people who went through the same incident. These aspects are not present in the previous two models

(Rose, & Tehrani, 2002). Lastly, the model focused on what was learnt from the experience of the incident, feelings around going back to duty and the problems that can arise from returning to the battlefield (Rose, & Tehrani, 2002).

The multiple stress debriefing model

According to Mirzamani (2006), the multiple stressor debriefing (MSD) model consists of four stages. During the first stage, the participants are introduced to debriefing and ground rules are laid down for the duration of the intervention. The participants are then asked to describe what it is about the incident that troubles them the most.During the second phase of this model, participants are asked to describe their feelings and reactions they experienced as a result of the incident. The third phase of this model emphasized the coping strategies that the participants will need and they are also given information regarding normal and abnormal reactions to stress. Participants are asked about their previous coping skills
in the past as well as how they are coping with the current stress. The facilitator will use coping strategies identified within the group and where possible not introduce new strategies. During the last stage of this model, the participants are asked to give their views on how they feel about leaving the disaster site. The emphasis of the discussion then moves to separating from coworkers and preparing them to terminate the PD session. Before leaving, it is emphasised that the participants must continue talking with their colleagues and their partners. By the time they leave, any remaining questions are answered and referrals are made if necessary (Mirzamani, 2006).

Frontline treatment

Frontline treatment has been used for many years in different militaries around the world. It is considered that the closer to the frontlines individuals are debriefed the quicker they will return to active duty. It has been suggested that soldiers must only be removed from the battlefield if there is no improvement in their abnormal behaviour (Freedy, & Hobfoll, 1995).The intervention of trauma usually starts by providing the soldier with temporary relief from stress and seeing to his/her biological and social needs (Freedy, Hobfoll, 1995). This model is based on the principles of proximity, immediacy and expectancy where the expectancy is that soldiers will return to active duty as soon as possible. According to Freedy and Hobfoll (1995). This model follows the following guidelines:

- ✓ Meet the individuals' physiological needs first.
- ✓ Treat the individuals as soon as possible.
- ✓ Temporary relief from the stressor is provided.
- ✓ Use human contact to reassure, clarify and share emotions.

- ✓ Humanise and legitimise fears.
- ✓ Allow expressions of grief, guilt and shame, but challenge self-depreciation.
- ✓ Convey to the individual expectation of full recovery and return to duty.
- ✓ Promote social support that will allow reintegration of the casualty in his/her unit.
- ✓ Do not change the soldier's status as a member of the combat team until appropriate
- ✓ Efforts to reverse the traumatic effects of the stress have been made and have been proven unsuccessful.

It is important to prevent isolation during the first stages of the treatment as this may worsen the traumatic experience. Based on the three principles of this model, proximity, immediacy and expectancy, it is suggested that the individual is treated as close as possible to the battlefield as soon as possible, with the expectation that he will return to the battlefield. This is the bases of the model and is believed to contribute to the success of PD (Freedy, & Hobfoll, 1995).

Battlemind psychological debriefing

Battlemind Psychological Debriefing is one of the newest models of PD. According to Adler et al. (2009), three types of Battlemind Psychological Debriefing have been developed. Two of these are 'in-theatre' models and the third one occurs at post deployment.For the purpose of this thesis, only the in-theatre models will be discussed. These two models are namely the 'Time-Driven Battlemind Psychological Debriefing' and the 'Event-Driven Battlemind Psychological Debriefing'. Time-Driven Battlemind Psychological Debriefing is designed to be implemented at intervals during deployment whereas Event-Driven Battlemind Psychological Debriefing has been designed to be implemented when support is requested after a traumatic event. Due to the fact that units may be deployed in remote areas for long periods of time, it is not always possible to provide them immediately with professionals to facilitate PD when such a request is made. For this reason, Time-Driven Battlemind Psychological Debriefing is favoured above Event-Driven Battlemind Psychological Debriefing. The Time-Driven Battlemind Psychological Debriefing model consists of 5 phases which includes the introduction phase, event phase, reactions phase, self and buddy-aid phase and the battlemind focus phase.

During the introduction phase, the facilitator briefly gives the participants some information about him/herself and his/her experience. He then introduces the program and its aims and gives positive expectations for the program. During this phase the

ground rules for the session are also laid down. It is important for the facilitator to make it clear to the participants that they will have to return to duty after the session is complete. During the second phase, the events phase, the facilitator establishes the events that have placed the unit under strain. The facilitator asks the members to discuss one or two specific events that may have happened during the deployment that may be difficult for them to think about. The facilitator must gather as much information about the incident from the group as possible, but must not allow the group to get over-involved on one point (Adler et al., 2009).The goal of the next phase, the reaction phase, is to have the participants share their reactions in order to normalise their reactions. This phase commences by focusing on the cognitive responses of the members and continues on to their emotional responses. Before the facilitator transitions to the next phase, he/she must summarise what was said and include reactions that may occur that might have been left out by the members. It is also important for the facilitator to address issues of self blame and doubt that the members might have regarding their actions. The fourth phase focuses on the identification of three major symptoms: anger, withdrawal and sleep problems. The goal is to normalise these symptoms and explain to the soldiers what they can do for themselves as well as their buddies. During the discussion of anger, it is important to explain to the participants that it is normal to develop a short temper and that feelings of revenge are normal, but it must be emphasised that they need to remain professional and be able to return home with a story that they "can live with". When discussing withdrawal, it is important for the members to discuss the signs of withdrawal as well as the importance of keeping an eye on each other to ensure that a fellow member receives the necessary support and professional help whenneeded (Adler et al., 2009).Lastly, when discussing the problems, it is important for the facilitator to once again normalize sleep problems and discuss solutions for sleep disturbances. The last phase of this model focuses on helping the group become psychologically ready to continue with their deployment (Adler et al., 2009).Facilitators ask questions to extract ways in which members have maintained perspective,focused on positive adaptation, identified coping strategies and recognised similarities and differences in their adjustment. This is done in order for participants to learn how to cope with the stressor through sharing it with each other. Participants must be reminded that they must

1) Trust their military training and personal decisions,

2) Watch out for one another

3) Listen to their leaders and inform their leaders if there are any problems. In closing, the facilitator should inform participants where they can receive further help if they should need it, and must emphasise that seeking help when in need of it is a sign of strength and leadership (Adler et al., 2009).

13. Proposed model for PD model for military forces in Africa

It has been suggested that high-risk organisations such as the military and police force should make use of models that do not only include an intervention model, but other tactics and strategies as well. One such model is the CISM model which consists of the following methods, in addition to CISD (Everly, & Mitchell, 1999, pp. 71–92):

- ✓ **Pre-incident preparedness training**: This refers to educating soldiers in high-risk occupations about the kinds of stressors they are likely to encounter on the job, about common stress reactions and about stress-management techniques. This can be given to soldiers prior to deployment so that they can know what to expect.
- ✓ **One-on-one individual crisis support**: This refers to attempts to mitigate acute stress reactions, often at the scene of the trauma. The counsellor attempts to provide psychological distance between the scene and the soldier in distress by having the person take a walk or withdraw for a couple of hours from the battle field. This may not always be possible immediately during military operations, but necessary when possible.
- ✓ **Demobilisation**: This refers to providing food, rest and information about coping with stress reactions to large groups of soldiers as they rotate off duty. This method includes group informational briefing, which refers to providing facts about a critical incident to a large group of individuals indirectly affected, as well as providing information about common psychological dynamics (e.g. grief, anger) and about how to access psychological services. These tactics are only relevant to the military in terms of providing food and rest to the individual for a couple of hours.
- ✓ **Debriefing**: This refers to a small-group intervention that usually takes place within twelve hours of the traumatic event. It involves having participants explore and discuss the incident and their emotional reactions to it. It is the practise in the CanadianDefence Force (Rosebush, 1998) and in the armed forces of the United

States of America (Keller, 2005) to sensitise and empower military leaders with knowledge of PD for the management and early referral of soldiers in operations.

- ✓ **Family support**: This refers to debriefing family members of the soldiers involved in the crisis. For example, giving support to spouses of soldiers in the military.
- ✓ **Referral mechanisms**: This is concerned with procedures for referring individuals for psychiatric or psychological services. The facilitator must provide the individuals with information on where and how to get help from trained specialists if needed.

If a model such as CISM is considered for the military forces in Africa then certain limitations may arise, such as problems with regards to having enough debriefers available to implement the program as needed. A possible solution to this problem would be to train platoon commanders and company commanders to be able to do PD in their platoons or companies as needed. This can be the first line of defence against the development of psychological problems. However, this

Would mean that they would also have to be trained to recognise the signs and symptoms of PTSD, CSR and ASR so that the affected individual can be referred to the field hospital when needed.

Another solution will be to train medics in PD so that the medic in the combat situation is not only trained to treat physical injuries, but also to prevent psychological disorders if we don’t have enough Clinical Psychologists.

CHAP III. METHODOLOGY

III.1. Sample

Our population is composed of ten cases of soldiers from Rwanbatt37 whom after consultation by the battalion Doctor were recommended to visit the battalion psychologist for supportive counseling and psychotherapy during the deployment phase .The most of them presented stress related disorders. We usually discussed with the battalion Dr and the chain of command about their symptoms management and their accompagnement in general. Some among them were rapatriated before the end of the mission and transferred in the military hospital for better management of the mental symptoms ,The most of them cured after arriving home; only one among them continue psychiatric treatment up to days.

III.2.Population

The participants are 787 soldiers in total;767 were male and 20 were female from Rwambatt37 , observed at different phases of deployment to go in mission area until the end of mission.In case of any desease,soldiers consulted the level one clinic and transferred to the battalion psychologist for mental assessment and psychotherapy, In case of critical incidence a debriefing was held to support emotionally soldiers, the sens of cohesion was uswally high .The research is entitled ''Battalion stressmanagement strategic plan, role of battalion clinical psychologist. Case of Rwanbat37 in Soudan (Darfur -north Sudan in 2013)

III.3. Inclusion criteria

All soldiers who participated to the mission of Rwanbatt 37 in Soudan and who at least consulted the level one clinic at least one time. The observation and behavioral assessment was focused on all soldiers of the battalion in interaction but the designated patients are those who consulted the clinic at least once when we were in mission and who were diagnosed, assessed ,interviewed deeply by a psychologist and followed up by the medical team.

III.4.Exlusion criteria

All soldiers who were not deployed to participate to the peacekeeping mission of Rwanbatt 37 in 2013 until the deployment phase, those who did not experience any behavioral trouble in pre-deployment phase.

III.5. Data collection tools

This research was realized using different interdependent methods of data collection:

1. Documentation (sustained the observations, the data collection and progressive analysis up to now) .
2. Participant observation (The researcher was living with the observed group …)
3. Retrospective cohort study (Soldier were exposed to common exposure factor, the role of the research in part was to determine it's influence in the development of stress symptoms and related deseases)
4. Qualitative (interview, observation, focus groups, action research)

We uswally used psychological tests in the level one clinic (chech list of stress symptoms, PTSD, depression).

Interviewed patients in level one clinics, for mutism cases or aphony, the information from the client was received from writing until he recovers the voice .

Used sometimes recoder and photo- camera.

Analysed the impact of all games and other activities (Musics, Rwandan culturetroop, psychoeducative drama and comedies, motivating animation, relaxing collective dinner or feasts , religious activities (choral, mass and praising songs organized by the Rwandan contingent interms of psychological relaxation and indeed in terms of stress prevention among all participants.

Though out different phases of deployment:

During the pre-deployment phase,We participated to the medical and psychological screening examination of soldiers, pretest counseling and post test counseling ,where some among soldiers were screened physically fit to participate to the mission ; But others screened unfit and not able to go in mission and observed their different reactions and behavior toward the medical results. We provided supportive cancelling for most of those mourning the loss of precious mission in Soudan.

We also observed different behavior during the deployment phase where the most of soldier reacted psychologically and somatically to the environment change as a form of adaptation syndroms.We interviewed some of soldiers affected psychologically by stress and all those who consulted the level one clinic for different complains of illness during consultation and psychological accompagnment.

We talked with some soldiers who presented different particular problems either at home or in work in order to help them find solution in collaboration with the chain of command through counseling sessions.

We participated to military briefings and debriefings after each operation in the camp and discussed the potentially stressful events and challenges encountered by the team or in individual session by diagnosing the impact of the stressful event on the mental health of the subject.

We used the check list of stress symptoms, and PTSD symptom scale, beck depression inventory (BDI) after interview for client transferred for psychological screening and suspect of poor mental health. The behavior monitoring day and night of all soldiers in collaboration with the chain of command was always done at daily bases and we all shared information about any unuswal behavior noticed from any body. We revisited previous publications about combat and stress management among soldiers etc…

We were curious to observe the reaction and behavior of close family members of soldiers on return just at the air port, at home for some cases. We tried to interview some of soldier's family members, how they felt the long absence of their husband, father, or brother soldier who was in mission, the problem they endured during his absence and the way they managed it.

We observed the behavior of young children and how they recognize a father, a mother or brather soldier who were absent for long time at home and who comes back.Surelly the interviews revealed many things about stress effects both for soldier and even his family during work and mission far from home.

During the deployment phase, we usually met clients during therapy sessions.

Participants.Here we usually analyzed the interactive behavior in general,the sense of cohesion and belonging among the group of soldiers, the body movement such as facial expression, the interaction with other multi national participant enjoying to pass a good time together socializing and exchanging culture,religious belief through prayers in different congregations in multinational environment. Through all this we observed the way Rwandan soldiers adapt themselves in a multinational and multicultural environment with discipline without acculturation etc…

III.6.Data analysis tools

Qualitative data were analyzed using thematic analysis.

III.7.Procedure

The participants were observed in different phases of mission: the pre-deployment phase, during which medical screening tests, both biological and psychological revealed them to be fit enough to participate to any military work the unfit were directly excluded from the mission during this period. They also were observed during the deployment phase after arriving in the mission area (Darfur/Soudan) where some of them experienced the first symptoms of adaptation, we received more cases of illness in the level one clinic the three first months.

We used to do mental status examination and some psychological tests such as the check list of stress symptoms, and PTSD symptom scale, beck depression inventory(BDI) after interview for client transferred for psychological screening and suspect of poor mental health

The behavior monitoring day and night of all soldiers were usually done in collaboration with the chain of command, we revisited previous publications about combat and stress management among soldiers etc…

All our observations was focused not only on clinical symptoms but also on general interaction of soldiers going and coming back to work,The interaction of soldiers with the chain of command,the problem resolution process among the troup ,the observation of the performance on duty of each soldier,their general behavior in the mission area etc…

I was curious to observe the reaction and behavior of some close family members on return just at the airport and visited some in their family in order to know how they endured the absence of their members who was in mission far from home. We observed them again during the post deployment phase to evaluate their reintegration on duty and in the familly when we came back home.

Let us remember that the general and clinical observation of different behavior of soldiers begun in the predeployment phase in Feb 2013 and the post deployment phase is extended until the new rotation of the battalion in peacekeeping mission after 2016, clinically this periode march with the medical periode of health follow up and rafrechment with home air in order to prepare the next rotation of peacekeeping mission.

III.8. Delimitation of research

This research was limited to soldiers of Rwanbatt37 who participated in peacekeeping mission in Soudan 2013 after the medical screening which showed that they were fit. Our research didn't cover all possible factors of stress during deployment phases. It assessed the strategic plan of stress management ,the role of leadership include the role of clinical psychologist in order to care effectively to emotional casualties in complementarity with all the chain of command during different phases of deployment.

CHAP IV.RESULT PRESENTATION

IV.1.Qualitative data

IV.1.1.Stressors in mission area

Here is some speeches from the testemonies of soldiers which reveals a lot about some stressors encountered in mission in Soudan- Darfur:

-«… Kafodi erea has been burned by aircraft…».

- «…I felt shortage of breath, the wind was hot, I was thirsty, and my swets was salty…».

- «…We feel extremely hot, dusty, foot are burned by heat…».

- «… Some one shot rapid fire in the air tonight at the garding place of the tower ,I tought it was the enemy,after reporting I observed carefully as recommended,Finally we concluded that Some Soudanese were celebrating a birth day of a new born…They are allowed by their culture to bear a gun and use it as they need…».

-«… … I'm informed that my wife has given birth to a new baby girl after caesarian….I'm waiting the baby photo on facebook...She is without assistance in the hospital…Our kids are still very young,they stay alone with our maid…I think you know how the most of them behave,No one can rely on them a hundred percent,some among them are robbers ,mistreats kids at the absence of all kinds …my wife is without any other person to assist him after caesarian birth…».

-«… I'm fed up with sending power of attorney ,my wife and relatives are asking me money that there is a need at home before the mission end…I will find no money after mission at my banking account…the half of my salary is fished is …».

«…Soudanese refugees are suffering, some are gathering in camping sites,when their enemies attacks them ; Some of them receive treatement in our military clinic,they are exhausted,hungry, thirsty , anxious and miserable…Wemen and girls were raped, under eighteen girls have children from rape…their villages were burned from aircraft bombs…Remaining body of man and animal lies every where on the ground …the conflict oppose rebels and gouverment of soudanese…We all communicate as dumbs as we can't speak arabic when no interpreter…but know I can speak a bit arabic… »

Those speeches from soldiers show somehow some of the stressors accountered in mission area which need self adaptation.They show that the security is always unpredictable in peacekeeping mission.The political crisis,the behavior of two or

more parties in conflict, the new culture,the civilian population traumatized and victim of war, the compassion with all population gathered in refugee's camp can affect also indirectly the toughts of a peacekeeper on terrain in one way or another.The stressors from home are the most dangerous to manage because some times you need a holy day before the mission end such as in case of close family member loss, etc….

In case of poor self coping mechanisms, some one can experience some stress symptoms related to the deployment.Through psychoeducation and military family psychological accompagnement, family members may be sensitized to be selective in the message to convey to family members in mission.There exist stressfull news which can generate negatively depressive toughts and plug some one in depression.

However, according to the culture some soldiers seem to transport up on their head their family where ever they are due to social-economic responsabilities .Peacekeepers has sufficient time to prepare their family to the separation during the predeployment periode.

If possible military psychologist in collaboration with the leadership may be facilitated to prepare psychologically the families of soldiers for the deployment separation mostly the wife and kids.

Around 1960 Hans Selye proposed that stress is part of the human condition: the inevitable events including positive and negative aspects of existence and everybody is always under some degree of stress. He stipulated that stress is an unavoidable part of life, a pressure of daily life, a normal part of human life.

« Military operations across the entire range of conflict in a country such as Soudan expose military personnel to a multitude of stressors. These stressors can lead to a variety of negative health consequences, both physical and mental » (Bartone, 2006)**.**

Rwandese Soldiers as others in the world deal with higher levels of stress than most people. The most common stressors in the mission area are family separations, remote location, a suddenly increased or decreased workload, Do not know or cannot influence what is happening with family back home (a sick parent or child, financial problem…).family changes that take place in the soldier's absence, health problems. Other stressors are due to the natural environment, such as intense heat, extreme cold, unpredictable security….

IV.1.2.Role of clinical psychologist in pre-deployment phase and in deployment phase

Pre- deployment phase

During this period the role of clinical Psychologist is:

-Studying and monitoring the pre-deployment behavior of soldiers

-Allocating enough time for pre-deployment individual counseling

-Psycho educating all soldiers about stressmanagement, psychological trauma, integration and adaptability efforts in mission ereas, stress and related behavioral disorders, conflict management and stress,etc….

A facilitator of mission experiences sharing among soldiers; this is helpful to understand the behaviors of soldiers during mission far away from home in a psychosocial perspective.

The screening of unfit was well done and all of them stayed in the country for more medical management. Those who screen unfit and miss this golden opportunity need more psychological accompaniment at this phase. Some can develop the mourning of separation with their colleagues and probably some can present psychological depression, behavior trouble etc….

Deployment phase

We noticed that the first three month was hard because during that period we noticed a lot of patients in the level one Hospital complaining headach, constipation, fatigue, less apetite, nosea, tachichardia, , nostalgia , night dreams include the romantic ones, increase need of communicating with family , passing a lot of time charting on internet with friends who are in Rwanda etc…

We noticed rapid increase of body weight among the majority of soldiers, diabetic case, aphony and other psychosocial needs and problems which needed self adaptation and discipline among soldiers etc…This adaptation efforts are also needed in our families in order to cope with the absence of one of the family members who is far a way on duty.

«It is important to learn how to recognize when your stress levels are “out of control” or having an adverse effect. The signs and symptoms of stress overload can be almost anything. Stress affects the mind, body, and behavior in many ways, and everyone

experiences stress differently, anxious thoughts are future oriented and often predict catastrophe».

During the deployment phase, We noticed that one psychologist is not enough to help efficiently all the battalion, the battalion usually have more than one detachments situated one far away from an other or the behavioral monitoring is a daily participant observation of behavior by a psychologist and this is the basis of behavioral guidance and counseling in terms of battalion stressmanagement.

We noticed that there is the best strategy of working in collaboration with the battalion chain of command in order to manage stress collectively by creating a strong battalion stressmanagement net working where the chain of command plays the major role of mission task achievement and discipline control and the psychologist becomes an expert of behavioral change ; who diagnose ,treats, advise other battalion Commanders about the meaning of present behavior change for each particular case and plan the way to help or to treat the soldier in case of pathological behavior.

IV.1.3.19th Genocide against Tutsi commemoration ceremony and trauma management in Rwambatt37

Evidence of genocide mental health consequences, despite being observed throughout the year, seems to be particularly acute during periods of genocide commemoration each year. In Rwanda, the second week of April is annually associated with an increase in collective traumatic crises whereby many people participating in commemoration activities present with various symptoms, including re-experiencing traumatic events of the 1994 genocide. Some survivors are taken back to their past traumatic experiences, which are acted out in the present. They see militia armed with machetes, attacking them or cutting into pieces legs or arms of their families, or they see their house being burned as vividly as if was occurring again. They re-see and re-vision exactly what they saw, heard and felt in 1994.

These traumatic crises are quite contagious (Gishoma & Brackelaire, 2008.P:47**)**

The routine work of patrols in car during such commemoration which potentially can reactivate ancient trauma from genocide need a close supervision, a client briefing and explanations about trauma victim basic behavior. A soldier in trauma crisis probably can fail down from the patrol car and be injured if others fail to pay attention to his symptoms.Some RDF soldiers are also survivors of genocide, the periode of

genocide against Tutsi commemoration is also a difficult time for some of them in terms of mental health in general. Usually the leadership provides an opportunity to prepare all soldiers to the coming event though psycho-education about psychological trauma, its symptoms, and the way to help each other and the management plan from the medical team include the Bn Psychologist. This is not a task of a clinical Psychologist alone but the responsibility of the battalion chain of command. It involves all the Rwandese diaspora in Soudan and all their frends working in UNAMID near the Bn camping site.

The official ceremony begun with a march anti genocide named « a walk to remember » organized by the contingent, the diaspora and all Rwandan friends in Sudan from the UNAMID Arc to Super camp. An ambulance and the team of medical staff were present to monitor behavioral change among participants for emergency help purpose.

All staff and Rwanda's friends attended different speeches, shared related songs and watched some films about genocide against Tutsi in the camp main hall all the week of mourning; Two rooms were prepared for psychological care the same day of the ceremony.

The emotional crisis among soldiers was manageable, the most affected girl regained psychological force two days after the ceremony. After the commemoration ceremony, we noticed that most of our soldiers were resilient, moralized and well adapted.When we ended the mission, the fresh air of home reenergized all of soldiers.

IV.2. Presentation, analysis, interpretation and interview summary of some interesting cases encountered during the deployment

In this part ten cases will be presented, items developed are not all similar, given the particular anamnesis of each client.

CASE N01

I.Identification

Name: B.E

Age: 29 Yrs old

Education Level: S2

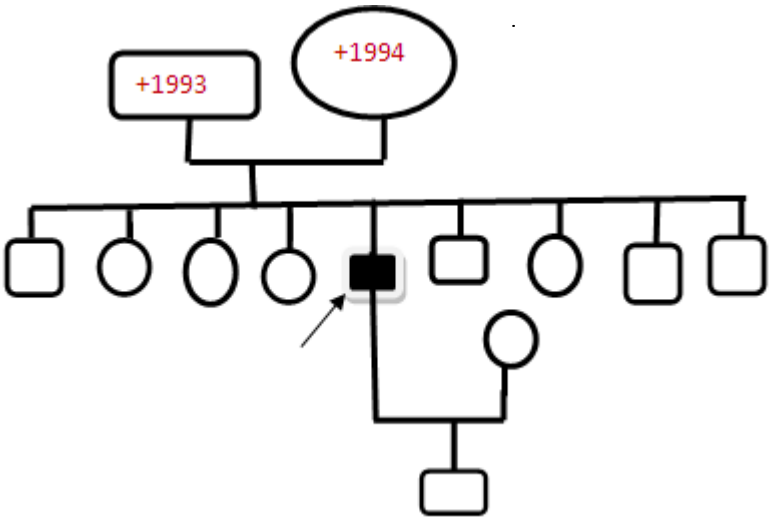
Marital status: Illegaly married

Unity: Unonymous

Familly address: Gisenyi

II. Familly anamnesis

II.1.genogram



His father was killed by soldiers at the boarder between RDC and Gisenyi, the family was victim of political crisis and ethnic discrimination.

Her mother and her three brothers and sister were killed during genocide. Only himself, one married older sister and one young sister remains in the family of nine children after the genocide. Both three escaped agressors by hiding days and night in the bush, their house was destroyed and all things stolen. Saved by RDF soldiers, he went to live with her sister and continued to study until in S2. He lived difficultly because he couldn't get any thing he needed as when her parents were still alive; His school were sponsored by FARG. He used to get good result but after the genocide his school results were poor. He felt not motivated to study as before and was rather motivated to join the army.

III.Military anamnesis

He then enrolled in the army since 2005 and did his military training in the infantry school at Gabiro, and then deployed as a soldier in working Unity. He used to be a disciplined soldier. He did his military training and seemed to be healthier but he most of time complained about headaches which cured after short rest and analgesic pills. In 2014 he illegally married and let her wife and her kid at G Wisenyi. He used to rent a house, her wife used to work in the saloon. Since his wedding he needs more time and money to go at home or he works at Kigali while the wife is at Gisenyi, Sometimes he is obliged to work even the weeck-end and must move from the camp after an official permission. Since 2013 he was proposed to go in mission but was

screened psychological unfit during predeployment screening because he is known to be indisciplined. He usually misses the work and go home without official permission or this is a misconduct and bad behavior in the army. He is most of time punished for drunkurdness but the diagnostic of a psychiatrist showed that the alcohol beers which he begun to drink was in relationship by poor mental health especially trauma.

He presented different symptoms such as: usually poor sleep, mental deconcentration, emotional trouble. He usually could watch television until morning when he is not at work.He treated him with antidepressants but the client claimed to go home until the medicine is finished but the leadership could not allow this for reason of adherence, behavior control and supervision, taking medicine in the camp is better for soldiers for more medical follow up than home, he was known not adherent to the medicine by fear of side effects. He adhered poorly to psychopharmacological treatement, rather he continued his drunkardness until no one could have confidence in him that he can fulfil well the military duty, He was allowed only to do work without gun.Throuly he had trauma symptoms which were not severe rather he felt stigma, some colleague called him a fool, he felt complex etc…and also this had a negative impact on his behavior, some colleagues believed that he want to be demobilized its why he pretends to be fool. We met on Feb16th 2015 for a psychotherapy session in his Unity on order of my leadership.Our relationship succeeded, he was very expressive about his situation, He seemed to be isolated and retraumatised by the attitude of some of his colleagues who could not understand him. He had a lot of psychosocial problems in relationship with his past trauma: ‹‹… I was not allowed to go in peacekeeping mission as I wished it as I, uswally take antidepressants .Really I was forced to take that kind of illness but I'm not a fool. I uswally felt weakness, and uncomfortable when ever I drink it.Let me tell you truth.My wife has gone to his parents as I'm most of time absent at home.We used to hire a house in wich she was living …our family has died, Even if I could have a home at my mother village, I can't live in it.when I arrive there,I fear to remember what happened during the genocide against toutsi. I find it difficult to build my own small house without going in Soudan mission.I, feel much disadvantaged and desapointed…».

IV. Experienced symptoms during crisis.

Poor sleep, uswally he is awake at 3o'clok A.M.

Headaches, hopelessness, loss of energy, nightmares, suicide ideas, emotional trouble after drinking alcohol.

The crisis occur when ever he has social problems, He is very motivated to the army even if he is not allowed to use the gun actually.

V.Analysis of the case

The client lost all his parents during younger age.

He abandoned the school earlier for this reason

His life was difficult since that time

He decided to join the army but he doesn't seem to be satisfied by his job,he presents many social problems and even her wife decided to go back home due to many social problems in their home.He seems to suffer from PTSD since young age,this PTSD derive from genocide,he has developed bad habit to drink alcohol in order to fight insomnia,he seems pessimistic and depressed,He doesn'tperform better his military work because of indiscipline.He doesn't adhere well on psychopharmacological treatement,He fear the stigma from other soldiers and fears the side effects of medecins.

VI.Conclusion

The client is failing to adjust his family life and professional life, missing to go in mission is synonyme of missing social economic means to reorganize his family life, this has an a disadvantage in terms of family-socio- economic management. This cognition can be labeled as a potentially depressive idea to the client. His poor resilience and all those social problems reactivate his ancient trauma through out pessimistic feelings and depressive toughts and all this has an negative impact on his own general functioning and the functioning of his own family, his health in general and mental health in particular.We can notice a poor performance in his military duty than before due to misconduct and negative behavioral change ; This is the impact of stress and trauma on his global functioning ,on his health and performance at work todays. The collaboration between leadership and the battalion medical team is trying to help him in all ways to cure by supportive counseling, behavior mornitoring and pharmacological treatement when ever necessary, the support of camarade is also needed in stead of stigmatizing him because stigma can reduce his self esteem and deepen him in depressive toughts. He is thinking more about the mission and benefits from the mission instead of thinking and focusing on treatement and cure for more professional productivity and health. Those pecimistic ideas reinforces much his

depression and his general behavior which is an obstacle to his mental health rehabilitation.Nothing is valuable then his health.Such a client needs more advise and help from the chain of command and other colleagues in order to think positively and optimistically.

CASE N02

I. Identification

Name: V. E

Age: 35 years

Marital Status: Married

Religion: Catholic

Education Level: S5/Nursing

Father's Name: R .J

Mother's Name: M. E

Home Adress: Gikongoro, there live her wife's family, but he is originating from Cyangugu where lives all his family.

Date of Entry in Army: 1999 /Gabiro Tw.

Military Unit: He worked in 153 then tranfered in 47Bn since September 2014 at Gikongoro.

Date of Arrestation: 11/06/2015 jailed some days at the 47 Bde HQS at Gikongoro then transferred in M.P prison since 15/06/2015

Motif of Arrestation: Desertion

Reason for Hospitalisation: Psychiatric expertise.

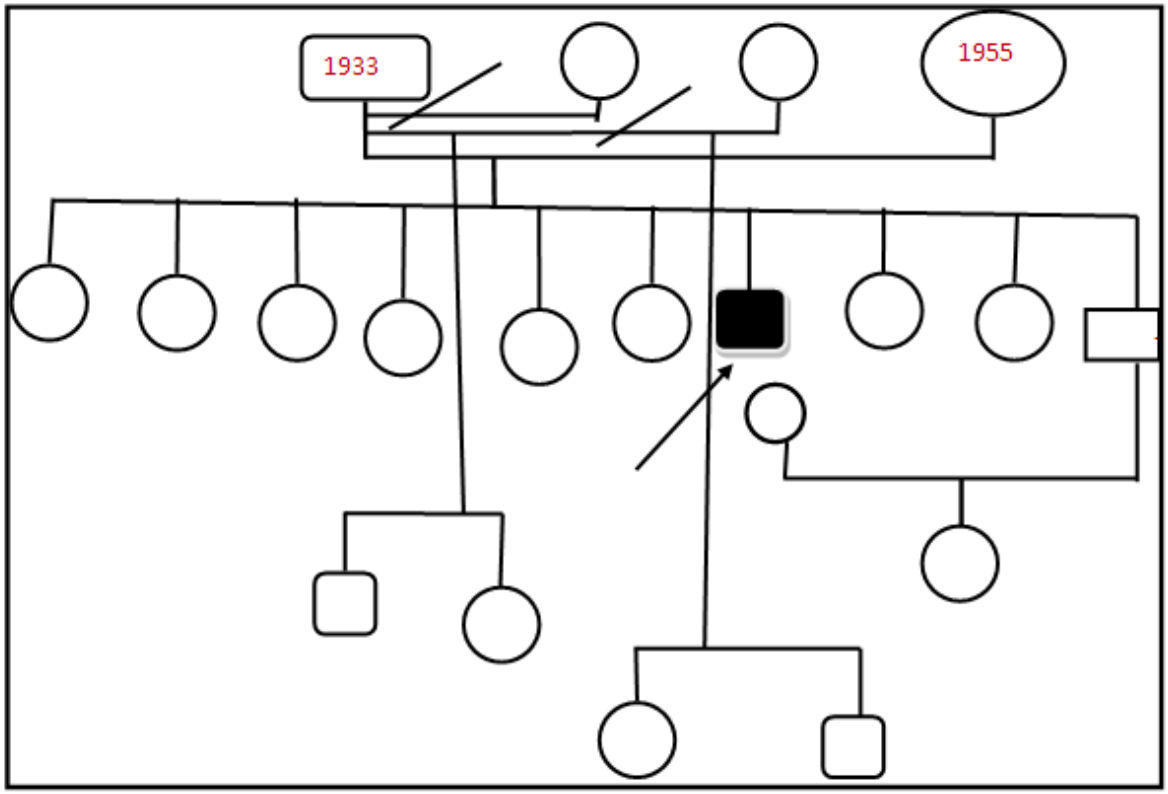
Date of 1rst Admission at CARAES-NDERA HOSPITAL:10/10/2015 from MP-27/11/2015 (hallucinatory behavior,persecution and marginalization feelings,suicide toughts in jail according to his transfert form).

II. What happened when the client was home after being a soldier?

Just after his military training he went in holliday home, He discovered a snake in the pot in her mother's room, he reported the news immediately in the familly and wanted to kill it. «Her mother instead to be pleased, was very angry and insulted him: «… Go away you foolish! Who told you to enter my room? go back in your military as you wished,die there! Instead of disturbing order of thinks in my house! ».The client was frustred by the words and since that time he went back in his military unit

but not much interested to go back at his mother village.He married a wife from Gikongoro where he used to work, and settled there until today, her wife is also a nurse in the nearest health center**.**

III. Genogram of the client's family



IV. Familly anamnesis

The client's Mother is the third woman of her husband; He separated with 2 other women before and got with those two women about four kids recognized legally. All her sisters are married except her old sister who was born before the client and the younger sister who got respectively each one her own child but never married.All those two unmarried sisters and their children lives with their parents.

Since 15/10/2014, the client worked as a nurse of his section.The Unit chain of Command gave him a permission of 10 days to go home to consult a witch doctor because he was experiencing a mysterious illness.

V. Symptoms experienced

Headach,Need to keep away from others, isolation,apathy,monologue,systematized hallucinations and delirium,sometimes anger,emotional disconnection,argumentative

behavior etc…those hallucinations could be easily confused with flash bach: « mumbabarire, nzabaha ibyo mushaka byose ariko nti muntwarire umwana»

it means« I'm sorry,I would give you whatever you want ,but don't take away my child » ; this was the frequent content of my client's hallucinations and delirium,this occurred usually when the client isolate himself in the inward prison toilet , lying straight in front of its door, or when sleeping on his bed. Its other prisoners who usually removed him in front of the toilet to carry him back to his bed place before to alert the battalion psychologist. the client confirmed that he felt tighted the hands and feet by the spirit who carries his child and then he reacts aggressively in order to run after them so that he may take back his son but in vain, during the crisis he seemed to quarrel with someone invisible…the crisis usually last about 30 minuts minimum, and the frequence was about two times a week when he was still in prison.

Laying down without moving feet together as tighted unconsciously delirium , hallucinations and monologue '' When he is in crisis, he usually seem to be in dialogue with someone invisible, He accuses insomnia ,general weakness,sometimes he refuses to eat.

The first crisis began since 2013 when he was in Sudan, two months before the mission end according to himself. The recent crisis happened on 24/06/2015.Usually the frequency of crisis is about one or two times a week, He is jailed in MP prison for desertion behavior.

Are those symptoms true or simply a way to explain that the desertion behavior for him is a way to escape to the military order which seemed to be heavy for him or stressfull « frustrated by it…».??? He seems to be emotionally divided between his proffetional life,his new family established at Gikongoro and the family in wich he was born at Cyangugu.He appear to have many intrapsychological conflicts reffering to his family anamnesis.

VI.Individual perception of the illness

The client thinks having been witched or cursed by his family for having not shared with them the money he got from peacekeeping mission in Darfur, Her mother was the angriest against him.

He consulted a witch Doctor who gave him traditional herbs called « Amasubyo » and told him: Warakize kandi ntacyo umariye iwanyu'' That means '' you got more money but you don't help your parents '' the witch doctor reavealed to the client. The

client seems to believe in the words of the witch doctor reffering to his conflict with her mother.He describes her mother's carracter as imposing, authoritarian and dominant and younger than the father who is weary,calm, older than the mother .

The client also has the culpability feeling because he didn't obey to the will of maternal grandfather who proposed him a power of attorney before his death include «kuragurisha urugimbu n'imiti ya Kinyarwanda: This is a kind of magic power to predict some one's future using a killed hen ».The client was not interested in the magic power, he was still young, felt frustrated by the words of his maternal grandfather, stopped living with him and later he joined the army. He said :« … I din't participate to my grandfather's burrial ceremony, He left me a piece of field in inheritence before he died,as I was still young my parents sold it and bought me a hen I remember , I was still a kid and didn't care about his death but still I remember what he used to tell when we were living together alone in his house…I used to help him to treat people,He was a witch doctor who could foretell about the future of any of his client using a killed hen (Kuragurisha urugimbu),the client used to light the ''urugimbu'' and welcome the grand father's guests when he was a kid… ».

Does this culpability feeling in relationship with the pathological mourning or in relationship with the missed power of attorney from the grand father ?As I've noticed during sessions the evocation of this part of history was not emotionally charged rather he told it as one of his own story well integrated .

VII. Psychological analysis about the case

There is a potentially stressful conflict between the client and his mother.Her mother is dominant in family decision instead of the old father, the mother was angry against his son when he joined the army and expressed her disapointment in such words:

«… How did you decide to join the army when you remain the only boy in the family? We didn't know where you were since all this time…» said her mother, when she visited his son in the military training camp at Gabiro, very far away from home.

The client do not live nearer his parents and brothers, He lives with her wife at Gikongoro where originates her wife and where his Military unity was set.The conflict with her mother begun since that time until today.The family of the client seem to communicate poorly,the mother is dominant,they belief in ancient tradition.

He deserted the army since October 2014.He said he didn't desert but he went home for traditional treatent and even went on official permission but delayed to go back in his military unit.

VIII. Diagnostic hypothesis

Paranoic schizophrenia developed progressively from the stressful family conflicts in relationship with other sources related to military deployment stress. He fears strongly the curse from all members of his family include his parents and maternal grand father.

Until today he doesn't like to pay them a visit and prefers to stay far from them.

« Even if I'm married,I don't have any share on my family land due to my dominant mother who has become against me since I joined the army, my dad does not decide at home »; The client and his family believes strongly in supernatural forces .

We guided him to RMH mental department for more consultation, treatment with forensic purpose.

IX. Treatment plan

Psychotherapy

We are helping with ecclectic approach, daily behavior monitoring, counseling and guidance, information sharing with auditora militaire staff and the leadership for a sustainable solution to the problems of the client .The systemic therapy approach could be very helpful but impossible because the client was not in a psychiatric hospital at the moment,rather he was in jail for desertion and indiscipline behavior.My first step as a military psychologist was to report his mental health status to the leadership and show how helpful is it to release him in order to facilitate his proper psychological treatement process .

Psychopharcology

1.Haldol 5mg/1ces/evening/day/30 days

2.Largactil 100mg/1ce evening/day/30days.

3.Amitriptiline25mg/50mg/ evening/day/ 30days since June 30/2015

4.Akineton 2mg/1ce evening/day/30days

He is on the third doze and is adhering well to the treatment.

X. Recent problem

Need of liberation for social integration to facilitate his treatment according to his belief about his illness.

XI. Limitation about case analysis and efficient treatment

The Therapeutic frame work was difficult when he was still in jail,The small autonomy power of a military psychologist.A military psychologist sugest his observation to his direct leader but the last decision depend to the assessment of the leadership according to each client individually.

Difficulty meeting the family of the client involved in his therapy.I met only two times with her wife when she visited her once in the jail week end visit and once when the client was being observed in CARAES - NDERA. The sessions revealed about his crisis behavior, at home he like to isolate, sometimes aggressive against her wife, likes unplanned long journey without ticket and without fearing any other risk at the beginning of his crisis.

Impossibility of the application of systemic therapy while it's the most efficient for the treatment of such mental cases when the client is still in jail .Even at Caraes Ndera the systemic approach was not used for this case.According to my own observation and discussion with CARAES referral psychologist for this client when the client was hospitalized for treatement and forencic purpose , this approach needs the commitment with the client's family,therapeutic facilities,enough founds for psychology department to facilitate family and local senstisation etc…

Lack of proper psychiatric observation ward for forensic purpose.The client were not at all in crisis when he was transferred at Carraes NDERA but he was hospitalized at the bigginning in crisis ward (word A) the first week of observation.He was claiming and Was pleased to see mee in the hospital.I did him advocacy to his referral nurse by discussing more antecedents of the client , clarifying the demand of the institution about this case in order to help effectively the client until he last discharged day from the Psychiatric hospital.

XII. Tool used

Psychological interview intending diagnostic and therapy.

Diagnostic Refference Manuel (DSM5)

During my resent therapeutic session with the client, I've noticed some suicide ideations and theatralisation of war trauma .He is not aggressive but this behavior can likely occur during crisis in case of schizophrenia mental disorder.

The medical team and other staff involved in security and carseral behavior monitoring are all aware and share information in order to reinforce the follow up.

XIII.Conclusion

According to my emotional investigation, Probably the desertion behavior of the client is in relationship with his mental crisis.A legal conclusion of his case would be helpful even during the treatement process for the good general health of the client.

I swear that all these informations conserning the client are sincere and given at the best of my analysis in mental health and carseral medical-psychology field.Discussions, comments and meta-analysis are welcome from legal officers

Capt NZABAMWITA MUSAGARA Euphrem

Regimental Psychologist.

The client was transferred at Ndera at 11/11/2015 one week after his liberation from the prison,He is transferred at CARAES Ndera Hospital from General HQs in collaboration with RMH.The reason of transfer was : Psychiatric expertise about his mental health in general and an deep explanation about :More crisis since 2013 from the mission in Sudan and specially when he was in prison in 2015, the persistence of suicide ideas after liberation from prison,hate and conflict oriented to her own mother and wish her to dy,Hoplessness, very angry but not in depressive mood.He has a predominant wish to reconnect with her wife and enjoy the freedom after imprisonnement and this is normal.It's easy to confuse the psychiatric nurse about the act of being angry and being depressed or in crisis.The best way was not to administer the chimiotherapy but to understand before and give value to the wards ,requests,complains of the client, He expressed his feelings in the following words : «…It's not easy to be liberated from prison and to be transferred the same day in a psychiatric hospital instead of being allowed to go home and meet you family ,what could allow me to be happy is to be liberated and be allowed to go home to join my family…my illness comes from my mother who cursed and hate me…».

XIV. Interaction between the client and her mother in the family dynamic

At the military training at Gabiro her mother payed him a visit: She expressed her feeling saying: «…Why did you join the army when you are the only elder son at home?We didn't know where you are since you left home, people said that probably

you may have joined soldiers…..» .After being a soldier,the client went proudly at Home in Holiday(Cyangugu). one day, as he entered her parents room and found a snake living in the pot.He wanted to kill it, but her mother was very angry against him even some of her sisters marginalized saying : «…stop you foolish!who told you to enter my room ? go away,die there!don't come back here again …».It's after this periode that he went in peacekeeping mission.

XV.When, where and how the client experienced the first symptoms of his illness

The client experienced the 1rst symptoms of mental disorder two months before the end of the mission according to himself.

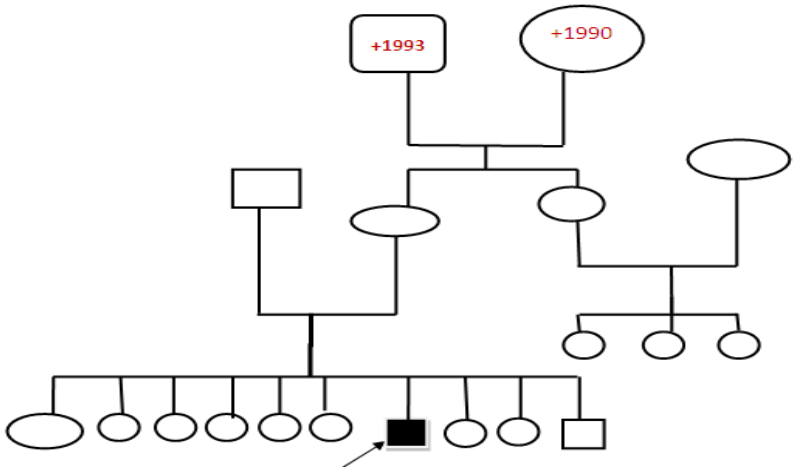
He was sleeping afternoon, then he run out naked and crying,went far away out the camp and was caught at the pool nearly 7 kms from the Rwandese military Camp .Symptoms objectivated:Halucinations ,deliriums,errence…He said «… I saw people running with my Kid and then runned after them in order to get back my child but invain…».

He was admitted in Level one Hospital about one month, He could be rapatriated but as they were at the mission end the leadership promised that he will come with the first flight to Rwanda.Some symptoms disappeared but he remained with poor sleep symptom.The battallian tought it was just the stress reaction in mission area but the client was thinking about witchcraft and curse from her mother.

XVI.Deep anamnesis of maternal familly of the client

At 12 years the client was sent to live with her maternel grand father at cyangugu it was not far away from home, the grandfather was living alone in the house after the death of her wife.

XVII.Genogram of maternal family



The client sayed : « My grand father was a traditional healer, I used to help him receiving his clients ,he was payed for that, he wanted to train me, I refused, He even renaimed me'' Rwica Umwuzuru '' later I went away from him ,we lived with him about one year,later he died,I didn't burry him,only my father and my mother went to the burial ceremony,they told me he left me a piece of ground in inheritance, the parent exchanged this in one goat.

He used to be transported also by devels sometimes during night, He could pass all the night in the valley and when ever he came back he told he was carried out by devels.Now he left me to those devels, sometimes those devils brought me to the hot stream in military uniform when I was deployed at Cyangugu.

After Soudan mission ,I went in holidays at home,after break,We were deployed at Cyangugu,as I was sick,my commander gave me a permission of three days,I went to see my parents home and they gave me medicinal herbs called '' amasubyo ''.my battalion was later mixed in 407 Bn and redeployed at Nyaruguru for the second time…»

XVIII. Military anamnesis and desertion behavior

He studied S5 in nursing, before to join the army in 1999; he was fit and ended successfully his training well. Before to join the army he was treated tuberculosis and expresses himself in this way:

«… I was fit before to join the army; Only I was poisoned tuberculosis long years ago and treated traditionally by herbs by vomiting the desease; when I experienced my

first symptoms of mental illness in the army, my commander gave me the permission to go home for traditional treatement as I requested,three months later as I was absent from work, my salary was stopped,I claimed but in vain; I felt desappointed, angrily, I decided to go to Kigali –Kagugu to stay with my nefew, his wife called my wife to take me home, when she arrived she asked me :« What are you doing here,you were getting treatement at Cyangugu and you stopped ,You are bothering and disturb other people…let us go back home . Frustreted by his words; then I decided to go alone without communicating to my body, took a bus at Nyabugogo and returned alone at my home at Gikongoro,I arrived at home about 3 O'clock A.M . During morning my brother in low came with soldiers from Gikongoro detachment to arrest me for desertion crime,from there I was tranfered at MP prison for military legal follow up and medical treatement since Jun10,2015-up to Nov9,2016 ».

Through this session, the client reveals that he was in pathological journey when he went from Cyangugu to Kigali aimlessly, abandoning treatement without informing any family member.His brother in law, his wife, and even his family recognize that he was ill, The collaboration of the brother in law with soldiers to arrest him is a way to help him finding good treatement and manage properly his pathological behavior and facilitate the process of his social reinsertion in the family.

XIX. How about the client today

Since Thursday, Nov26th ,2015 the client was improving well, he could be discharged but the RMO did'nt come to take him.Emotionally during the afternoon when other patients improved were going home,the client was in emotion desperately and expressed his sorrow in words: « …Let me leave here please!if you refuse me to go home while I'm officially discharged, I will not sleep again in this hospital,this is not a prison…From Ndera hospital to Kanombe is not very far by foot,I'm able to get there alone without accompaniment…I'm accustumed to walk more distance then this with only my feet…» The referral nurse tired with the afternoon work; was disappointed by this rebel behavior of the client and he sent him back again in ward ''A'' so that he may not escape from the hospital, one day after he brought him back again in Ward ''B''.This morning he is calm and the will to escape has disappeared,he is waiting patiently his RMO to come to take him.Since more than 4 years, he is experiencing hypo- sexual libido and said: «…I need pills for sex usually thirty minuts before and my wife knows it; It's in relationship with this mental

deseases; My wife told me that my mother needs a hen from me for the therapeutic sacrifice ritual,I refused as I'm a cristian; …I usually pray God and never forget to put on my rosary…».

We noticed that the behavior of the client was totally different in different circumstances. He exhibited a hallucinatory symptom when he was still in jail, but during hospitalization just the first day, he was coherent and well oriented psychologically according to hospital follow up observation.

XX. Current need of the client

To go home and meet his family as he is no longer in crisis, need to enjoy the freedom.How ever,He will be countable in GHQ as other soldiers not working in active military unit and who are not hospitalized .

XXI. Psychotherapeutic analysis of the case

The client didn't resist to military deployment stress, his battalion was not understanding his behavioral change and considered it as indiscipline at the beginning, his military criminal behavior (desertion) was in relationship with mental disorder (schizophrenia). He was born in a dysfunctional family were her mother seem to dominate on her old husband, the client believes in witchcraft even if he is Christian, he strongly believe that he must have been witched by her own mother. His military moral is down; he needs more freedom in his life. When he is at her parents' home, he doesn't get in crisis, the traditional herbs provided in family are helpful according to him. The army regulations which oblige him to think first about the military duty and secondary her own family etc… seem to be for him an unbearable havy barden, for this reason the symptoms becomes the special way to explain his wish of freedom in order to obey to the grand family testament. However ,his family does't count much on him as he is a soldier, It's as if actually their take him as a stranger in the family; Through the symptoms he is also claiming his place(belonging feeling).This hypothesis is the real cause of her mother's anger behavior towards the client.also the family considered the client as someone important as he is a soldier; The familly believed that he could help them financially with his mission allowance, this perception also increased the negative perception of the client by the member of the family and even reinforced the anger and the hate of the mother towards his son.

XXII. Analysis of the behavior between his referral nurse and the client when the client was claiming to go home as the representative of his military unit failed to obey the rendez-vous.

The Nurse is suprerior and the client remains inferior considering the model of communication relationship .We tried all to explain to the client why he has to stay in the hospital even if he was discharged until the representative of his military unity arrive to take him but he insisted that he will go home and promised to escape, so the referral Nurse took the decision to readmit him in crisis ward as punishment and final decision safeguarding the norms and process of discharge. I finally remarked the next day when he brought him again in ward B, the client was not complaining again because he was afraid to go back in crisis ward again, and the following day the institution sent the battalion nurse to discharge him.

The client and his family believe in ancient tradition, he was renaimed and sacrified by his maternal grand father to super natural forces when he was still young.He things that his symptoms are probably the revenge for having not obeyed to the will of the maternal grand father, and a curse from her mother etc…

XXIII. Recommendation in order to help the client

- Psychological acompagnement of the client. The reconciliation and mediation is needed between the client and all his family, a work centered on the belief of the whole family system would be important.
- Systemic approach would be helpful so that he may not relapse.
- Therapeutic ritual would be also important as he is nearer his retirement due to the illness.
- Demobilization if possible.

XXIV. Limitation about the case effective treatment

Lack of means and facilitation to access all the family members who may be involved in therapy.

Lack of means to make a very deep investigation about the desertion behavior (official permission and financial means do see his family for more psychological investigation details about the client etc….)

XXV. Mental status examination

Physical appearance: The client was sad, disenergic when he was still in gail.this appearance changed positively when he was liberated. He taught he could be allowed to go home after the liberation but as he still had some suicide ideas and against her mother according his words; he was transferred in CARAES Hospital for more help and advice to the army. He was claiming to go home and visit his family.

Affect and mood: Sad, anger oriented to her mother, wish to join her family after liberation

Perception: During crisis he had auditory and visual hallucinations, flashback from military operations, beliefs he was cursed or witched by her mother and this was the source of his anger against her. Her mother was considered as the source of all his misfortune. The crisis took not more than two days usually.

Thoughts and speech: Hopelessness, was depressive.

Orientation: The client was oriented in time and space.

Memory and concentration: Normal

Insight: He believed he was cursed or witched by her mother.

Vegetative life:

Sexuality: Unnormal, errection problem after the mission in Soudan, only it's possible when he uses some pills that he was unable to name.

Sleeping: Most of time insomnia

Eating: Normal

XXVI.Differential diagnosis

1. Trauma of war and PTSD

a)Specific element : Flashbacks,insomnia,depressive rumination. Theatralisation of war scenarios saying he is commanding a military operation when he was in jail. Audio and visual hallucinations and delusions at the beginning of the crisis, preoccupaid by his judicial desertion problems, excessive social discomfort.

b) Unspecific element: theatralisation of scenarios of military operation saying he is commanding the war.

c). Facticious disorder and Burn out syndrom: looking for the proper way to leave the army, demoralization, need to do other job, desire more freedom in his life, need of self realization in other way than the army.Inadaptability to the army life style.

d). Psychosis: Audio and visual hallucinations and delirium.

XXVII. Retained diagnosis

Burn out syndrom (see DSM-IV TR).

XXVIII. Multiaxial assessment

AXIS I: Clinical Disorders

Major psychiatric disorders are diagnosed on Axis I. When you think of a "psychiatric diagnosis," these are the kinds of disorders that probably come to mind. For example, major depressive disorder and posttraumatic stress disorder are diagnosed on Axis I. Disorders of learning, such as reading or arithmetic disorders, and developmental disabilities, such as autistic disorder, are also diagnosed on Axis I.Axis I tends to be reserved for major disorders that are thought to be somewhat episodic (i.e., they typically have a clear onset and periods of remission or recovery). But, this is not true of all Axis I disorders (e.g., autistic disorder is not an episodic condition).

In this case we think probably of paranoic schizophrenia

Axis II: Personality Disorders or Mental Retardation

Axis II also includes some conditions that we might consider "psychiatric disorders," but these are thought to be longer-standing conditions that are typically present before age 18.

The personality disorders are longstanding, pervasive patterns of thinking and behavior that usually appear before the age of 18 but are typically diagnosed after 18 (when the personality is considered more fully formed).

In this case nothing was objectivated.

Axis III: Medical or Physical Conditions

Axis III is reserved for medical or physical conditions that may affect or be affected by mental health issues. For example, if someone has cancer, and their illness and treatment are affecting their mental health that would be important information to be conveyed in the diagnosis. So, the cancer diagnosis would be included on Axis III.Alternatively, someone might have a medical condition that is impacted by their mental health. For example, someone with diabetes might not comply with their medical treatment regime if they have a psychiatric disorder that causes impulsive or erratic behavior. Diagnosing the medical illness on Axis III might alert a clinician of a potential problem.

In this case the client was complaining of stomachaches when he was still in jail, sexual difficulty, and errection problems.

Axis IV: Contributing Environmental or Psychosocial Factors

Often, a psychiatric diagnosis happens in the context of major environmental or social stressors. For example, job loss, divorce, financial problems, or homelessness may contribute to the development or maintenance of a mental health condition (alternatively, a psychiatric disorder can contribute to the development of these stressors). These important contextual factors are coded on Axis IV.

In this case we can find the following factors contributing to the crisis of the client:

- ✓ Being arrested and imprisoned for about a year;
- ✓ Loss of salary, being stigmatized by others;
- ✓ Living far from home most of time in stressful military deployment.
- ✓ The poor communication in the family;
- ✓ The traditional belief of the client and his familly;
- ✓ The perception of the client towards her mother, and in his family;
- ✓ The perception of the client vis a vis his military duty;
- ✓ The sexual relationship between him and her wife,suspicion of family unfaithfulness.

Axis V: Global Assessment of Functioning

The last axis, Axis V, is reserved for the global assessment of functioning, or GAF. The GAF is a number between 0 and 100 which is meant to indicate level of functioning, or a person's ability to engage in adaptive daily living.Lower scores indicate lower functioning, with a score of zero indicating that a person is incapable or maintaining their own safety or basic hygiene, or is an imminent threat to the safety or welfare of others. Scores near 100 indicate superior functioning.

In this case the client’s GAF can be evaluated at about 99 %.

CASE N03

I.Identification

NAME: B.E

Age: 49 yrs

Marital status: Married

Home Adress: Kibungo

Originated from: Butare

Date of consultation: Dec 8th 2013

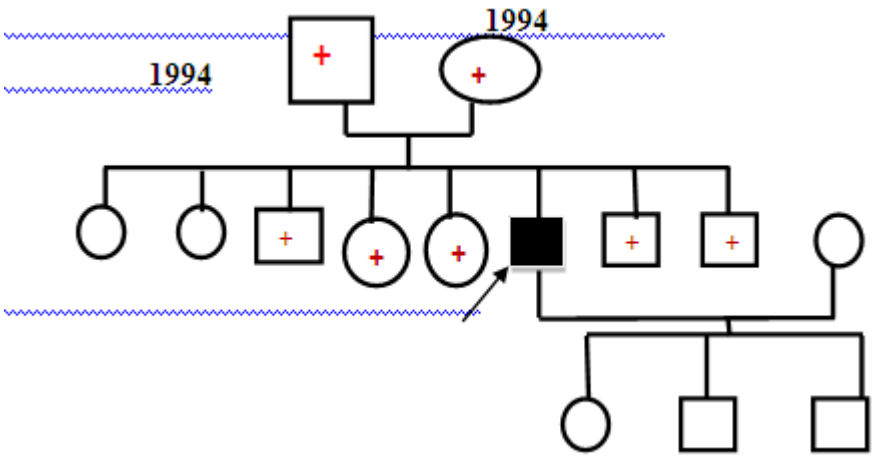
Education Level: S6

Profession: Military

B.E is married, father of three kids, her wife doen't have a job but studied midwife nursing, he is a genocide survivor; He joined the army since 1993, he went in peacekeeping mission in Soudan 2013, He was motivated on job but after 6 month, he got poor health, his performance on duty decreased since the end of mission, he consulted the mental department of Rwanda Military Hospital before and after mission for high blood pressure one years ago ,received treatment which he said was helpfull and was advised to eat less salt and fat.Consulted CARAES NDERA for ambulatory treatment after mission in Soudan .He confirmed their couple relation is good.

II.Familly anamnesis

II.1.Genogram



The client is originated from Butare, his parents and brothers were massacred during genocide against Tutsi. He remains only with two sisters all married, one lives at Butare and other one in Europe.The client was deployed at Kibungo and there he married the nearest nurse from a district hospital eight years ago, and he organized his life there due to the imployment stability of her wife.His family land is deserted in Butare, no one in the family thought to reorganize his life there after the genocide. He didn't find the body of all his parents after genocide so that he may burry them in honor. He got the news in 2013 from the country that his parents bodies may probably be among the mass of people discovered burried nearer the airport of Butare, it was during the periode of preparation of the 19th commemoration of genocide against Tutsi in 2013,or during that time we were in mission.

III.Military anamnesis

The client joined the army in 1993. He did the work in different unities and perfomed well his military duties. Since last year, he was anxious because he feared one of his elder leaders who frustrated him for having made a negative report against him, this was in the attribution of the client.This frustration did a negative impact in terms of mental health on the client.

He expressed his fear in those words: ‹‹ I had no peace as my leader have known all about the report I have written against him, I was in bad mood at work since that day, he threatened me since that time and I was a fraid of him but This was in my attribution to report what happened in my unity,what I wrote in the report was real, thanks God, as we have been separated when I came in Sudan, Even todays I still feel the same, He can harm me any time in any way if he gets opportunity, He was very angry with me… ».

The Doctor discovered that he had High blood pressure.He could not eat either meat nor fish because he was an adventist, he was selected for a special diet and recommended him for psychological follow up while in mission.During the first interview with a psychologist he revealed that even last year he was also diagnosed with High blood pressure and received helpful treatement and was advised to diminish fat and salty food. Before to go in Soudan he felt no problem.When he was in Soudan in 2013, her sister who is in Butare informed him that probably his parents may be among the mass of people massacred by interahamwe in 1994 nearer the airport of Butare, and who had to be honorably buried in the genocide memorial of Butare,Those news affected much his mental status; Through out interview he reveal the need of visiting the genocide memorial of Butare after the mission end.The depression test confirmed that he had medium depression and the PTSD scale confirmed that he presents many symptoms of trauma about the genocide, and was living pathological mourning.We helped him with supportive counseling until the end of mission. His anxiety developed from work stress intereacted probably with his ancient trauma from 1994 genocide and resulted in high blood pressure, stomachachs as somatisation symptoms. He frequently honors ambulatory medical RDV at RMH and CARAES NDERA hospitals.

IV. Symptoms experienced

He presented the following symptoms: concentration,fear,persecution ideas,tachycardia,chronic stomachaches,isolation tendencies,poor appetite,poor sleep,nightmares,very toughtfull about genocide related stories and other psychosocial problems correlating with Maslows piramid of needs. Since 1994, he wished to know the real story of his parent's death and where they have been buried, after mission he consulted the psychiatrist in Rwanda Military Hospital and received the following treatement:

Haldol5mgx2/day/30 /30days

Dibiperon40mgx2/day /30days

Akineton2mgx2/day/30 days

V.Context of crisis

The client confirmes that his anxiety and high blood pressure problem occurred one year before the mission in soudan ,when he was frustrated by one of his former direct Unity leader fearing that he could harm him any time due to a report he made against him.He lived with that fear without sharing it with any one. This marks the beginning of his poor mental symptoms.he consulted a Doctor who prescribed him some medicine to regulate the blood pressure and he improved well without a psychological support, the blood pressure reoccurred in 2013, six month after, when he was deployed in Sudan. The high blood pression was accompagnied by symptoms of mild depression and PTSD.

VI.Psychodiagnostic analysis of ‹‹ B.E»

STRESSFACTORS	CLIENT REACTION	PROBLEM DESRIPTION	MENTAL STATUS	ATTITUDE/ BEHAVIOR
PTSD FROM GENOCIDE	Remembers much about genocide, lost family and thinks but always tries to be resilient.	He heared the news that probably the remaining body of his parents were probably discovered in Butare when he was in Soudan	Mild Depression	Isolation,numbness.but He doesn't manifest emotion,weackness

Frustruted by one of his leaders for having written a report against him one year before to go in Soudan	Fear,anxiety	He feared that this leader would harm him in a way or an other	Stressed/developed high pressure which finally were regulated with medicine prescription without psychotherapy	He developed anxiety trouble and high blood pressure and decreased motivation at work.
In Soudan environment, unpredictable security ,work overload	He developed weackness,high blood pression,poor concentration,persecution ideas,insomnia, poor appetite, stomachaches	He was hard working and motivated but six month after he became weack	High pressure was accompagnied by mild depression	He is weak and continues ambulatory psychiatric consultation at the military Hospital.

VII.Role of leadership to help this soldier

After the report of the medical team, the client was allowed to rest in the camp, have special diet and treatemt. He was visited by the chain of command and the medical team in order to inquire about his improuvement.

CASE N0 4

I.Identification

Name: K.M

Age: 44 yrs

Marital status: Married

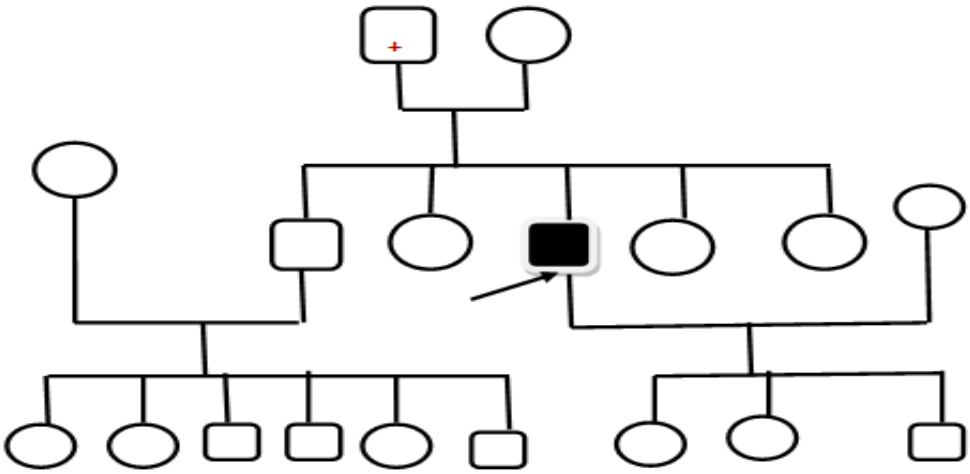
Education Level: S6

Religion: Catholic

II.Familly anamnesis

II.1.Genogram

2000



K.M is a sergeant born in 1972 in Bunia-Zaire, he studied S6 and joined the army in 1993.His parents were refugees in Zaire since 1960 due to political crisis in Rwanda; during this year. Her mother had only the first-born when he was still a baby.the grand parents remained in Rwanda because they were old and incapable to flee, and died later.The father of the soldier was a driver and machins operator in a campagny working at the air port of Bunia.In 1993 K.M joined the army, he did his training at Karama-Byumba , was selected to attend military instructors cause and become a military instructor at Karama, and then at Gabiro. In October 1994 he was deployed in 73 Bn at Kigali, during this time he found the opportunity to inquire about his family left in Zaire in 2003, He needed to know if his family was

Repatriated.Where ever he went in town this periode he observed carefully all civilian around the camp and in town looking for some one who probably can provide him some news about his family repatriation and where they may be settled probably. One morning as him and other soldiers were going to fetch water at Muhima in a pick up,He saw his uncle whom he left also in Congo; He shouted joyfully and asked his comrade to stop the car in order to speak to him.This uncle gave him an appointment to meet and gave him the work and home address but he assured him that the family was rapatriated and settled in Gatare-Cyangugu- refugees camp.The nextday K.M

visited his uncle at home and it was a great moment for the hool family,His uncle expressed him his sorrow about rapatriation situation saying : «… It was not easy during rapatriation, killers from Rwanda continued to attack any Toutsi found in Zaire, Some Tutsi were even killed during repatriation from Zaire, Zairians soldiers also were searching every where include body and things, if you have money they take it,it was difficult to be rapatrieted in Rwanda and arrive safely with money crossing Rusizi boader, people are trying to reintegrate slowly now in Rwanda…» .The soldier was comforted by the uncle who up dated him always about the family situation.Two months later the soldier was deployed at the course far from Kigali until de 2015.He was deployed at Gisenyi and from there he got a permission to visit his parents who was in refugees camp in cyangugu,then the family rented a house in town but the father was in the process to regain his farm that he abandoned in 1960, it was in the nearest district from town.The client's father had an elder brother who didn't go out Rwanda during the trouble of 1960, he persisted on the ancestors land but later in 1994 he was massacred with all his family eccept five children out of twelve grand children who survived from genocide , hiden by some of their good neighbors.So the local authority accepted that they may divide the ancestor's land between those two remaining family,but the family of K.M will continue to take care of those five children because they were still very young,the elder among them was twelve years old. After the death of the K.M's father in 2000, K.M asked a permission from his military chain of command to visit her mother living a lone after the death of his father,the mother expressed her feelings saying :‹‹ All the family children have grown up and went to live at Kigali,no one among you all need to live at the ancestor's land with me after the death of your father,I fear that genocide perpetraters whose family are here will massacre me also as they did to other members of family whom their killed during genocide; Sometimes I feel as if I can suicide myself instead of living alone as if I've never got children,I'm suffering from chronic stomachaches,massors pains,dizness… » .K.M found that Her mother was anxious and depressed,no other person was able economically to help her,so he decided to live with her mother at his own home.As he was preparing to go in Soudan in 2013, her wife said: ‹‹…I'm sorry, I'm pregnant you know and soon I'll go to maternity, your mamy is weak and needs special care as well as our young children; As you are going in mission far

from home, I'll not be able to take care of both our young kids and your mamy….let her be independent from me…»

K.M discussed with her wife explaining her that the mother needs the wormness of the family in stead of living alone in the house, he explained that her mother was anxious before becaused she were left about 10 years ago alone in the house after the death of her husband, he compared the health of her mother when she was living alone and after reintegration in the family of his sun, so that her wife may see the difference but her wife could not understand:

‹‹ Can I let the mission to care about my mamy, impossible, it's for me a good C.V. Can I force the wife to take care of my mamy? Can I hire a house and a worker for my mamy? It's very expensive and not helpful in her context… What can I do? » K.M asked himself.Finally when her married young sister and her husband heared such a discussion, they decided to care about their mother and K.M relaxed and prepared better to go in mission ….

Until todays, the soldier's mother is healthier; the illness has cured and plays happily with her grand sons.

Three weeks after deployment phase, the wife gave birth after caesarian; she expressed her feelings in such words: ‹‹… Other women are assisted by their husband at the maternity, the mine is always at work far from home; I'm accustomed to this style of life even if it's not easy…my kids are very young and sturbon…When a maid knows well that you are all absent, she can sometimes neglect to care properly to the kids…I asked to be discharged from maternity earlier as my husband was working far from home…» said the soldier's wife.

During the mission, the husband had the nostalgia of all the family mainly the desire to see the young baby, he asked her wife to send him his photo on facebook and he sent the baby's name on email.

III.Role of commander to help this soldier

During the prediployment phase of mission, soldiers usually study and exercise more in order to prepare themselves to perform better in their mission; But uswally commanders try to listen to each one and help who ever has a problem, to solve it before to get into the next phase of real deployment ; and this is very good in terms of stressmanagent in the predeployment phase.The soldier were given frequent permission during the week-end in order to solve family issues during the

predeployment in order to prepare the next phase with less socio-familly problems potentially stressfull which can undenger his mental health and his productivity at work.He finished safely his mission in good health.The leadership accompagnied accompagnied him in the way to find proper solution to his problems in order to be more productive in deployment phase.

IV.Analysis about the case of K.M

According to our culture,where ever some one can go, he seem to carry his family in him in terms of responsibility.The soldier balanced well his family problems and his military duties during all three phases of military deployment.The way the soldier selected proper solution to the problem facilitated him to perfom better in deployment phase of the mission;There are some circumstances that can disturb a soldier who is preparing to go in mission.Sometimes family problems and other psychosocial problems interfere with time limit or other means to look for an adequate solution for these home problems and this can generate stress because the soldier has many question marks in his psych,These unanswered questions can have an negative impact on his behavior in some way or an other such as decrease the motivation and performance of the soldier at work, decreased collaboration and interation with other camarades if the soldier is not resilient,development of depression,violation of military code of conduct,or indiscipline ,arrestation and legal problems, etc….

CASE N05

I.Identification

Name: T.S

Age: 43 yrs

Marital Status: Married

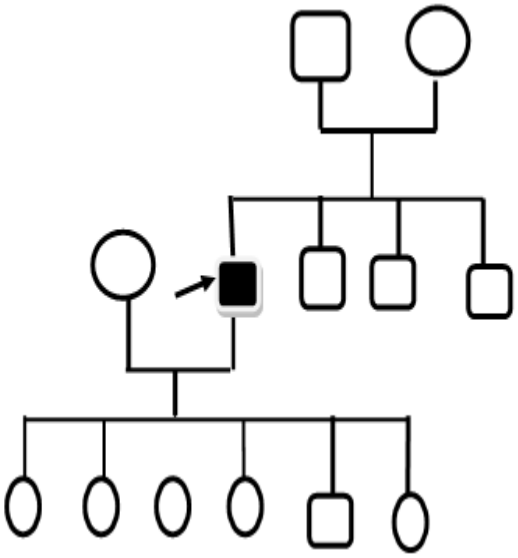
Religion: Protestant

Level of Education: P6

Home address: Bugesera

II.Familly anamnesis

II.1.Genogram



T.S is a Pte born in 1970 accountable in B Coy of his Battallion,His family was living in Burundi since 1959,there the family survived from trading and farming,the family was originated from Bugesera. Due to the political crisis of 1959, the father was obliged to flee to Burundi with his parents, during this trouble, his parents lost some members of their family.His father got married in 1968 and their family lived happily. The client abandoned the class after P6, because he lost his lovely father in 1982 and took responsibility of his brothers.Her mother forced him to go back to school but after his father's death nothing interested him.

III.Military anamnesis

T.S Joined the army 1993, he did successfully his military training, worked in different military unities, he was healthier and strong enough to perfom well all military duties, he was coolaborative, interactive with other comrades and no indiscipline behavior was ever reported against him.He is counted in army reserve actually.In 1996, as he was on patrol car in town (Kigali) he felt dizness, nausea, tachichardia , weackness, shortage of breath and was about to fail from the patrol car but his comrade helped him.Their stopped the car but after a shot rest he felt ok.Some camrades thought that it's probably body fatigue, their returned from work and two days resting only he felt no problem.

One day as he was deployed far from home (Moba-zaire), He was very angry because he querelled and was frustrated by his commander, He felt the same symptoms until two hour after, but headachs and tachycardia was the most predominant. He

consulted the battalion doctor in operational area the same day, who told him that he probably has Hypertension. He received an injection of valium as anti anxiety and the next day he was well.

In 2008, the client was deployed in Byumba when he felt the same symptoms, and he was transferred urgently at King Faysal's Hospital and hospitalized about four days.

On 08/03/2013 in Soudan, the client was in peacekeeping mission, he was hospitalized in level one clinic since 06/03/2013, and during the medical round the Doctor recommended the patient to consult a psychologist:

The client presented the following symptoms on admission: Headachs, dizness, trouble of vision, tachichardia, etc…

IV.Mental status examination

The client's appearance was good,voice enough,the speech was normal but emotional when talking about his own military life and some frustration uncountered through out his carrier, speech quantity was normal, he was cooperative, franc and friendly, his mood was not anxious nor depressed, the affective expression was normal and congruent

V.Context of stresssull events and military work in researching about the client's symptoms

The client joined the unity from reserve force; he claimed that he has never get more than two hours of rest since he arrived in Soudan. He uswally have poor sleep.

VI.Psychodiagnostic tools

Stress scoring test: The client scoring questionnaire revealed medium stress, his hypertension usually occur in case of anger, frustrating situation, fatigue and exhaustion.

Anger test: which revealed that the client is very sensitive to frustrations and can be over angercontrol and become aggressive?

The depression Test: Revealed that the client do not present depression symptoms in stead he was experiencing hyperalertness due to anxiety.

VII.Treatment received

Medical treatement: Analgesics,

Psychotherapy: Angermanagement teaching technic, supportive counseling and psychological accompagnement.He returned to work on 09/09/2013 and was well improved.

VIII.Conclusion

The client was suffering from medium stress and adaptative syndrome; this adaptation syndrome is normal for soldiers who are new in mission far from home country. He usually participated on day and night, long and short patrol, guarding towers in an area where the security is uswally unpredictable additionaly to geographical climate changes in the desert, a climate totally different from the one in our country. Sleep dept and exhaustion fatigue can lead to body weakness and different body unusual reaction but good rest and good foods allows to recover energy.The medical battalion believed strongly that he probably invented the illness in order to rest in the clinic by fear to return at work.The routine work in mission area sometimes can be stressfull .in some cases a soldier can oppose to go to work without any apparent good reason or pretend to be sick in order to rest in the house .This is also meaningfull in terms of stress behavior assessment.The best way to help such a soldier is not forcing him to go to work but listening him in order to motivate him.

CASE N0 6

I.Identification

Name: GJB

Age: 37Yrs

Marital status: Married illegally

Level of Education: P4 & Electrician certified

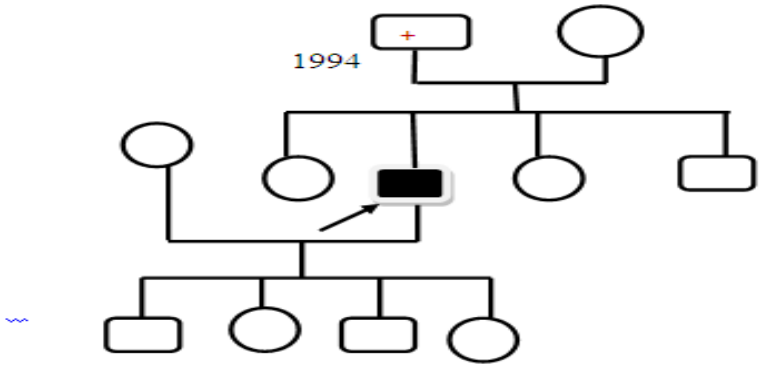
Religion: Adventist

Home Adress: Rwamagana

Joined RWABATT37 from army reserve

II.Familly anamnesis

II.1.Genogram



GJB was born in Rwamagana in1976, he joined the army in 1994 after genocide against Tutsi, only his father died during genocide, Her mother and all his brother survived from hiding, her mother was not concerned by genocide and this facilitated her to hide all his children until the liberation .His family lived from farming, he didn't get the chance to study a lot, he stopped in P2 But he knows to read and write Kinyarwanda. He did his military training at Gabiro T.W. His parents used to live in harmony.He plays the role of family responsible after the death of his father, he is very attached to her mother, He says that his family had a lot of social problems after the genocide but they tried to survive by building a house of her mother and the own house of the client, for this reason, he asked the demobilization earlier in 2010 and is counted in reserve force, after demobilization he had no job or he doesn't like to farming, some times he made some money by repairing electricity for neigbors,for many years he wished to do motor taxis but he couldn,t get his own due to shortage of morney.He is married illegally, and the couple relationship is good ,the big problem he has actually is to satisfy all the needs of his four children include school fees.It was easy when he was still a soldier.He was victim of socio-economic problems after demobilization.

III.Military anamnesis

He joined the army in 1994 and demobilized in 2010, now he is counted in reserve force, he worked in maintenance as an electrician.In 2013 the client was given the favor to top up in peacekeeping mission,was motivated through out the predeployment phase and screened physically fit both medically and psychologically.

On 14/03/2013, the soldier was transferred from the Bn medical doctor to the Bn clinical psychologist for mental examination.

One week before, the client consulted the doctor at the level one clinic, He was complaining that he has swallowed a piece of plastic when he was smoking cigaret, since about one month; He confirmed that he was feeling painfully strange object in his throat, obstruction of air ,respiration and expiration problem. The medical consultation proved that the client doesn't have any thing strange in his throat, the behavior surveillance proved that he eats and drink withought any problem according to other soldiers who jocked about him.

The client persisted claiming the next week in the consultation about:

- ✓ Breathing a very bad odor that probably it must be an infection from the strange plastic he swallowed but the Doctor doesn't believe him he confirmed.
- ✓ painfull temporal borns
- ✓ Obstruction of noise
- ✓ Intracranial heat sensation mainly when he puts on helmet.

The Doctor hypothesized that probably he was suffering from sinusitis or temporal arthritis, he prescribed him Amitriptiline 25mg/every evening/5days and aspirinx3/day/5days and hospitalized him in the level one clinic; As the symptoms persisted, the Bn Doctor transferred him at level II hospital for more consultation but the result confirmed that the client doesn't have any strange object in his throat.The doctor noticed that the patient kept accusing new symptoms and could not believe that nothing strange was find in his throat.

IV.Psychological evaluation of the client

IV.1.Psychological screening and tools

Anxiety screening test: moderate anxiety
Depression screening test: mild depression

Stress screening test: High

PTSD screening test: moderate trauma symptoms

Psychological interview

IV.2.Psychological consultation

General presentation: Black boy, Medium hight.

Mood and Affect: Sad

Perception: Centered to his symptoms, no hallucination

Toughts: Centered on his symptoms

Speech: Relatively coherent despite the claim about health

Orientation: Well oriented in time and space

Memory: Remember well the present and the past events

Gugement: Relatively good but Centered on his painfull symptoms.

Vegetative symptoms: Insomnia

IV.3.Differential diagnosis

1. Facticious disorder: Favorable element: Confirming that he has a strange object in the throat but the result are negative both at level one and level two clinic medical examination.
2. Anxiety disorder: Fear of working in an unpredictable security area.
3. Pathological Stress with adaptative syndrome

IV.4.Retained diagnostic

Pathological stress with adaptative syndromes

VI.5 Multiaxial diagnosis (biospychosocial)

AxisI: No particularity

Axis II: No particularity for personality disorder and no mental retardation

Axis III: No medical condition induced disorder

Axis IV: Death of his father during genocide, living far from home, working in an unpredictable security area, Climate change, fear of military orders etc…….

Axis V: GAF: Between 71-80%

IV.6. Treatment

IV.6.1.Medical treatment

Hospitalised in level one clinic since March14th,2013 and discharged on April 6th 2013,He uswally needed worm water to wet his head.He was treated with amitriptiline 25mg every evening/5days and aspirinesX3/day/5days.

VI.6.2. Psychotherapy

We used an ecclectic approach to help him, Suportive counseling and follow up, daily behavior mornitoring.We discussed about his case with the medical team and in the morning brief.

The medical team suggested him to be attached in engineering as an electrician and maintenance staff because there he was allowed to work without helmet.

V.Evolution and prognosis

He was very hapy of this deployment, He improuved well and worked productively as a maintainence and electrician staff in the camp until the end of mission. All the symptoms disapeared progressively since when he was discharged until the mission end he had no problem.

VI.Conclusion

Both psychological Tests and interview show that the client is suffering from anxiety relative to operational stress and all symptoms can be qualified as an adaptation syndrome of stress. The sensation of strange object in the throat and all other symptoms experienced was probably the somatisation of this anxiety trough the body, the complain of intracranial heat sensation when wearing a military helmet expresses the anxiety felt, fatigue of patrols, and tower guard where it's an imperative order to put on a protective helmet for the security of soldier, the soldier must wear his helmet between six and 10 hours when he is on duty. Also, the soldier needs an effort to adapt himself to the heavy protective helmet in the overwhelming hot climate of the desert. All these symptoms show that the client is stress affected. He is very anxious when ever he thinks about work which is synonym of putting on helmet in the hottest sunrays from the desert. He was appointed as an electrician in the camp where he can work without helmet, since that day he was very motivated and cured the end of the mission.

CASE N07

IDENTIFICATION

Name: P.M

Age: 24 Yrs

Religion: Protestant

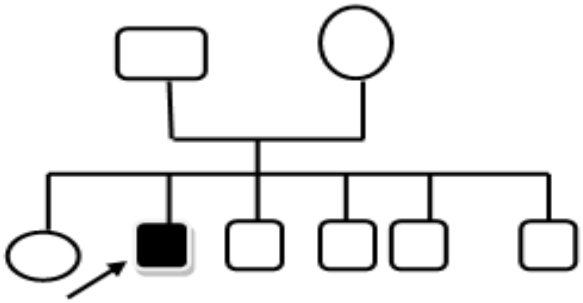
Level of Education: S3

Marital status: Single

Adress Famillial: Umutara.

I.Familly anamnesis

I.1.Genogram



P.M is a young soldier, he was born in 1989 in Uganda, He was 5 years old when his family was rapatriated in Rwanda after the genocide against Tutsi in1994.His parents are farmers and lives actually at Mutara.He is the second son in a family of six children.He developed well during the infancy without complain of any invalidating deasese. no history of mental illness is known in his family.

II.Military anamnesis

P.M joined the army in 2006, he did his military training successfully at Gabiro Infatry school, despite the hard training military exercise he didn't fail ill, he was always moralised with a normal anxiety of performing well, He was deployed in MP after the training and he is known as a disciplined soldier.He did a vehicle accident in 2008 when he was on convoy at Gatuna and treated at Kanombe, he had pain on the neck, back, chest and left hand.The doctor confirmed that it was not very dangerous, and gave him some pain killers and he felt good after four days. In 2013, he was selected to participate in peace keeping mission in Soudan.He prepared himself and updated always his family about the depature,He used to work on long and short patrols,or on tower guarding either day or night.

He sayed: ‹‹…Here, we use vehicle both on long and shot patrols, the only difficult thing is the overwelming sun and heat, dusts, sands, sometimes mudy , tampest and winds or temporary water which sometimes delays us in the way, the unpredictable security of Janjawid fighting with their brothers is not a big problem….».This was his second mission experience.

He did normally his work since he arrived in Sudan, no unusual potentially traumatizing situation was met on terrain according to the psychological investigation made,but surprisingly on Sept23,2013 he was transferred from Zaringe to Supercamp and Hospitalised in level1 Hospital, His single complain was the embrupt loss of

voice from undetermined reason. He presented no pain in his throat nor injury on consultation, but he could not speak at all. the level one doctor, taught that probably may be, it was due to the dryness of vocal ropes or flu as we live in the desert, he tought the client would cure easily.As the symptom persisted, then tranfered him to the Bn Psychologist for more psychological investigation and psychotherapy.The Doctor signaled that since one month he was giving him medicine but without effect.

III.Mental status examination

General description: black, medium hight boy, underweight, strong

General appearance: Clearn and smart

Attitude to examiner: Friendly

Perception: No hallucination

Mood and Affect: No depression

Toughts: Good, no pessimistic toughts

Speech: Unable to speak since two month but hears correctly

Orientation: Well oriented in time and space

Memory: Remember well the present and the past events

Gugement: Relatively good

Vegetative symptoms: No Insomnia, he is eating without pain normaly.

III.1.Differential diagnosis

1. Aphony
2. Mutism
3. Facticious disorder
4. Depression
5. Anxiety disorder

III.2.Retained diagnosis

Selective mutism

III.3.Multiaxial diagnostic

Axis I: No particularity

Axis II: No particularity

Axis III: No paricularity

Axis IV: The separation with the family, the work in desert in an unpredictable security area

Axis V: GAF:71-80%, the client has symptoms/problems, but they are temporary, expectable reactions to stressors. There is no more than slight impairment in any area of psychological functioning.

III.4.Treatment of the client

1. Psychopharmacology

He was prescribed amitriptiline 25mg every evening/ 3o days.

2. Psychotherapy

He used to write in order to answer to a question.During the session I tried to address my self to him verbally.He made phonology exercise 30 minutes per day since Sept 20, 2013 up to December 21, 2013.We proposed that he would come back home in the first flight and consult the ORL department and a psychiatrist because we were ending the mission. Suprisingly he shouted unconsciently when he arrived at Kanombe airport and began to talk as usual.

IV.Conclusion

It appear that he was stress affected and had depression despite his incongruant mood.

CASE N08

I.Identification

Name: T.S

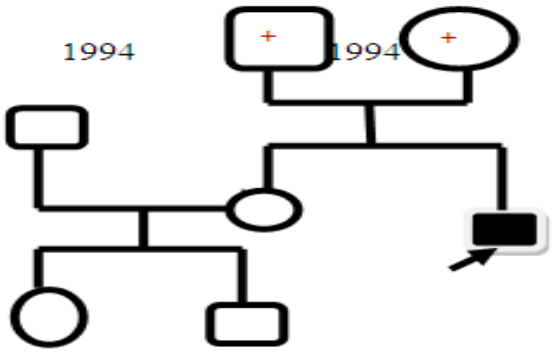
Age: 23 Yrs

Marital status: Single

Education level: CERAI

II.Familly anamnesis

II.1.Genogram



T.S was born 1990, his family used to live at Mutara, he lost all his parents during genocide against Tutsi in 1994. That time he had only four years old. Until todays he

doesn’t know nothing about his parents, either where they have been massacred or where they were burried; what he knows only exactly is that they were massacred during genocide against Tutsi in 1994. He and her sister were cared for by their maternal grand mother because the majority of their father’s family was all massacred except one paternal uncle who actually decided to live in Musanze district.Her sister got married younger because the life was difficult.Their lovely grand mother died recently in 2011. He studied in CERAI proffetional school where he learned the construction art.He keeps good relationship with her sister and brother in law but he doesn’t feel confortable there he confirmed due to the complexe feeling of Rwandan culture.

III.Military anamnesis

T.S joined the army in 2008, he did his training in Gabiro infantry school during one year.He passed out his training in 2009 and deployed to work in engeniering regiment. During holidays he stays at her sister’s home as he doesn’t have any where else to reorganize his life except in his battalion where he feels comfortable with his commarades.

IV. Major complaints

Since Sept12, 2013 he was hospitalized in level one clinic for gastritis and was discharged on Sept19, 2013 after treatement and good improuvement according to the Doctor.This trouble of gastritis is frequent to him.

On Sept22,2013 the client is rehospitalised for gastritis accompagnied with aphony,weackness and loss of appetite.The Doctor tranfered him to the psychologist for more investigation after prescribing him amitriptiline 25mg/day/4days every evening and magnesium pills.

V.Mental health assessment

V.1. Mental status examination

General description: black, medium hight boy, underweight, weak

General appearance: Clearn and smatt

Attitude to examiner: Friendly

Perception: No hallucination

Mood and Affect: Depressive

Toughts: Pessimistic toughts

Speech: Unable to speak since Sept22, 2013

Orientation: Well oriented in time and space

Memory: Remember well the present and the past events

Gugement: Relatively good

Vegetative symptoms: Insomnia eats only special diet due to gastritis.

V.2.Differential diagnosis

1. Aphony
2. Mutism
3. Pathological mourning
4. Depression
5. PTSD

V.3.Retained diagnosis

Depression and selective mutism in comorbidity with pathological mourning and PTSD

V.4. Multiaxial diagnosis

Axis I: Major Depression

Axis II: Uknown personality disorder predisposing him to the depression crisis but presents pathological mourning one of different factors which can influence depression crisis.

Axis III: Gastritis is a medical problem of the client probably relevant to PTSD and major depression interpreted as somatisation of PTSD.

Axis IV: The death of parents at younger age during genocide, loss of family members during genocide, The death of her maternal grand mother, the work in desert in an unpredictable security area.

AxisV: There is no more than slight impairment in any area of psychological functioning.(verbal communication).

GAF: 71-80%, the client has symptoms/problems, but they are temporary, expectable reactions to stressors.).

V.5.Treatment

1. Psychopharmacology

He was prescribed amitriptiline 25mg every evening/ 4 days.

2. Psychopharmacology

He used to write in order to answer to a question. During the sessions, I tried to address my self to him verbally. He made phonology exercise 30 minutes per day since Sept25, 2013 and on October7, 2013 he regained the verbal communication.

The client confirmed that this is his first time to loose his voice; He confirmed that he has stomachaches crises sometimes.

V.6.Psychodiagnostic analysis ‹‹ T.S »

STRESS FACTORS	CLIENT REACTION	PROBLEM DESCRIPTION	MENTAL STATUS ASSESSMENT	BIHAVIOR IN POST DEPLOYMENT PHASE
Unpredictable security in mission environment(desert of Soudan)	Somatisation(gastritis)	Ractivation of old trauma related to 1994 genocide	Mutism	He regain communication after one month of phonology exercise and amitriptiline25mgs/8 days/every evening
Work overload	Fatigue		Psychological crisis	

V.7.Conclusion

It appear that he was suffering from psychological traumatism in relationship with 1994 genocide against Tutsi, the gastritis and selective mutism are the expression of related emotions by the body(Somatisation),the fatigue of body due to work overload, the unpredictable security in the work environment are stress factors which reactivated the old trauma of the soldier; and this probably contributed to his crisis.

CASE N09

I.Identification

Name: M.

Age: 35 Yrs

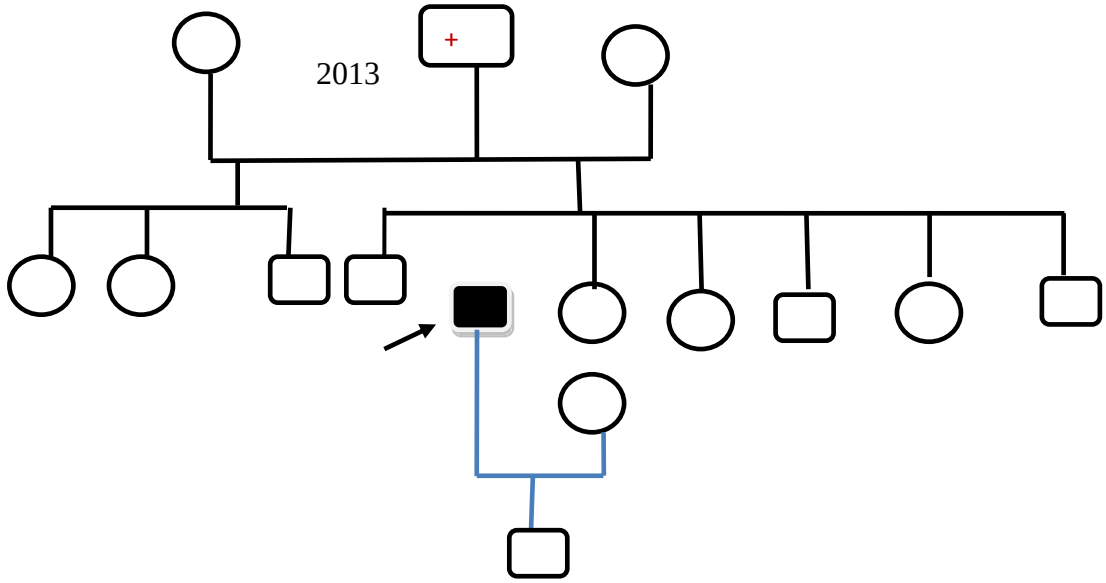
Marital status: Married

Level of Education: S6

Familly Adress: Kigali

II.Familly anamnesis

II.1.Genogram



‹‹His family shifted at Kigali-Nyamirambo.His family was polygamic, the second wife's home was settled at Gisenyi, and had also three children, two girls and one boy. His father was a trader.He died on Nov2013 from chronic Heart attack and diabetis at seventy years old; This illness weackened him and he could no longer work as before, he was most of time hospitalized in case of crisis.So the Kids were obliged to take responsibility and take care of their dear father and mother who were old include M ,even if he was most of time absent at home due to his work.The five first child of the first wife are married; Also the two first girls of the second wife are also married.M married in February 2013 two weeks before to go in peacekeeping mission in Soudan.

III.Military anamnesis

M joined the army in 1992, and worked in different military Unit, he is still active.He had to prepare his wedding during pre-deployment phase; Thing which is not easy because of an overloaded program related to predeployment rehearses and wedding preparation at the same time. He got married two weeks before the deployment phase,and settled her wife at Kigali a bit far from the family.She remained with a younger brother who went to school few months later too.The wife remained alone in the house; Four months after the deployment phase,her wife had so many problems include nostalgia,lonlyness and got depression.He shared this problem with a Bn

psychologist saying: ‹‹Madam is suffering, I didn't sleep well since when she phoned me tonight, I fear to ask for a permission as we are far away from home and needed for work,she told me that actually ,she lives alone in my house because my younger brother who left with her, went back to school …I decided to ask the permission to the chain of command so that they may provide me the last advise, the permission to go home at least one week would be helpful in this case even if it could be very expensive to me but it destubs my preestablished plan….».

He was anxious to ask for permission, but he decided finally to do it.The leader after listening to him, he granted him a permission of 21 days to go home.

When he came back to work, he was moralized and hapy because the axious problem was finished:‹‹… Now I'm feeling happy as I come back safely ,the problem about my wife has been resolved.But I'm anxious about the worse health of my father, His heart attacks and diabetis are weackening him more and more, we are wasting a lot of maney to care about him,….»

Just at the end of Nov 2013, His father died, while we were preparing to go back home in December 2013; He was granted an other permission for one month before the mission end.All those events were stressfull for him and disturbed his work performance and his preestablish self progam during and after mission. Despite all those adversities encountered he appeared resilient and always looking for proper solution in the right way.

IV.Psychodiagnostic analysis of ‹‹ M»

STRESSORS FACTORS	REACTION	PROBLEM DESCRIPTION	MENTAL STATUS ASSESSMENT	ATTITUDE OF COUPLE POST MISSION PHASE
Preparig both mission and wedding	Adaptative	Preparing both mission and wedding	Anxious	Good
No horney moon period after	Adaptative to man but maladaptative	The wife says she need to be pregnant,She	Anxiety and pain of separation of the couple	Good

wedding,he left the wife one week after wedding	to the woman	claims she could not resist to stay alone in the house		
The wife developed depression 4 months after his husband depature	Maladaptative but the man visited the woman 21 days from soudan	Depression of wife,resolve somehome problems etc…	High anxiety and pain of separation,Depression of the woman 4 months after separation with husband	Good
The loss of father while in mission	Mourning /He returned one month before the mission end for burial ceremony	Father's burial ceremony preparation	Normal Mourning	Good
Living both far from wife and familly	Adaptative to man ,maladaptative to woman	Wife need the presence of her husband at home during horney moon period	Anxiety and pain of separation, Adaptation in the new home.	The couple is joyfull and got a new kid recently,the depression and mourning has finished

V.Role of stressmanagement networking to help this soldier to find solution to his potentially stressfull problems during deployment phase in Soudan

The client shared his problem both to psychologist and all the chain of command, He was provided successfully 21 days for problem related to the depression of her wife, and one month to solve the problem related to the mourning and burial ceremony of his father but all this engaged more financial means and expences because he had to

travel and pay air tickets etc…received necessary psychological accompanment and counseling, emotional support from comrades etc…

CASE N0 10

I.Identification

NAME: A.N

AGE: 23 Yrs

Religion: Catholoc

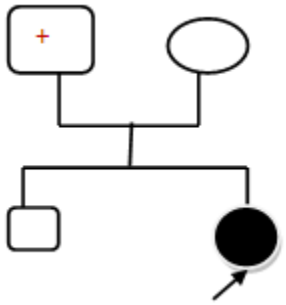
Marital status: Single

Education Level: S6

Unity: Anonymous

II.Familly anamnesis

II.1.Genogram



A.N was born in 1990 at Gitarama, his father was died during genocide, she studied until S6.His brother is a student in the university.

III.Military anamnesis

A.N joined the army in 2009, she did successfully her military training at Gabiro infantry school.In 2010 after training she was deployed in MP.In 2013 she was selected to go in peacekeeping mission in Soudan.She was very motivated at work and physically fit.

On 16/09/2013, She needed a help from a psychologist,She expressed her stressfull problem in the following words :

‹‹…I'm a Christian, I asked the Priest to teach both me and my fiancé because we are preparing our wedding just after the mission when we arrive in Rwanda. This could facilitate us to save more time because we could bring just his recommendation at our parish so that they may recognize that we attended already wedding lessons,In Rwanda it takes about three weeks of priest lessons before the wedding but if you

have a recommendation from any other priest certifying that you attended wedding advise,you don't study again .Thus, you save the time…..I'm unhappy because the platoon commander restricted the Soudan priest to teach both me and my fiancé wedding instructions in order to get a recommendation here in Soudan which would facilitate the cristian blessing of our wedding in Rwanda after mission…So We're angry against this decision which is an obstacle to our religious wedding plan.It's suprising and we decided we will not attend the church here in Soudan until we go back in Rwanda again….

We agreed to prepare our wedding just when we were preparing to come both in mission because we know that during that period we would have economic means to facilitate our wedding project.

…We get time to meet during free hours afterwork, sometimes we go together in mess for food, the most of time we are with other soldiers.We are in the same company and the same platoon…I feared when I heared rumors saying that we make love together,This is not true ,you know that it's not allowed here…We are all mature enough,We never think about that whenever we meet….Imagine yourself, is this possible in our overpopulated rooms and overcrowded camp?....we are overwhelmed bye all those rumors….lastday my fiancé was corporally punished by an RP on order of the SGT for having been speaking with me only nearer the clinic in front of other soldiers, is it a fault to speak with your friend? Why did he not punish me also as they punished him because we were conversing together. I believe that It,s a kind of hursment and marginalization. Me and my fiencé are angry about the Sgt who ordered that. Both me and my fiance are not in good mood now, We are frightened….We were in camp…I think it's a kind of jalousy against us because some of other soldier needed me and I refused their friendship . So they were surprised to hear that my friend is among soldiers of my platoon.I believed this is probably the reason of such a hursment of both me and my fiencé.

…The platoon commander decided to separate us because we work in the same platoon, company so that we may not meet again; but we are mature enough, we never abuse our relationship even if we are in the same platoon…

…One of his colleagues is spreading the rumors that my friend is married and father of one kid, but this I'kow well and we got time to discuss it long time ago; truly he

has one child but never married with her mother,this is not a big problem for me….People are opposing themselves to our union,I keep asking ourself why…»
The client acused stomachaches and was hospitalized once during this problematic periode.

IV. Psychodiagnostic summary of ‹‹ A.N»

Stressfull factors	CLIENT REACTION	PROBLEM DESCRIPTION	MENTAL STATUS ASSESSMENT	Attitude/behavior after mission
Rumors about sexuality behavior	Frustration,Fear of punishment in Soudan,Fear of emprisonment when arriving	She projected to marry with one of his colleagues when she comes back from soudan	She was anxious,	Both girl and her fiancé deserted after the army aftermission.
	home and failure of the wedding project.			

V.Role of leardership to help soldier to find solution to his potentially stressfull problem

The client received necessary psychological accompanment and counseling from the Bn Psychologist. During the deployment phase, some members of the chain of command didn't understand well the problems of these two soldiers confirming to be fiancé while in mission; This was not bad,the rumors around their union preparation , the fear of punishment and emprisonment from military regulations was a second potentially stressfull factors for both those two soldiers. Finally this fear of punishment has begotten a new desertion behavior of both two soldiers finally.The rumors of all kinds exist in the mission and are also potentially stressfull to the conserned people.According to myself, understanding well social phenomenon and psychology of people leaving together, could facilitate to understand this phenomenon of rumors which is potentially stressfull in the mission.Some persons can manage well

the stressfull psychological consequences of rumors,stressfull behavior of others but others can even develop depression due to this as it is in this case.

The Knowlegdje of Psychology approaches can facilitate the management of different soldiers in different circumstances if well applied by all commanders.Those two soldiers planning to marry after mission, psychologically are in the process of self realization.and it's Normal .Here the role of the leadership is to advise them before their union if this doesn't have any negative impact on their military duty in particular.The best attitude of the Platoon commander was to advise them friendly in stead of frustrating them as if they did a sin. The best thing was to listen to them and help them find proper solution about the issue of their wedding together and if there were any military particular restriction related to their union due to military ethics, It could be the role of the platoon commander to explain them.

Legends

1.  :Male alive in the familly

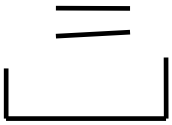
2.  : Male designated patient in the familly

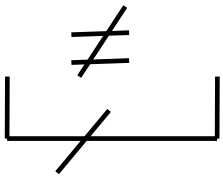
3.  : Male dead in the Famill

4.  : Female alive in the familly

5.  : Female designated patient in the familly

6.  : Female dead in the familly

7.  : Wedding or marriage relationship between a man and woman

8.  : Divorce or Separation of couple

9.  : Brotherhood relationship or sisterhood

CHAP V. RESULT DISCUSSION

V.I. Pre-deployment phase and role of clinical psychologist

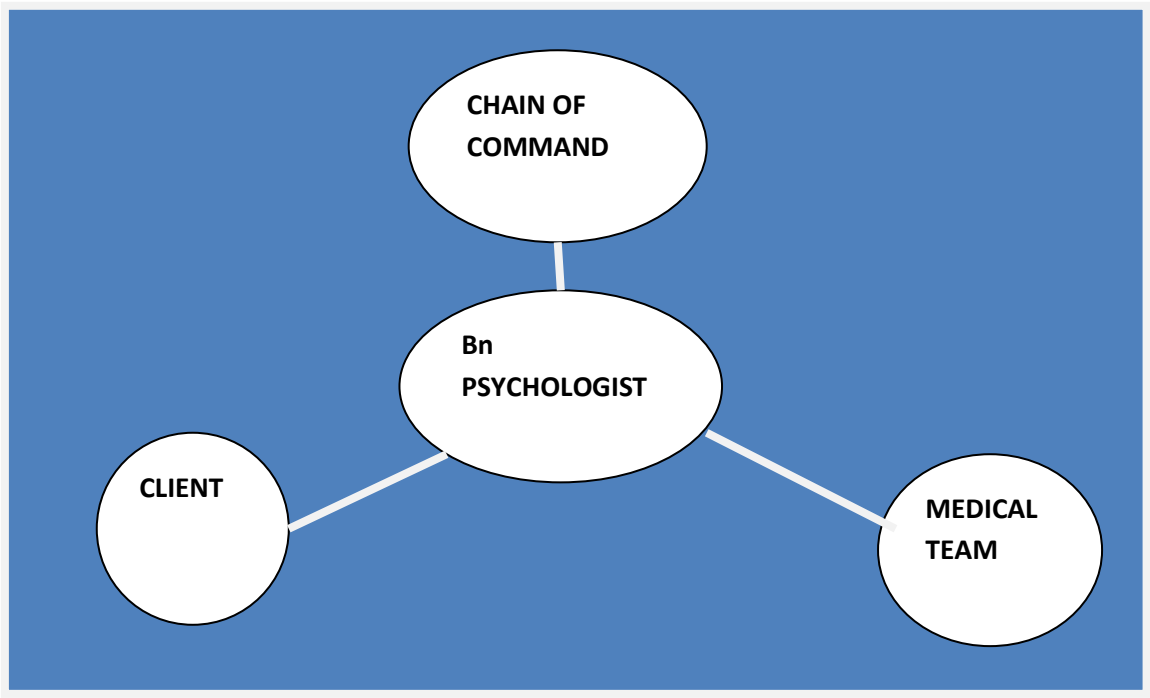
The predeployment phase remains the phase of psychological preparation to the mission, during this phase the soldiers pass medical and psychological examination to screen if he is healthier enough to participate to the mission, both are all motivated to go in peace keeping mission usually; according to the medical result some are excluded if their have poor health; It,s also a periode of training and rehearses, the participant learn the do and don't in mission area.It's also a periode where a soldier get the opportunity to prepare psychologically his family to the separation. Soldier's whose medical result is positive can develop easily some particular psychological reaction such as the pain of separation with colleagues, deny the reality of the medical results, worthless feelings, anger and even depression. A special clinical attention and psychological accompanment and counselling is always necessary to them in the camp. Some of them live the loss of the mission and can develop a kind of pathological mourning and depression and other behavior related to this important loss. It's why the deployment of a clinical psychologist is important for all those soldiers who miss the chance to go in mission due to poor health. On the other side the psychologist in charge of psychotherapy must collaborate straightly with all the chain of command by giving a report about each client conserned and discuss with the leaders about the treatement plan of each case in particular.

V.2.Deployment phase and role of clinical psychologist

The deployment phase begins when soldiers arrive in mission area (North Soudan).
The environment geography is totally different to the environment of Rwanda,The peace keeping mission is also a multination mission,multiculture but Rwandan soldiers usually learn how to collaborate with people of different culture and learn this during the predeployment phase."Military operations across the entire range of conflict expose military personnel to a multitude of stressors. These stressors can lead to a variety of negative health consequences, both physical and mental" (Paul T. Bartone, 2006) **.** Soldiers deal with higher levels of stress than most people. The most common stressors in the mission area are: serving in non-family duty stations (family separations), remote location, a suddenly increased or decreased workload, Do not know or cannot influence what is happening with family back home (a sick parent or

child, financial problem…). Family changes that take place in the soldier's absence, health problems. Other stressors are due to the natural environment, such as intense heat, intense rain,winds,climate changes,hostile environment,unpredictable security etc…During this phase the medical team have to collaborate straightly with the chain of command in order to manage the health of the battalion promptly.The RMO must collaborate straightly with the battalion Psychologist, they must exchange all information about all cases of patient in the level one hospital because there we can notice many cases analysed as psychosomatic deseases due to stress effects. Both patients received in the level one hospital are considered as designated patients of a system and can inform some how the medical team and all the leadership about how the body of soldiers is reacting againt stressors from military operation and challenges of new geographical environment; The number of patients receved per month with their different symptoms can also inform some how about the adaptability effort of soldiers in this new operational environment.

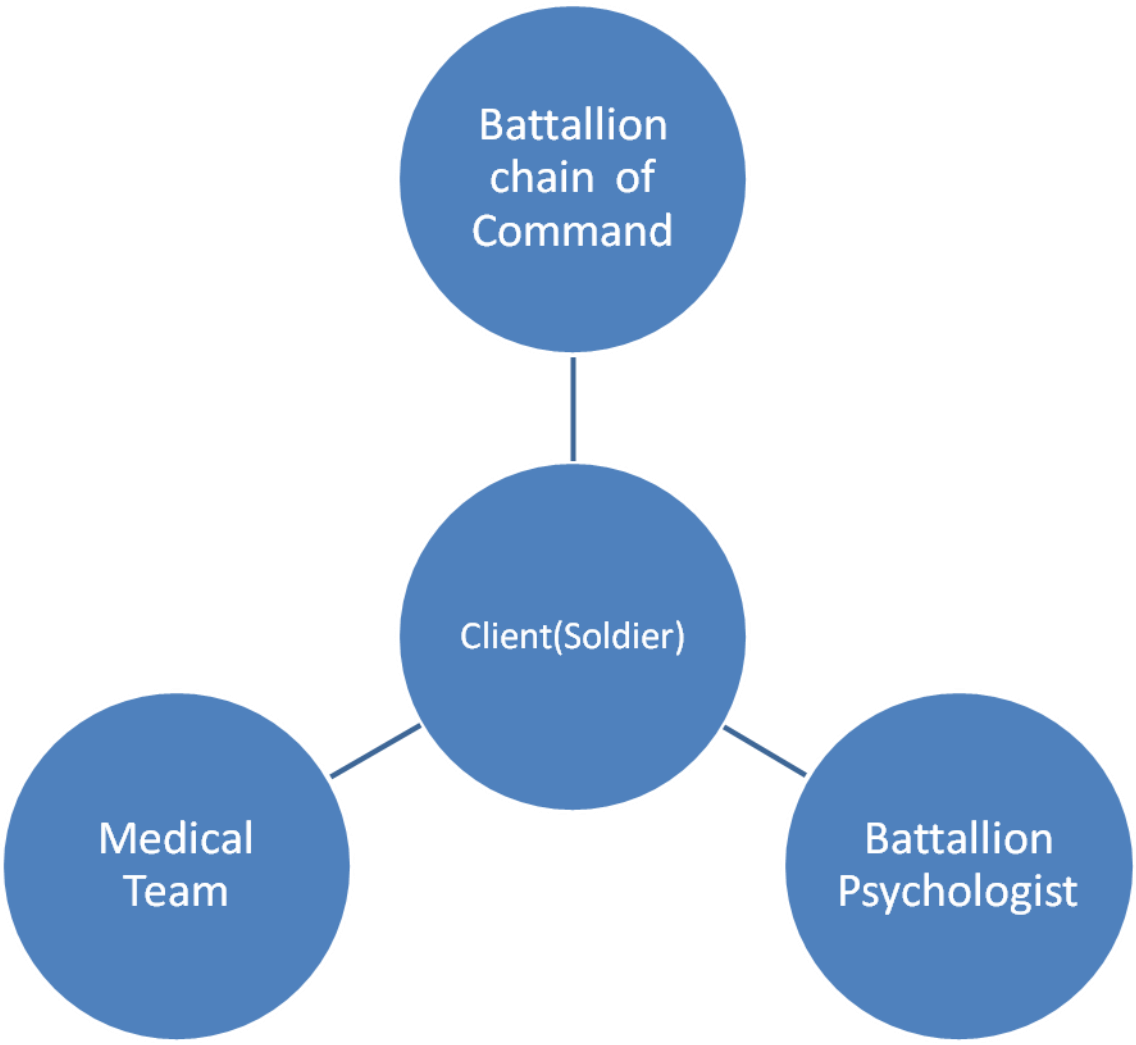
V.3.Schematic representation of the psychologist position in a battalion



Here the Psychologist is in the middle position in order to explain the new behavior of the client to the client himself, to the chain of command and to other members of the medical team in order to facilitate a conjugated effort for his medical and clinical psychology care in order to recover as soon as possible and participate to the

task and mission of the battalion as part of the force.When one person of a military section is absent or sick all the section will feel and suffer this absence too in terms of manpower, task distribution etc…which is potentially stressfull too.

V.4.Schematic representation of the position of the client in the Bn



Here the client needs the care, support and attention of the three different groups to recover quickly and contribute as he can to the life of his battalion to fulfill the mission.We noticed that promoting together all antistress activities in the battalion were helpful in general in terms of stress prevention and our stress prevention plan were appreciated by the UNAMID staff but never the less, we noticed that the three first months in deployment phase are difficult and most of people can present a kind of adaptation syndrome considered as the transition between your native land and new operation area in the native country of a soldier or abroad. During this time of

first three months we can notice more persons at the clinic with different somatic complaints, some times with patrol fatigue, sleep depts. etc…..20/787 experienced psychological symptoms which needed a special clinical therapeutic attention of a psychologist, 2/20 of them were rapatriated before the mission end, among them ,there were two female only who needed special psychotherapeutic attention, one among these two girls deserted the army just after the mission, His desertion behavior was in relationship with the consequence of stress from the mission, she had a wish of self realization, which We analyzed refer to the Maslow pyramid of human needs, She wanted to marry her colleague from the same company after the mission but their attitude and need of being together the most of time provoqued the curiosity of the company commander who interpreted their attitude as indiscipline,their were both frustrated fearing that probably they could be punished after rapatriation because the rumors about them got heared every where in the camp, During counseling she expressed her stressfull feelings :

‹‹ We have known each one during the predeployment phase but I used to meet him some times in the camp at Kanombe, he told me about himself and said he wishes to mary me, I accepted and we agreed together that we should celebrate our wedding after the end of mission…Here in Soudan We need the written permission from the priest so that we may be allowed easily to Christianly marry as soon as we arrive in the country , it would be helpful to us because we would save enough time by not attending wedding education about one month from the catholic parish when we shall go back in Rwanda…I'm unhappy because the catholic congregation influenced by some military colleagues prohibited the Soudanese priest to provide me the written permission or he was ready to provide us wedding education here in Soudan…people are saying rumours about us that sometimes we make love but it's not true and you know that it's not allowed in mission…we are troubled by those rumours…only we meet some times when we are not at work during evening and we talk together here in the camp,only every Friday we meet to pray in the church and uswally we are busy with prayers and you always meet us in the church ,we return in the camp just after the mass…Other soldiers sayed that my fiancé is married, have one kid…He told me that he got a child but never married…Only I feel I love him, having a child is not a big problem….Our S/Major do not actually like to meet us together….Lastday he

punished him because he met us tolking together…He was unpleased and we interpreted this punishment as a harassment...».

Just after the mission those two soldiers both deserted.Their desertion behavior is the consequence of stress encountered during the mission.

The second girl had problem of psychological trauma and related pathological mourning which ended progressively with the end of genocide against Tutsi commemoration period,She got trauma crisis since the evening the first day of genocide against Tutsi Commemoration.As we were out the country, a therapeutic ritual of flowers deposing near the Rwandan flag was psychologically important and meaning full to some one with genocide trauma and related pathological mourning.His traumatic symptoms desapeared progressively with the end of genocide commemoration.

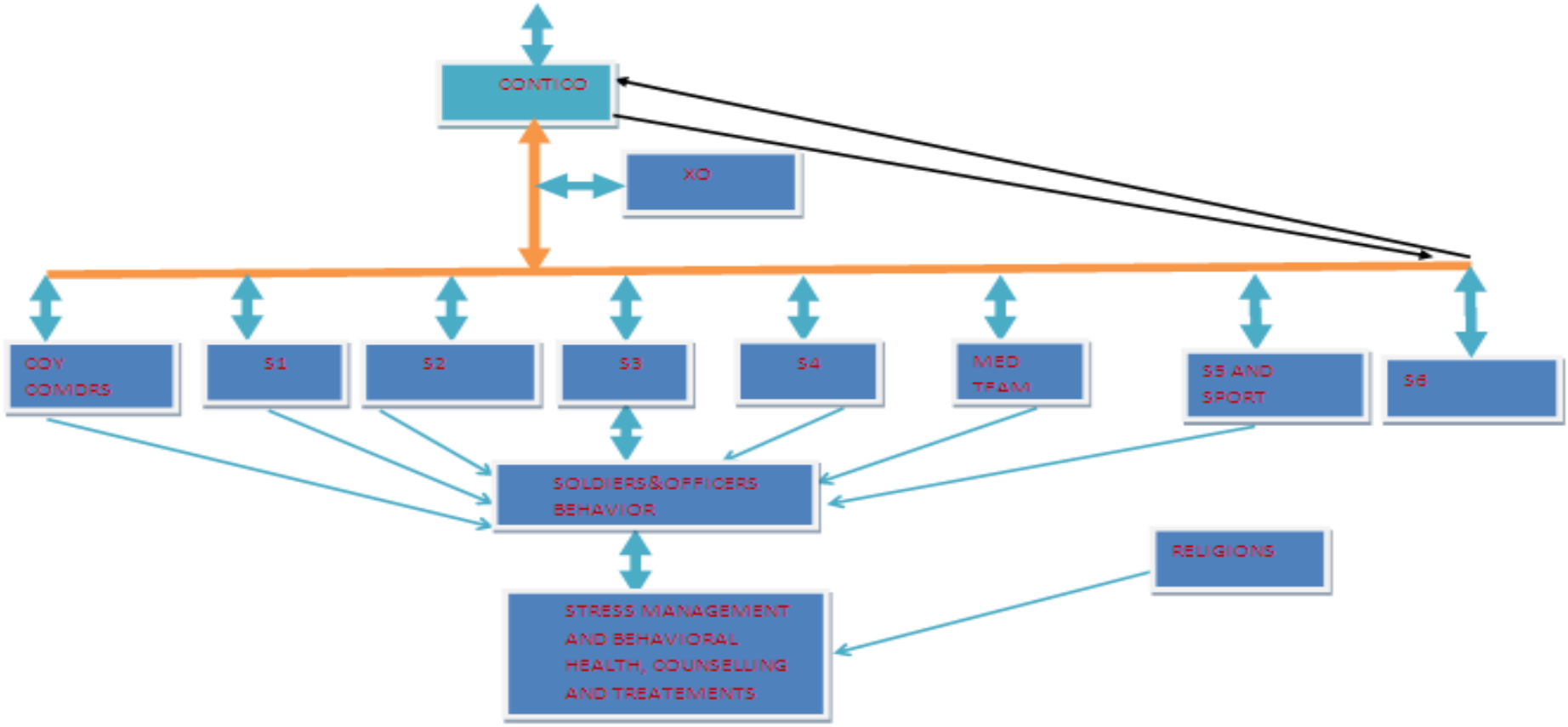
In this hard deployment phase: The main battalion psychologist activities are:

- Keep working closely with Bn chain of Command, the medical team by exchanging information about the improvement of the global health of the client and see if he recovered well enough to participate to any military work and keep networking.
- Keep observing and analyzing deeply all factors (individual and/or collective) that can generate negative stress among troops and take preventive measures as early as possible because when stress is at its peak, it is hard to stop and regroup.
- Advise commanders if the factors of stress are related to the work, leadership and command.
- Psycho-educate troops on topics related to the identified problems in order to make them aware of their effects.
- Work closely with representatives of religions in order to help troops cope with stress, more especially in the management of grief and mourning according to their belief.
- Keep monitoring cases received in the clinic to find out if they are psychosomatic in order to intervene through provision of psychotherapy.
- Organize a Post Critical Incident Debriefing (if necessary).
- Preparation of the 19th commemoration of Genocide against Tutsis and management of trauma emotional crises among soldiers. Linking the situation of commemoration against Tutsis with military operation and soldiers behavioral monitoring at work.

Psychological preparation to the end of mission which is also very busy and can provoke a certain psychological mourning because after one year of social

interaction emotionally a human being develops a certain strong relationship with some others in the environment, and the new separation during mission end is psychologically a kind of loss which is felt by every one in a certain way. At the separation sometimes the ceremony of thanks giving opened by the UNAMID by giving certificates and gifts to some members of the battalion is emotionfull.exchange of gifts and bye bye words and visit between people is also emotionfull and shows the kind of self management of the feeling of separation between people. There is also the joy to see new colleagues who comes to replace your team preparing to go back in a synchronized way.

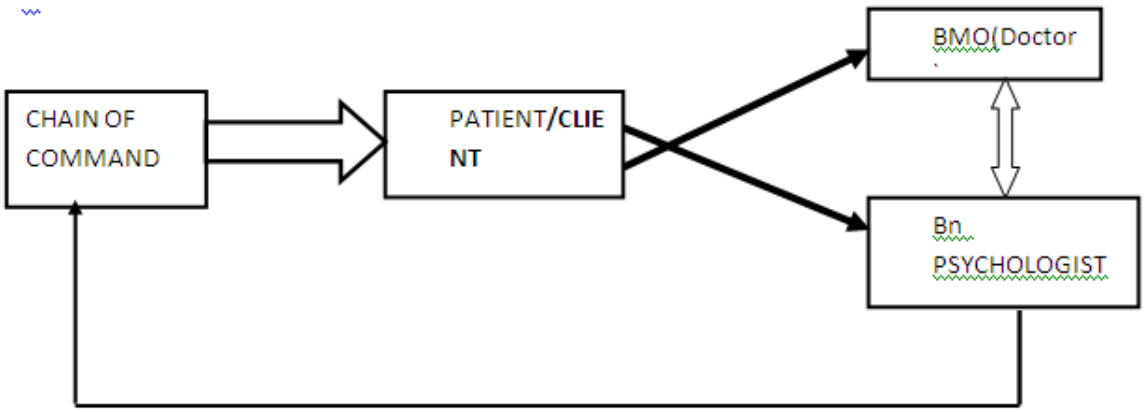
V.5.Battallion stressmanagement networking: Battallion Psychosocial care



V.6. Collaboration between battalion stressmanagement networking

There is a permanent exchange of information among this stressmanagement networking about potential stressful events and potential traumatic events which can have a negative impact on the health of subordinates in general and in particular the events which can have negative impact on the mental health.This network always work in complementarity in order to manage every potentially traumatic event better.Here the battalion psychologist become not the counselor of the patient but the adviser of this battalion networking in order to share the same common understanding about the psychological or and somatic symptoms presented by the client and plan together the proper way to help him.When one soldier is sick in his section, this have an negative impact on the assigned task and the work plan and even the mission in general, if the patient don't have an other soldier who can replace him when he is sick . It's why the network tries always to conjugate their effort together in order to help cure the patient so that he may recover as soon as possible to reinforce his section.This strong collaboration of the battalion stressmanagement networking is the key to understand better the behavior change of any soldier at different time, help him to face his different frustrations in usual life , everyday proffetional life and help him find proper solution to his problems.

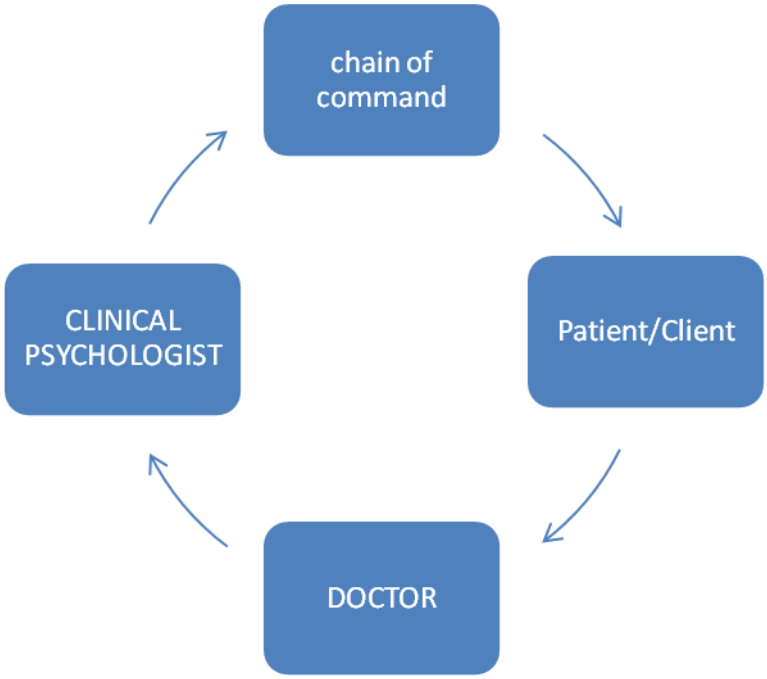
V.7.Patients global care, treatment process and follow up by the battalion networking



This schematic representation, illustrates the situation of the consultation demand and the collaboration between the battalion stressmagement networking in order to help and support the treatment of the patient or the client .There is always need of manpower,when one soldier is sick, or absent, his section will suffer with work. It means that the commander

of this section is working under pressure in order to find an other fit soldier who can feel this gap.The medical team must pay attention during consultation in order to discourage any malingering behavior.For any unusual behavioral change the leader may call the battalion psychologist to help him instead of punishment measures which increase frustrations and hopelessness fellings which are dangerous to the mental health of the soldier.

V.8.Patients' care, treatment process and follow up by the battalion stressmanagement



The behavioral monitoring is made on daily bases in collaboration with the chain of command and the medical team. Sensitization compain and stress symptoms awareness were done in our Battalions as well as among other contingents. We discussed about the role of the leadership in stress management. Every staff in the chain of command is considered as a leader as well as a stress manager.

In military every duty, task or new deployment begins by the commander's briefing including sensitization on discipline and behavior in general.The commander usually has the task to explain clearly the nature of the task to his subordinates at the beginning.

Visit at Towers are everyday made by the Commander on duty in order to observe the readness of his subordinates on duty.Soldiers on guard are psychologically concentrated on sharp observation about any potential threat around Supercamp. In the same purpose of behavior monitoring of subordinates on duty by the commander, the temporary visit sometimes involve immediate problem solving and moral support to a subordinate in need. If

there is any complain about health and behavior, the soldier is replaced by another and transferred to the clinic for treatment and support immediately. There he can meet the medical team include a clinical psychologist for quick consultation.

V.9.Adaptative reactions to stressors in peacekeeping mission by Rwanbatt37 soldiers

Stressors, when combined with effective leadership and strong peer relationships, often lead to adaptive stress reactions which enhance individual and unit performance.

20/787 experienced psychological symptoms which needed a special clinical therapeutic attention of a psychologist,2/20 of them were rapatriated before the mission end, among them ,there were two female only who needed special psychotherapeutic attention, one among these two girls deserted actually.It means that 767 were resilient and adapted to the stressors of peacekeeping mission until the mission end.The military resiliency is acquired during military training and rehearses of all kind.We can confirm that the predeployment phase which is the phase of training and psychological preparation of a soldier to the peacekeeping mission increase the resilience of the soldier.

V.10.Battallion policy of stress prevention

Entertainment and recreation: leisure, enjoyment or amusement activities (when soldiers go for shopping, they explore those activities). Other entertainment or occupational activities: reading, movies, TV show, music, internet café, cultural dense, tallant show and psychoeducative drama were usually done at least once a week and this was good time to relaxe, socialize with Rwandan diaspora in Soudan and sociolize with the multination and learn about their different culture.

Briefly, aerobic exercises, entertainment, occupational and recreation activities, playing and coping strategies. These activities were used as stress management technic and contributed to refresh mind and body of our soldiers in mission area.

According to Ogunmola (2002) recreational and sporting activities are necessary to free from diseases, attain enough strength, agility, endurance and skill to meet the demand of daily living; sufficient reserves to withstand stresses without causing harmful strain; mental development and emotional adjustment appropriate to the maturity of the individual.

Finnicum and **Zeiger (1998)** and **Jatau (2000)** also stressed that recreative exercise is important because it improves body functions and reduces the risk of degenerative diseases as well as other risk factors of sedentary life that include high blood pressure, obesity, high blood sugar, high cholesterol, tissue weakness, diabetes and backache.

Gaya and **Bwala (2001)** supported that physical-inactivity is one of the risk factors of cardiovascular diseases. They explained that recent studies have shown that active participation in regular programmes of physical activity decrease total blood cholesterol, triglycerides and low-density lipoprotein level. Essentially, increased level of physical activity minimize the narrowing and hardening of arteries by decreasing the concentration of blood cholesterol in organism.These researchers have shown how entertainment, recreational and sporting activities are very important to deal with pressures, demands of our daily living.We can confirm that the stressmanagement strategic plan in Rwambat37 was good.

V.11.Post -deployment phase include the Post mission follow-up on return from mission

Activities must be centered on the following ideally:

- ✓ Visiting the Bns in its deployments in the country,
- ✓ Assess post mission stress related problems and intervene in order to prevent their escalation towards complicated psychological problems,
- ✓ Psycho-educating the troops on post-mission stress related issues and possible psychological problems that may rise when not managed accordingly, Etc.

We can notice more absence to the work just after the peace keeping mission, desertion behavior among some junior soldiers, drunkedness behavior , joy of reconnecting with the family ,etc…We can notice that the most of behavior qualified good or bad among soldiers after mission is a compasasion of a certain psychosocial need .The chain of command include the Bn Psychologist reinforce usually counseling and psychological support to soldiers during this phase.The indisciscipline behavior is not tolerate in the army, those who develop more indiscipline behavior are punished after the decision of unit disciplinary commity and this is a time of autoevaluation behavior, need to change and military advise and counseling about behavioral change. According to Maslow(1943) a shortcoming or inadequacy of each of the human needs can generate psychopathology , in which the real cause is from the deficiency of satisfaction rather than from psychological trauma .This can influence also the stressful behavior in one way or an other.

V.12.Limitation

Impossibility to observe all my population in post-mission follow up as it was easy in predeployment and deployment phase of the mission.

V.13.General conclusion

The major factor making soldiers most stressed in the mission is being away from their families, increased workloads, financial problems, changes in their family situation, and passing several months in deployment in a very stressful environment with unpredictable security etc….

Physical exercises, entertainment, occupational and recreation activities strategies are the most used as preventive activities in stressmanagement, contribute and play prominent roles to refresh mind and body of Rwandan soldiers in mission area.Psychological accompanment, counseling, psychotherapy and daily behavior monitoring of soldiers in different circumstance of the mission are the major task of Bn clinical psychologist in collaboration with the chain of command. This collaboration can facilitate to share the common understanding about psychological symptoms experiencing by a comrade and can influence greatly the way to help him better.Let us remember that:

1. Most Soldiers are resilient. The resiliency displayed by those Soldiers is what we refer to as mental toughness or Battlemind.

2. Battlemind skills, developed in military training, provide Soldiers and leaders the inner strength to face fear, adversity, and hardship during combat and operation with confidence and resolution and the will to persevere, win and reach their objective.

3. No amount of training can totally prepare a Soldier for the realities of combat. Sometimes even the strongest Soldiers are affected so severely that they will need additional help. Combat and operational stress behavior experiences will impact every Soldier in some way. Just because a Soldier may not be affected by a specific event, it does not mean that every Soldier in the unit is handling the stress in the same way.

V.14.Recommandations

To the leadership

- ✓ To create one clinical psychology department well coordinated in the army in order to help military psychologists to organize themselves well and be more productive in the institution.
- ✓ To reinforce psychological screening test at the recrutment and for the mission pre-deployment phase.
- ✓ To sensitise all battalion leaders to ask a psychological consultation to any soldier presenting behavioral problem, misconduct or indiscipline behavior in his military Unity.

- ✓ To facilitate the coordination of military clinical psychologists in order to be more productive for their institution.
- ✓ T o facilitate the clinical Psychology department to make clinical supervisions every year for psychologists who come back from peacekeeping mission or any other potentially stressful military operations in order to reenergize psychologically themselves so that they may get more force to support emotionally others in future potentially stressful operations.
- ✓ To continue facilitating the training of psychologists for higher levels in terms of capacity building.
- ✓ To deploy at least always two psychologists in a battalion going in peacekeeping mission because most of time the battalion have at least one detachment situated far away from the headquarters.
- ✓ Continue promoting healthy behavior among soldiers where ever they are on duty:
  good foods, allow time for recuperation rest and relaxation, set entertainment and recreation program, drink plenty of water to strengthen ability to manage stress. The programs are useful in promoting unit cohesion, they are also important in a protection against battle fatigue.
- ✓ To facilitate military psychologists to organize psychological debriefing in case of critical incidents as it's indicated in terms of psychological trauma prevention.
- ✓ To create a military psychotherapeutic center which can provide counseling and psychotherapy to active soldiers from different potentially stressfull mission including peacekeeping operations.This center can also help retired soldiers victim of different psychological trauma and related diseases.
- ✓ To provide the budjet which can facilitate psychotherapeutic interventions in the army.
- ✓ To continue supporting initiatives related to stressprevention in peacekeeping mission such as bye stress, culture troop,sports and games of all kinds.
- ✓ To teach some lessons related to human psychology in military academy in order to prepare new officers to become mature in human leadership.

To all military psychologists

- ✓ Comradeship and teamwork
- ✓ Organise psychoeducation through drama, games in peacekeeping mission etc…
- ✓ Work in complementarity with all battalion stressmanagement networking to be more productive.

- ✓ Explain clearly the symptoms of the client to him self and to the chain of command so that you may all have the common understanding about his sickness so that the client may be treated with all his dignity.
- ✓ To organize a scientific discussion at least once a year in order to discuss how to harmonise medical-psychology interventions in our battalion in order to prevent post traumatic stress disorder among our soldiers.

To the medical team

- ✓ Multidisciplinary medical team work: Work in collaboration and complementarity in order to help the patient better.

To all soldiers

- ✓ To help each other in case of psychological crisis without stigmatization.This is noticeable in some battalion where some soldiers try to imitate the symptoms or speak about the behavioral crisis of their colleague in a jocking manne**.**
- ✓ To be willingly motivated to consult the psychologist without fearing stigma before acute symptoms.

BIBLIOGRAPHY

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders, fourth edition*, text revision. Washington, D.C.

American Psychiatric Association (APA). (2005*). Let's Talk Facts About Posttraumatic Stress Disorder*. Arlington: APA.Arendt, M., & Elklit, A. (2001).Effectiveness of Psychological Debriefing. *Acta Psychiatrica Scandinavica*, 104, 423-437

Annals of Pharmacotherapy; 36:1375-1379.

Adler, A.B., Castro, C.A., & McGurk, D. (2009). Time-Driven Battlemind Psychological Debriefing: A Group-Level Early Intervention in Combat. *Military Medicine*, 174, 21-28.

Author Barer, C. (2002), *Research Methods in Clinical Psychology*. New York: John Wiley.

Bartone,P.T.(1997) American IFOE Experience: Stressors in the early deployment period,in J.L.Soeters&J.H.Rvers(eds.NL.Arms:Neterlands,Annual review of military studies(The Bosnian Experience)(pp.133-139). Breda, the Netherlands: Royal Military Accademy. Bartone.P (1980).Stress in military settings, in C.Cronin(ed).Military Psychology: An introduction (pp.113-146).Needham Heights: Simon and schruster custom Publishing.

Baumann, S.E. (1998). *Psychiatry and Primary Health Care: A Practical Guide for Health Care Workers in South Africa*. Cape Town: Zebra Publications.

Bisson, J. I., McFarlane, A. C., & Rose, S. (2000). Psychological Debriefing. In E. B. Foa, T. M.Keane, & M. J. Freidman (Eds.), *Effective treatment for PTSD (pp. 39*–59). New York: Guilford Press.

Breznitz (Eds.), *Handbook of stress: Theoretical and clinical aspects* (Vol. 2, pp. 511-531). New York: Free Press

Bruwer, N., & Van Dyk, G.A.J. (2005). The South African Peacekeeping Experience: A Comparative Analysis. *South African Journal of Industrial Psychology, 31*(2), 30-39.Bryant,

Cannon WB.Bodily changes in pain, Hunger, Fear and rage.2nd ed.New York: Appleton; 1929.

Carll, E.K., (2007). *Trauma Psychology. Issues in Violence, Disaster, Health and Illness.* Westport: Praeger Publishers.

Carlson, J.G., Chemtob, C. M., Rusnak, K., Hedlund, N. L., & Muraoka, M.Y. (1998).

CiGrang, J.A., Peterson, A.L. & Schobity. (2005). Three American Troops in Iraq: Evaluationof a Brief Exposure Therapy Treatment for the Secondary Prevention of Combat Related PTSD. *Pragmatic Case Studies in Psychotherapy*. Vol 1, Module 2, Article 1,pp 1-25.

Crocq, L. & Crocq, M.A., (1987). Trauma and Personality in the Causation of War Neuroses.In Belenky, G. (Ed.), *Contemporary Studies in Combat Psychiatry* (pp 103-116). Westport: Greenwood Press

Cronin,C(1998).Military Psychology:antroduction.washington,DC: Simon and shusler.

Danna, K., & Griffin, R. W. (1999). Health and well being in the workplace: a review and

Deahl, M., (2000). Psychological Debriefing: Controversy and Challenges. *Australian and New Zealand Journal Of Psychiatry*, 34, 929-939.

Devilly, G.J., & Cotton, P. (2003). Psychological Debriefing and the Workplace: Defining a Concept, Controversies and Guidelines for Interventions. *Australian Psychologist*, 38, 144-150.

Devilly, G.J., Gist, R., & Cotton, P. (2006). Ready! Fire! Aim! The Status of

Dhladhla, T.J, & Van Dyk, G.A.J. (2009). Management of Post-Traumatic Stress Disorder in the Military: An Intervention Model. *Journal of Psychology in Africa, 19*(4), 591-596.

Dhladhla, T.J. (2008). Demobilisation and Reintegration of Ex-Combatants into CivilianLife: Healing the wounds? In G.A.J. Van Dyk (Ed.), *Strategic Challenges for African Armed Forces for the Next Decade* (pp 65 - 83).Stellenbosch: Su Media.*Psychological debriefing for AfricaTD*, 6(2), December 2010, pp. 379 – 394.393

Distress. *Review of General Psychology, 10*(4), 318-345.

doi:10.1037/1072-5245.14.2.160.

Dyregrov, A. (1997). The Process in Psychological Debriefings. *Journal of Theraputic Stress, 10*(4),589-605.

Edwards, D., Sakasa, P. & Van Wyk, G. (2005). Trauma, Resilience and Vulnerability to PTSD: A review and clinical case analysis. *Journal of Psychology in Africa*, 15(2), 143-153.

Emergency Mental Health, 2(4), 211-225.

Erkutlu, H.V, & Chafra, J. (2006). Relationship between leadership power bases and job stress

Everly, G.S. & Mitchell, J.T. (2000). The Debriefing "Controversy" and Crisis

Everly, G.S., Jr., & Mitchell, J.T. (1999). *Critical Incident Stress Management (CISM): A new era and standard of care in crisis intervention* (2nd ed.).Ellicott City, MD: Chevron.

Eye movement desensitization and reprocessing treatment for combat-related posttraumatic

Foy, D., Schnurr, P., Weiss, D., Wattenberg, M., Glynn, S., Marmar, C., & Gusman, F., (2001).

Foy, D.W., Erikson, C.B., & Trice, G.A., (2001) Introduction to Group Interventions for Trauma Survivors. *Group Dynamics Theory, Research and Practice, 5*(4), 24251.

Freedy, J.R., & Hobfoll, S.E., (1995). *Traumatic Stress: From Theory to Practice*. New York:Plenum Press.

G.Dennis Reiner; Combat and operational stress control manuel; Field Manuel N0 6-22.5 Washington,DC, 18 March 2009.

Gishoma &Brackelaire: Rwanda Journal series F, medicine and health sciences vol 2, N02, (2015)

Group Psychotherapy for Posttraumatic Stress Disorder. New York: The Guilford Press Grey N,

Halgin, P., & Krauss. (2007). *Abnormal Psychology*. New York. Mc Graw-Hill.

Hemels M, Koren G, Einarson T. (2002). Increased use of antidepressants in Canada. *The*

Intervention: A Review of Lexical and Substantive Issues. *International Journal of*

Keller, T. (2005). Soldier Peer Mentoring Care and Support: Bringing psychological awareness to the front. *Military Medicine, 17*(1), 355-363.

Lazarus, R. S. (1999). Stress and emotion*: A new synthesis*. New York:

Lazarus, R. S., & Folkman, S. (1984). *Stress, Appraisal, and Coping*. New York: Springer.

Lazarus, R. S., & Folkman, S. (1984). *Stress, appraisal, and coping*. New York: Springer.

Lewis, S.J., (2001). Do One-Shot Preventive Interventions for PTSD Work? A Systematic Research Synthesis of Psychological Debriefings. *Aggression and Violent Behaviour*, 8, 329–343.

Malach-Pines, A, &Keinan, G. (2007). Stress and burnout in Israel police officers during

McNally, R.J., Bryant, R.A., & Ehlers, A., (2003). Does Early Psychological Intervention Promote Recovery from Posttraumatic Stress? *Psychological Science in the Public Interest,4*(2), 45-79.

of subordinates: example from boutique hotels. *Management Research News* 29(5): 285-297.

Palestinian uprising (intifada). *International Journal* of *Stress Management, 14*(2), *160-174*.

Psychological Debriefing and Therapeutic Interventions: In the Work Place After

Selye, H, (1976). *The Stress of Life*. New York: McGraw-Hill.

Selye, H. (1974).*Stress without Distress*. New York: Lippencott.

Springe publishing .Co.

Springer, & Selye, H. (1976). The Stress of Life (rev. Ed.). New York: McGraw-Hill.

Stress disorder. *Journal of Traumatic Stress*, 11, 3-24.

Synthesis of the literature. *Journal of Management*, 25(3), 357-384. doi: 10.1177/014920639902500305

ELECTRONOC ADRESS

Army knowledge online(www.us.army) retrieved on June 2013

A.MASLOW: Motivation and Personality (1943) ,Retrived May10,2013 from http://WWW.Psychology.Com.

Army knowledge (www.us.army.mil), retrieved on May 2013.

http://www.ncb.nlm.nih.gov/pmc/articles/PMC2568977/ retrived on June22,2016/11h30

Perry, B., (2006). *Effects of Traumatic Events on Children.* Retrieved February 15, 2009, from http://www.childtrauma.org/ctamaterials/interdis.asp

Psychology resilience,Retrieved May 10,2013 from http:// www.Psychology about.com

Stress and stress management :http://hydesmith.com retrieved on May 15,2016

Yalom, I. (1985). The Theory and Practice of Group Psychotherapy. New York: Basic Books.

Yehuda, R. (2001). Traumatic stress: The assessment and treatment of PTSD . Washington: American Psychiatric Press retrieved from www.traumacenter.org/products/pdf files/Complex_PTSD.pdf