
The stresses of peacekeeping: Rwanda 1994

A personal experience

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In August 1994 the British Army mounted its first ever Humanitarian Aid effort. I was the psychiatrist to this endeavour and this is a brief account of the stresses on those intimately involved with the medical aspects of 'Operation Gabriel'.

The stresses of any deployment may be divided into those associated with Pre-deployment (preparation, separation); Deployment (general, theatre specific) and Repatriation (reunion, readjustment).

Of the 75 paramedics interviewed approximately 60% had been on previous operational tours and less than 20% had never encountered death at work or in the family. Two had to postpone their marriages because of the tour and only 4% had marked personal problems before deployment.

Little was known of Rwanda. Most expectations were based upon information gleaned from the media which proved stressful for all concerned. For family members at home media 'horror stories' create anxiety for the safety of loved ones. When a story drops out of the news it seems as if no-one cares that their loved ones are still 'risking their lives out there'. All this is in addition to having to adjust to accommodate the absence of a partner/parent.

For most this was their first experience of Africa. Physical threats came from the climate, endemic disease (malaria, dysentery, HIV) and difficulty in getting fresh food and water.

The joy of being in Rwanda was the joy of being able to 'do something'. We deployed with medical and surgical assets; environmental health teams; engineer, logistic and signal support which allowed the provision of static and peripatetic medical facilities, a field surgical team, environmental health advice and practical help in providing safe water and sanitation, support to non-government organisations (NGOs) and work with orphanages.

The main effort was at Kibeho, a camp with 60–100 000 refugees and the site of one of the many massacres that occurred in Rwanda during 1994. With 3–4 doctors and about 20 paramedics roughly 1000 patients were seen in a 3–5 hour period, 6–7 days a week for roughly 10 weeks. The facility provided triage, oral rehydration supplementation, resuscitation, minor/major treatments, obstetrics and a ward. Such a high workload is extremely demanding and each specific 'area' had its own particular stressors.

Triage was difficult. Seeing so many ill and despairing people crowding into the facility was distressing and led to irritation with and projection of anger onto more 'fit' patients who pushed in front of the more sick ones. Crowd control in Africa is not for the faint-hearted. Communication was an ever-present problem despite working with local interpreters. Oral rehydration therapy is the key treatment of diarrhoeal illnesses and often proved to be a social therapy for the soldiers, allowing them to succour and feed families. The resuscitation bays allowed for aggressive rehydration which was often successful in saving lives. This counterbalanced the sadness engendered by the all too frequent deaths in children.

Although the treatment facility offered a multitude of procedures the pressure was hard to bear. The paramedics are predominantly trained in dealing with trauma, the concepts of which, unlike medicine, are straightforward. It was difficult for a number of paramedics (and even some doctors!) to understand that people, even in the UK, attend doctors for physical, psychological and/or social reasons. The lack of secondary or tertiary medical facilities accentuated the moral and ethical dilemmas of humanitarian aid. Many would cope by immersing themselves from time to time in a practical procedure in order to 'escape' the work load.

The high neonatal, infant and child mortality was daily evident. For the first 6–8 weeks I was one of only two doctors with any obstetric experience and ended up delivering a number of babies, including my first set of twins. One poor 19-year-old soldier witnessed his first birth and death in the same confinement.

Ward work was one of the most stressful and unpleasant tasks to be endured. Likened by one doctor to the Crimea, no-one liked working on them. Initial successes gave way to a distillate of terminal care cases ranging in age from 1–50 years. Emotions were at times intolerable.

There was little chance to undertake any psychiatric work with the local population in Kibeho. I saw two chronic psychotics who attended with a copy of their prescriptions. Neither were acutely disturbed yet were the source of ridicule by their fellow countrymen. Although there was so much 'real' illness I am convinced that much distress was somatised. Rwandans are stoics and only close observation revealed their deep mental anguish.

Later in the deployment I helped Gerard, a medical assistant, in the slowly reforming Ndera psychiatric facility where over 300 inmates and refugees had been killed. Gerard was working hard to provide assessments and treatments for the patients who were being referred there. In November there were about 40 in-patients. Half were acute cases, half recrudescences of chronic psychoses. There were twice as many women as men.

Without exception, all admissions had been triggered by the war – rape, assaults, participation in atrocities. Patients were generally referred because of 'behavioural disturbance' and all received one or two neuroleptics and an antidepressant. Not surprisingly some improved but a fair number were obviously receiving too much or inappropriate neuroleptics. I tried to teach and tactfully alter Gerard's prescribing habits while procuring for him more drugs through Pharmacie Sans Frontières. Of all the health workers I encountered Gerard was the kindest and most

caring. I hope he is still there. On my exit from Rwanda my Canadian and Australian colleagues promised to visit regularly to provide medical help, but sadly none were psychiatrists. As in the other war zones I have visited alcohol was the self-medicament of choice.

I undertook 75 individual and 30 repatriation group interviews with those paramedics involved in 'Operation Gabriel'. Unlike the NGOs, the military are a group before, during and after any deployment, indeed the group is the key to the whole experience. Return home alters this group dynamic which is felt keenly by those who were 'attached' to the group from outside units.

The repatriation groups reviewed their achievements, good and bad experiences and the memories they would take away. Then they explored expectations of return. How would they have changed? How would their partners/children have changed? What would other's expectations of their return be? What would it be like to return to the mundane? Who would envy them? What stories would/should they tell? What questions would others ask?

On return 7–10 days were spent in camp re-adjusting to life in the UK (part of the time at home, part at work) before going on leave. This is standard practice now and has proved to be particularly useful although not instantly appealing!

All who participated in 'Operation Gabriel' have been changed by the experience which most saw in a positive light, gaining in skills, confidence and compassion. Only two thought the reality was worse than their expectations. Unfortunately for many, the recent killings in Kibeho have brought back memories and with these memories, sadness that some of those we may have treated will have survived only to fall victim to the bullet.

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