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PSYCHOLOGICAL DISTRESS AND COPING STRATEGIES OF GHANAIAN MILITARY PEACEKEEPERS IN PEACE SUPPORT OPERATIONS

PETER OWUSU-DARKWAH

2023

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PSYCHOLOGICAL DISTRESS AND COPING STRATEGIES OF GHANAIAN MILITARY PEACEKEEPERS IN PEACE SUPPORT OPERATIONS

BY

PETER OWUSU-DARKWAH

Thesis submitted to the Department of Education and Psychology of the Faculty of Educational Foundations, College of Education Studies, University of Cape Coast, in partial fulfilment of the requirements for the award of Master of Philosophy Degree in Clinical Health Psychology

OCTOBER 2023

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DECLARATION

Candidate's Declaration

I hereby declare that this thesis is the result of my own original research and that no part of it has been presented for another degree in this university or elsewhere.

Candidate's signature………………………... Date……………………...

Name…………………………………………………………………………...

Supervisors' Declaration

We hereby declare that the preparation and presentation of the thesis were supervised in accordance with the guidelines on supervision of the thesis laid down by the University of Cape Coast.

Principal Supervisor's signature………………… Date……………………...

Name…………………………………………………………………………….

Co-supervisor's Signature……………………….. Date……………………..

Name…………………………………………………………………………….

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ABSTRACT

This research study explored the topic "Psychological Distress and Coping Strategies of Ghanaian Military Peacekeepers in Peace Support Operations." The study was guided by the biopsychosocial and the transactional stress models. It adopted a quantitative research design through surveys to investigate the experiences of Ghanaian military peacekeepers during peace support operations. Three hundred and seven (307) participants from the Ghana Armed Forces aged 23-57 who were serving in Peace Support Operations (PSOs) were chosen for the study using purposive sampling. The primary objectives were to measure the levels of psychological distress as well as the coping strategies of these Ghanaian peacekeepers. The study also investigated the difference between age groups in the coping strategies and also investigated the relationship between psychological distress and their coping strategies. Questionnaires that included standardised measures such as DASS 21, Brief Symptom Inventory and the Brief Cope were used in collecting data. To test the various hypotheses, one-way MANOVA, Multiple Regression analysis, Pearson product moment correlation and Spearman rank correlation tests were utilised. Most military peacekeepers displayed significant levels of psychological distress. The study also uncovered that maladaptive coping strategies were prevalent among these soldiers. Another finding from the study was the positive correlation between psychological distress and maladaptive coping mechanisms among the soldiers. It is advised that military high command give peacekeepers access to cognitive health assistance throughout the time of PSOs. Additionally, it is very essential to promote the integration of training in adaptive cooping systems. Finally, the military must promote peer support initiatives among peacekeepers as a culture.

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DEDICATION

This project is in honour of my late mum, Mrs Hanna Owusu Animah, with heartfelt gratitude for the immeasurable sacrifices she made to nurture my life and education. Her memory will forever be the driving force behind my pursuit of knowledge and the embodiment of the strength and resilience I aspire to demonstrate in all that I do.

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LIST OF ABBREVIATIONS

AMISOM.	-	African Union Mission for Support to the Transition in Gambia
AU	-	African Union
BSI	-	Brief Symptom Inventory
DAPKOP	-	Directorate of Army Peacekeeping Operations
DASS	-	Depression, Anxiety and Stress Scale
DDA	-	Disarmament, Demobilization, Reintegration
ECOMIB.	-	Economic Community of West African States Mission in Guinea Bissau
ECOWAS	-	Economic Community of West African States
GAD	-	General Anxiety Disorders
GAF.	-	Ghana Armed Forces
GHQ (DI)	-	General Headquarters (Defence Intelligence)
GHQ (PA)	-	General Headquarters (Personnel Administration)
GMP	-	Ghana Military Police
IRB	-	Institutional Review Board
MDD.	-	Major Depressive Disorder
MINUSMA	-	United Nations multidimensional Integrated Stabilization Mission in Mali
NATO	-	North Atlantic Treaty Organization
NGOs	-	Non-Governmental Organizations
OCD	-	Obsessive Compulsion Disorder
PSO	-	Peace Support Operations
PTSD.	-	Post-Traumatic Stress Disorder

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SSD	-	Somatic Symptom Disorder
UN	-	United Nations
UNIFIL	-	United Nations Interim Force In Lebanon
UNIFSA	-	United Nations Interim Security in Abyei
UNMISS	-	United Nations Mission in South Sudan
UNOC	-	United Nations Operations in Congo
UNTSO	-	United Nations Truce Supervision Organization
WHO	-	World Health Organization

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CHAPTER ONE

INTRODUCTION

Psychological distress is a common issue among military peacekeepers who are often exposed to stressful and traumatic events during Peace Support Operations (Sareen et al., 2007). Military Peacekeepers in Ghana are no exception and are also susceptible to psychological distress. Kessler et al. (2009) professed that psychological distress alludes to a condition of mental anguish that results from adverse events or circumstances. In the case of military peacekeepers, psychological distress can arise from exposure to combat and violence, separation from loved ones, hostilities, and subside to the challenges of adapting to a new environment (Thoits, 2010).

Coping strategies are behaviours and actions that people engage in to regulate the stress as well as psychological distress they experience (Bhandarker & Rai, 2019). Coping strategies can be adaptive or maladaptive, depending on their effectiveness in reducing psychological distress. Effective coping strategies for Ghanaian military peacekeepers may include seeking support from colleagues, friends, and family, engaging in physical exercise and relaxation techniques, practising mindfulness, and meditation, and seeking professional counselling or therapy (Tindle, Hemi & Moustafa, 2022).

It is quite essential for military organizations and decision-makers to prioritize the emotional and mental well-being of military peacekeepers by providing access to resources and support for coping with psychological distress. This can include providing training and education on coping strategies, ensuring access to mental health services, and creating a supportive

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and inclusive work environment that prioritizes the well-being of military personnel.

In peace support operations, the psychological well-being of peacekeepers plays a pivotal role in ensuring mission effectiveness and individual resilience (Cheonga & Pieters, 2022). This study delves into the intricate interplay between psychological distress and coping strategies among Ghanaian military peacekeepers who are engaged in peace support operations. By examining the specific difficulties that these individuals come across and the strategies they employ to navigate the demands of their roles, this study clarifies the significance of understanding and addressing the psychological dimensions of peacekeeping. Through a comprehensive analysis, the research aims to uncover well-being and performance of Ghanaian peacekeepers on the global stage.

Background to the Study

According to Woodhouse and Ramsbotham (2005) peace support operations (PSOs) can be linked to the early 20th century, with their advancement and evolution influenced by various international events and conflicts. The early 20th century saw the beginning of contemporary peace support operations, particularly after World War I and the creation of the League of Nations. The League's main objective was to advance peace and security via agreements on collective security and diplomatic efforts. The United Nations (UN), founded in 1945 in the wake of World War II, played a crucial part in the growth of peace support operations. The organisation was given the power to apply force, if necessary, to sustain or re-establish global stability peace, and security by the UN Charter, which served as the

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organization's founding document. In order to monitor the cease-fire between Israel and its surrounding countries, the first UN peacekeeping deployment was sent in as the United Nations Truce Supervision Organisation (UNTSO) by 1948 (Myers & Dorn, 2022).

Regional bodies in Africa like the African Union (AU) began taking the lead in peace support operations after the UN (Boutellis & Williams, 2013). The AU's efforts included missions in Darfur, Somalia, Mali, among others. These missions addressed continent-specific challenges and conflicts. PSOs continue to evolve in response to changing global security dynamics. Conflicts involving them have occurred in Afghanistan, the Central African Republic, South Sudan, and elsewhere. The UN, as well as regional bodies like the AU, NATO and European Union remain key actors in Peace Support Operations (Boutellis & William, 2013; De Coning, 2019).

The number of Peace Support Operations (PSOs) is quickly rising, particularly throughout the continent of Africa. This can be attributed to the reason that national defence forces are sending a lot of personnel to nations that are experiencing conflicts. A peace support operation (PSO) is an organised international aid project that supports the sustenance, monitoring, and integration of peace in conjunction with the avoidance of ferocious conflicts returning (Demir & Varlik, 2012). The two kinds of peace support operations are peacekeeping and peace enforcement. Peacekeeping operations, which are frequently carried out in the framework of a peace treaty, monitor, and support the establishment of peace as opposed to peace enforcement, which are allowed to employ force and establish the circumstances for peace (Johnston, 2004). According to the UN Charter, the AU, and NATO, the

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majority of peace support operations are permitted by a resolution passed by the UN Security Council (Born & Urscheler, 2017). In general, Chapter VI of the UN charter authorises peacekeeping operations, whereas Chapter VII of the charter authorises peace enforcement activities. A resolution of the UN Security Council may give permission for a United governments peace support operation, a regional organisation, or a coalition of interested governments to carry out a peace support operation. The mission of peace support operations, which establishes the operation's primary duties, is determined by UN Security Council resolutions. If circumstances have altered in the areas impacted by war where the PSO is head-quartered, a mandate can be amended by the adoption of a new Security Council resolution (Johnston, 2004).

These missions can range widely in terms of their character, from more restrained peace enforcement operations that frequently entail using force to more muscular peacekeeping efforts. The experiences of the soldiers on these missions, the difficulties the operations provide, as well as the reasons for serving on the missions, have all been extensively written about. For instance, in regard to the latter, Battistelli (2020) discovered that the motivations for deploying on these missions are a combination of professional (material rewards), institutional (altruism), as well as self-fulfilment motivations like adventure or the desire to try something new (Wilén & Heinecken, 2017).

In order to promote peace processes and state-building in nations and areas that are emerging from hostilities, the United Nations sends thousands of peacekeepers. Since 1960, when it participated in the United Nations

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operation Congo (UNOC), Ghana, a nation that has never fought a war on its own soil, has regularly been a significant troop provider to the UN. As one a key contributor to international peace support operations, Ghana has a long-standing commitment to sending peacekeepers to regions experiencing conflict and humanitarian crises.

Countries to which Ghana in the past has contributed troops for UN Protection Force missions include Rwanda, Lebanon, Liberia, DR Congo, Cambodia, Sierra Leone, Cote D'Ivoire, etc. Today, Ghanaian soldiers are used in peacekeeping efforts across the world. According to the Directorate in charge of Army Peacekeeping Operations (DAPKOP), each year, a minimum of about Two thousand four Hundred and Eight (2408) Ghanaian soldiers are deployed as contributing troops to conflict affected countries like Lebanon, South Sudan, Mali, Guinea Bissau, Central Africa Republic, and Gambia to keep peace. Eight hundred and sixty-two (862) troops are organized to serve with the United Nations Interim Force in Lebanon (UNIFIL), Seven Hundred (700) troops are deployed with the United Nations Mission in South Sudan (UNMISS), five hundred and seventy (570) troops are deployed with United Nations Interim Security Force in the Abyei (UNISFA), One Hundred and Twenty-Five troops are deployed with United Nations Multidimensional Integrated Stabilization Mission in Mali (MINUSMA), One Hundred and One (101) troops are deployed with ECOWAS Mission in Guinea-Bissau (ECOMIB), and Fifty (50) troops are deployed with African Union Mission for support to the Transition in Gambia (AMISOM). Soldiers have a unique set of difficulties in these peace support operations, whether they are peace enforcement or peacekeeping missions (Litz, 1996). There are several

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problems that troops must deal with, even within the scope of peace support operations, which includes everything from domestic disaster assistance to humanitarian and peacekeeping missions. This mostly relies on the nature of the processes.

Soldiers in Ghana do not voluntarily serve on peacekeeping operations. As part of their active-duty service, they are deployed. Furthermore, unlike many Ghanaian friends, Ghanaian soldiers are not individually assessed for selection for peace support activities (Biswal, 1992).

Peace support operations which are sometimes interchanged for or referred to as “Deployment” could also mean a prolonged distance from a loved one and uncertainty about having a loved one in an unfamiliar territory or zone (Jett, 2000). The setting created by this circumstance makes it likely that deployed troops might experience serious emotional issues during deployment. Troops who face severe pressures at home and in the military, on the other hand, are at danger of acquiring negative mental health effects. According to MacLean, Glen, and Elder (2007), it is generally recognised that soldiers who are deployed run the risk of experiencing potentially traumatic incidents. Since the nature, severity, and frequency of such missions vary, so do the risks associated with them, this possibility is unpredictable (Mulligan, D’Errico, Stees & Hughes, 2012). For instance, Lanteigne (2019) opined those missions in South Sudan, Mali, and the Gambia as well as some African countries in general are high risked compared to missions in the Middle East. This is because there have been instances where peace support operations which were initially meant to be peacekeeping turned to peace enforcement in some African countries. Such rapidly chaning or escalations can within

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military deployments adversely have a repercussion on the mental well-being of deployed personnel (Buckman et al., 2011)

Psychological Distress

It refers to a broad spectrum of psychological and emotional manifestations that an individual is experiencing significant discomfort or suffering (Grossman, Niemann, Schmidt, & Walach, 2004). It is a state of emotional turmoil, unease, or mental strain that can impact an individual's overall wellness and functioning. Psychological anguish as it is sometimes referred to can arise from various sources, including personal life events, stressors, trauma, mental health disorders, and external factors such as work pressure, financial difficulties, or relationship problems. Common symptoms of psychological distress may include Depression, Anxiety, Stress, Sleep disturbances, Fatigue, Somatization, Hostility, and Psychoticism. In both clinical and research settings as well as in public health, psychological distress is a frequent indication of mental health and psychopathology (Drapeau et al., 2010).

It encompasses mood disorders, sadness, anger, and even physical conditions like headache or stomach-aches. It can either be acute or chronic, and its influence on a person's well-being can differ greatly (Ross, Mirowsky & Goldsteen, 1990). Factors contributing to psychological distress are multifaceted and can include personal experiences, genetic predispositions, environmental stressors, and social influences. Major life changes, like the passing of a beloved, instability at work, relationship problems, and financial difficulties, can trigger distress. Moreover, pre-existing mental health

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conditions, unresolved traumas, and lack of adequate distressing feelings can also trigger distress (Rey & Hazell, 2000).

Psychological distress can arise from a multitude of sources, both internal and external. Some common causes may include high levels of stress, whether related to work, relationship, or other life events, can contribute to psychological distress. Chronic stress can result in a rise in anxiety disorders as well as other emotional disorders. Going through a traumatic situation, such as physical or sexual abuse, a natural disaster, or combat, can trigger severe psychological distress (Javidi & Yadollahie, 2012). PTSD is a well-known consequence of trauma. Some individuals may be genetically predisposed to mental health conditions, making them more susceptible to psychological distress.

Neurochemical imbalances in the mind involving dopamine or serotonin, can as well play a role. That notwithstanding, living in a hostile or unstable environment, exposure to toxins, or having limited access to resources can contribute largely to psychological distress. The death of a loved one or significant life changes, such as divorce or job loss, can trigger intense grief and sadness, potentially leading to psychological distress. Lastly, loneliness and the absence of social support are significant factors in psychological distress. Humans are inherently social creatures and isolation especially from dear ones can result in symptoms of anxiety and extreme sadness.

Consequences of psychological distress are wide-ranging and can impact various features of an individual's life. For instance, it often leads to the development of diagnosable diseases of the mind, such as panic disorder,

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severe depressive illness, or generalised anxiety disorder. There is a well-established connection involving psychological distress and physical well-being. Chronic stress, for example, can contribute to heart failure, high blood pressure, and compromised immune function. Suffering from psychological distress can strain personal relationships as well. Individuals may become withdrawn, irritable, or socially isolated, affecting their connections with family and friends. Psychological distress can hinder one's ability to perform at work or in academic settings. Decreased concentration, motivation, and absenteeism are common consequences. Individuals experiencing psychological distress often struggle with self-esteem issues. Negative self-perception and self-criticism can exacerbate their emotional struggles (Puckett, Levitt, Horne, & Hayes-Skelton, 2015).

Fortunately, there are numerous coping strategies and interventions available to help individuals manage psychological distress. Some of which include psychotherapy, counselling, medication, social support, self-care, stress reduction techniques, etc. Psychological distress is a pervasive issue that affects millions of people worldwide including military personnel in Peace Support Operations. Its causes can be complex and multifaceted, and its effects can have far-reaching consequences on a person's well-being. However, with the right support, coping strategies, and professional help, it is possible to manage and overcome psychological distress (Chan, Khong & Wang, 2017).

Depression

Major Depressive Disorder (MDD), a significant disorder of the mind, which is defined by persistent signs of melancholy, despair, as well as

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disinterest in or enjoyment from doings that were once enjoyable (Uher et al., 2014). It goes beyond the usual feelings of sadness that everyone experiences from time to time It affects a person's mental thoughts, feelings, and behaviours and can negatively impact how well they operate on a regular basis. Persistent sadness, loss of interest or pleasure, exhaustion and lack of energy, changes in appetite and weight, sleep disturbances, feelings of guilt or worthlessness, trouble concentrating, psycho-motor agitation or retardation, and thoughts of death or suicidal ideation are some of the key symptoms of depression.

Studies on peace support operations and depressions have examined the mental health challenges faced by military personnel and persons involved in peacekeeping. Some key findings include high prevalence of depression. Studies have consistently shown higher rates of depression among military personnel and peacekeepers compared to the general population. Sareen et al. (2007) and Hoge et al. (2007)) divulged that the manifestation to stressful and traumatic events, prolonged deployments, and the challenges of operating in conflict zones can contribute to increased vulnerability to depression. Again, peace support operations often involve exposure to violence, death, and other traumatic incidents that might result in depression and other mental and emotional issues. Witnessing or experiencing these situations can have a significant influence on a person's mental well-being.

Longer deployments have been associated with a higher risk of cognitive health concerns, including depression (Eibner, Ringel, Kilmer, Pacula, & Diaz, 2008). Extended periods away from home and loved ones, coupled with the stress of the mission, can take a toll on the psychological

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health of a person. Personnel may be hesitant to seek assistance for depression owing to perceived stigma or concerns about the potential impact on their career. This can lead to under reporting and delayed treatment, exacerbating the mental health challenges (Clement et al., 2015).

Anxiety

Humans naturally and typically experience anxiety in reaction to stress or impending danger. The strength of the emotion can range from light to strong, and it is one of discomfort, apprehension, or concern (Puglisi & Ackerman, 2019). Even though occasional anxiety is a natural part of life and in some situations can even be helpful by improving awareness and getting the body ready for action, excessive or persistent concern can become dangerous. Anxiety becomes a disorder when it interferes with daily life, causing distress and affecting a person's capacity to carry out everyday activities. There are several types of anxiety disorders, each with distinct characteristics. They include Post-Traumatic Stress Disorder (PTSD), obsessive-compulsive disorder (OCD), generalised anxiety disorder (GAD), panic disorder, social anxiety disorder, specific phobias, and others. Genetic factors, brain chemical imbalances, traumatic events, and environmental stresses are just a few of the reasons of anxiety disorders (Fedoce et al., 2018).

Relatively, more projects have been carried out to investigate the link between peacekeeping and Anxiety. Anxiety is a common response that can be experienced by peacekeepers during deployments in peace support operations (PSOs). Peacekeeping missions are often challenging and demanding, exposing peacekeepers to various stressors that can trigger anxiety. One such factors include the High-risk environments. Peacekeepers

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often work in areas with ongoing or recent conflicts, where the potential for violence and danger is prevalent (Beardsley & Gleditsch, 2015). This constant threat in personal safety can lead to heightened anxiety.

Uncertainty and ambiguity are other factors that can lead to anxiety among peacekeepers. Peacekeeping missions can be unpredictable and involve in dealing with complex and fluid situations. The lack of clear outcomes or defined roles can easily lead to anxiety among troops. Peacekeepers may witness and experience traumatic events, such as violence, human suffering, and loss of lives, which can have a profound emotional impact and contribute to anxiety.

Again, isolation and separation or being away from family, friends, and familiar support systems for extended periods can lead to feelings of isolation and homesickness, amplifying anxiety levels. Peacekeeping missions may face resource constraints and lack of adequate support, making it challenging for personnel to cope with the demand of their duties, leading to increased stress and anxiety (Bellamy, William, & Griffin, 2010).

Lack of information and intelligence or inadequate information about the local situation and potential threats can increase anxiety as peacekeepers face uncertainties in their decision-making (Smith, 2013). Also, dealing with hostile parties involved in the conflict areas can result in a highly demanding and anxiety-inducing for peacekeepers. Recognizing and addressing these factors is crucial for supporting the mental well-being of peacekeepers and improving the effectiveness of their missions. Adequate training, access to mental health support, debriefing sessions and ongoing care are very essential components of mitigating anxiety during Peace Support Operations.

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Stress

Stress is an intricate and natural response that our bodies and minds engage in when faced with challenges, pressures, or changes (McEwen, 2012). It can arise from a variety of sources, such as work demands, personal responsibilities, or unexpected life events. While some levels of stress can be motivating and even beneficial, excessive, or chronic stress may be harmful to our health, both physically and mentally. According to physiological principles, stress causes the body to produce chemicals like cortisol and adrenaline to be ready for a "fight or flight" reaction (Tort & Teles, 2011). This response can be crucial in situations where immediate action is required, but when stress becomes chronic, these hormonal fluctuations can heavily have an effect on the body. This can lead to a range of bodily manifestations, including headaches, muscle tension, digestive issues and even a weakened immune system. Over time, chronic stress has been linked to serious health conditions like cardiovascular diseases, hypertension, and even mental health disorders.

On the mental and emotional front, stress can manifest as psychological distress, affecting our mood, cognitive function, and overall mental well-being. People experiencing high levels of stress often report feelings of anxiety, irritability, or sadness. Concentration and decision-making might become more difficult, leading to a sense of being overwhelmed or unable to manage tasks effectively (Starcke & Brand, 2012). The onset or worsening cognitive well-being such as anxiety disorders and extreme sadness can be attributed to chronic stress.

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Different individuals may respond to stress in varied ways, and the effectiveness of coping strategies can also vary. What is effective for one individual may not be as effective for another. Moreover, cultural, social, and personal factors can influence how we perceive and manage stress. Recognizing the signs of stress and developing a repertoire of healthy coping strategies is essential in maintaining overall well-being. Seeking professional help in a world filled with constant demands and changes, understanding stress, its impact, and how to effectively cope with it is crucial for leading a balanced and resilient life. Stress is a type of psychological pain (Simandan, 2010) and may be caused by real (physical elements within an individual's environment) or perceived factors. Physical and psychological stress has been implicated in peace support operations. Stress is a significant concern for peacekeeping personnel, given the challenging and high-pressure environments they operate in.

Peacekeeping is a demanding and complex endeavour that often involves working in high-stress environments. Peacekeepers are tasked with maintaining stability and security in regions affected by conflicts, violence, and unrest. The type of job they do can expose them to diverse stressors, both physical and psychological. They include heart-wrenching experiences, isolation, high-risk environments, cultural and language barriers, long work hours and uncertainty.

Somatization

According to De Gucht and Fischler (2002), somatization is a psychological phenomenon where emotional distress or psychological issues manifest as physical symptoms without a clear medical explanation. It refers

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to the process of expressing psychological distress or emotional turmoil through physical symptoms. Individuals that are dealing with high risks of stress, anxiety, and similar emotional difficulties may manifest their distress in the form of physical complaint. These complaints often lack a clear medical explanation and may not correspond to a specific physical illness or condition. Common examples of somatization include headaches, stomach-aches, fatigue, muscle pain, and various other bodily discomforts. These physical symptoms can be very genuine to the one who is experiencing them, even if they cannot be fully explained by medical tests or examination (Leder, 1990).

Somatization is often associated with somatic symptom disorder (SSD), a psychological disorder characterized by excessive and persistent distress about physical symptoms and concerns that significantly impact daily functioning. People with SSD might experience a heightened focus on their physical sensations, frequent doctor visits, and extensive medical tests, often with little relief from their symptoms. Somatization and somatic symptoms disorder do not imply that the symptoms are not valid or that the person is "faking" the physical discomfort. Rather. It emphasises how intricately linked the mind and body are, where emotional distress can manifest as physical symptoms (Martin & Rief, 2011).

In the context of peacekeeping, somatization can be a concern for peacekeeping personnel who experience significant amounts of stress, and trauma during their missions. Peacekeeping missions can be emotionally challenging and may involve exposure to violence, human suffering, and traumatic events. The stressors experienced in such environments can lead to psychological distress, which, in some cases, may be expressed as physical

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symptoms. Some examples of somatization in the context of peacekeeping could include unexplained headaches, digestive issues, body aches, and fatigue that cannot be attributed to any underlying medical condition but are a result of the psychological strain experienced during the mission.

Addressing Somatization in peacekeeping involves recognizing the link between emotional stress and physical symptoms. It's essential for peacekeeping organisations to provide pre-deployment training that includes education on stress management, resilience-building, and mental awareness (Doode et al., 2021). Offering access to mental health professionals and support services during and after missions can be beneficial for identifying and addressing somatization in peacekeeping personnel. Promoting an open and supportive environment where personnel feel comfortable discussing their emotional well-being can further contribute to early detection and management of somatization issues. By putting first, the well-being and mental health of peacekeepers, organizations can better support their mission effectiveness and the overall welfare of those involved in peacekeeping operations (Bove, Salvatore & Elia, 2022).

Coping strategies

The link between coping mechanisms and peacekeeping is closely intertwined, as coping strategies are essential for peacekeepers to effectively manage the challenges and demands of their peacekeeping missions. Coping strategies empower peacekeepers to better navigate the complex and sometimes hostile environments in which they operate (Neethling, 2011). When peacekeepers are equipped with effective coping mechanisms, they can concentrate on their mission objectives, such as conflict resolution,

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humanitarian assistance, and community engagement, more efficiently. Peacekeeping missions often involve the exposure to stressful and traumatic situations, including violence, conflict, and human suffering. Coping strategies help peacekeepers manage and mitigate the psychological and emotional stress associated with their work. This, in turn, enables them to remain focused and make rational decisions under pressure. In short, coping strategies are the tools and approaches that peacekeepers use to address the physical, emotional, and situational challenges they encounter during their missions. These strategies not only safeguard the well-being of peacekeepers but also enhance their ability to fulfil the mission's objectives, which ultimately aim to bring about peace and stability in conflict-affected areas.

Coping is the conscious effort implemented to reduce stress (Lazarus & Folkman, 1984). Coping is part of health and well-being that includes healthy environments, healthy activities, resilience, and the treatment of illness (Stallman, 2017). Coping mechanisms are methods or practises people employ to deal with and manage stress, painful feelings, or difficult circumstances in their life. They are essential tools that individuals use to manage and navigate the challenges, stressors, and adversities they encounter in life. They help individuals adapt to difficult situations, regulate their emotions, and maintain their overall well-being. Coping mechanisms can vary widely, and their effectiveness often relies on the specific situation and the individual's personal preferences and resources.

These strategies can either be positive and negative. Positive coping strategies involve healthy and constructive approaches, such as seeking support from friends or family, engaging in physical activities, practising

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mindfulness, or problem-solving. On the other hand, the negative side of coping strategies, are often unhealthy and can lead to further problems, such as avoidance, substance abuse, or self-harm. It is however essential to develop and use efficient coping mechanisms to keep one's emotional wellbeing and resilience. Coping strategies are not one-size-fits all. What functions for one individual may not function for another. Developing a toolkit of diverse coping mechanisms is beneficial, as different strategies might be more effective in different situations. Health coping mechanisms are those that promote well-being in the long term, while unhealthy coping mechanisms (such as substance abuse or avoidance) might provide temporary relief but can have negative consequences. Ultimately, the ability to choose and utilise appropriate coping strategies is a valuable skill that contributes to mental and emotional toughness, enabling people to overcome obstacles in life more easily and adaptably.

Coping strategies employed by Peacekeepers during PSO will determine their quality of life during the operation and even after deployment.

Statement of the Problem

The global increase in peace support operations as well as its significant association with poor mental health (psychological distress) requires further research. Research indicates that the number of soldiers who experience psychological distress vary depending on the specific operational mission, the duration of deployment and the overall conditions. However, a significant number of soldiers may feel psychologically distressed, including experiencing indicators of stress, anxiety, depression, and other mental health challenges.

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Brouneus (2014) emphasised that peace support operations have been associated with poorer mental health among military personnel, behavioural problems among soldiers due to stress, hostilities in military/civil relationship and higher rates of suicide. Not surprisingly, military personnel and some relations perceive peace support operations as "one of if not the most stressful facet of life in the military" and the situation worsens if the operation is extended due to unforeseen circumstances such as pandemics, natural disasters, unpredictable attacks, or alteration of operational plans (Omand, 2014).

Peace support operations which are designed to bring financial relief and support to the vulnerable and offer incentives as well as allowances for troops come with their own problems, it could be a "blessing or a curse" (Rujala & Rustard, 2012). For instance, while some soldiers have returned with criminal-service charges, others have lost their ranks and forfeited promotions due to some offences committed during the operation. Furthermore, some soldiers have been repatriated back home and eventually dismissed from the Ghana Armed Forces for committing service offences during the operations. Although the root cause of these predicament is not readily known, it has been attributed to psychological distress experienced by troops (Dohrenwend, 2000). While some soldiers have also returned with poor health conditions, others have also had problems back at home with their families which have affected their effectiveness and their well-being after the operation. According to a study of US Navy personnel, worries about wives and kids increased markedly both during and after deployments compared to when they were first expressed (Lester et al., 2005). In a comparative study

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conducted by Kwame et al. (2018) to assess the psychological distress among Ghanaian peacekeepers and their international counterparts, the findings revealed Ghanaian peacekeepers reported similar levels of psychological distress as the international troops.

There has been much study about the outcome of trauma associated with peacekeeping duty on mental health. In contrast, the peacekeeper's experiences of psychological distress, such as life threats and danger as well as life after deployment and deleterious psychological effects specifically in the Ghanaian context have been under-researched (Chu, et al., 2016). Among the many worries that arise during deployments, military members may worry that some parts of their service may have a detrimental influence on themselves, their families, or both. Most studies on military issues tend to focus on peace enforcement (warfare), mental health of personnel and operational events while research examining the distress involved in peacekeeping especially and the general well-being of military personnel and their relations as well as their coping strategies are less frequently researched (Rowe, et al., 2014).

This study inquired about the respective levels of depression, anxiety, stress, and somatization among Ghanaian military peacekeepers during peace support operations, adding to the existing corpus of information. This research also looked at the Coping Strategies employed by Ghanaian Peacekeepers, the connection between mutual anguish (psychological distress) and coping mechanisms among these Peacekeepers, and the relationship between demographic characteristics (gender, age, and marital status) and psychological distress of Ghanaian Peacekeepers.

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Purpose of the Study

Explicitly, the study's fundamental goals were to gauge the psychological distress and coping strategies among Ghanaian military peacekeepers in peace support operations. Specifically, it sought to:

1. Measure the levels of psychological distress among Ghanaian military peacekeepers in peace support operations.
2. Investigate the coping strategies of Ghanaian military peacekeepers in peace support operations.
3. Investigate the difference between age groups on coping strategies of Ghanaian military peacekeepers in peace support operations.
4. Investigate the relationship between psychological distress and coping strategies among Ghanaian Military Peacekeepers in Peace Support Operations.
5. Discover if sociodemographic factors (marital status, gender, and age) will predict psychological distress among Ghanaian Military Peacekeepers in Peace support Operations.

Research Questions

The following questions were the focus of the current investigation:

1. What is the level of psychological distress of Ghanaian Military peacekeepers in peace support operations?
2. What is the nature of coping strategies for Ghanaian Military peacekeepers in peace support operations?

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Hypotheses

The corresponding alternate hypotheses in this study are:

H_1: There will be a statistically significant difference between age groups on coping strategies of Ghanaian Military Peacekeepers in peace support operations.

H_2: Sociodemographic variables (age, marital status and gender) will significantly predict psychological distress among Ghanaian Military peacekeepers in peace support operations.

H3: There will be a statically significant relationship between psychological distress and coping strategies among Ghanaian military peacekeepers in peace support operations.

Significance of the Study

Studying psychological distress and coping strategies among military peacekeepers in Ghana is important for several reasons. As earlier asserted, military peacekeepers are exposed to high-stress environments, often operating in unfamiliar terrains, which can have significant psychological effects. Understanding how these individuals cope with the stress and trauma they experience can help develop effective interventions to reduce the negative outcomes of their experiences. The mental state of peacekeepers is essential not only for their personal health and job performance but also for the overall effectiveness of peace support operations.

The outcome of this study will also contribute the broader understanding of the psychological well-being of Ghanaian soldiers in general. Rafferty et al. (2018) averred that military personnel to a greater extent than the overall citizenry is probable to experience mental health issues

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due to the nature of their work. Thus, this study could provide insights into coping mechanisms that are specific to military peacekeepers, which could be useful in coming out with interventions to support the mental health of military personnel more broadly.

Additionally, this study will have practical implications for the military organization in Ghana. By identifying good mechanisms that are efficient in lessening psychological distress among military peacekeepers, the organization could implement interventions to support the well-being of their personnel. This, in turn, could lead to improved retention rates, job satisfaction and performance.

Again, it will inform clinicians and other health workers on the psycho-social well-being of military personnel. This information will in turn go great lengths to proffer gathered knowledge on how to support military personnel to manage their well-being after peace support operations.

It will contribute to the field of study in the subject of military psychology and provide important information for next scholarly investigations. It will again, provide as a starting point for more investigation, enabling a fuller comprehension of the psychological difficulties military peacekeepers encounter and the efficiency of different coping mechanisms.

Apart from this inquiry contributing to the field of study or literature on the mental well-being of soldiers, it will also serve as a guide for other security services such as the Police and Prisons Service who also embark on peace support operations.

Additionally, insights from this study can be valuable not only for Ghana but also for other countries participating in international peacekeeping

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missions. Understanding common patterns of psychological distress and effective coping mechanisms can foster international collaboration in developing standardized support protocols for peacekeepers worldwide.

Overall, the study is significant as it will help improve the mental health and general well-being of military personnel and have a practical implication for the military organization in Ghana.

Delimitation

This study is delimited to military personnel who are serving in the various peacekeeping Area of Operations such as Lebanon, South Sudan, Gambia, Mali, Guinea Bissau, and Central African Republic and those who have returned from peacekeeping in the last week and are in active service. The levels of psychological distress and coping mechanisms measured to know how peace support operations influenced the psycho-social well-being of troops and how they coped with the situation.

Limitations

The exploration hinged on quantitative methodology of gathering data and thus lacked detailed experimental information from participants. A qualitative methodology would have explained in detail the livid experience these peacekeepers encounter during peace support operations.

Operational Definition of Terms

Psychological Distress: It is a broad term that encompasses various negative emotional states and experiences that impact a person’s well-being and functioning.

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Coping Strategies/mechanisms: they are techniques, and the methods people employ to manage, reduce, or tolerate the challenges and stressors they encounter.

Peace Support Operations (PSOs): also known as peacekeeping operations or external deployment, are military, civilian or Police missions conducted by international organizations, to help maintain peace, security, and stability in conflict-affected regions.

Gender: It differs from biological sex, which is based on a person's physical and genetic traits. It talks about the social, cultural, and psychological characteristics and roles that come with being male or female. In this study, the terms sex and gender were used synonymously.

Organization of the Study

This study is comprising of five chapters, the first of which provides an overview of the study's history, the statement of the problem, and the significance of the study methodologies. In Chapter two, the relevant literature for this investigation is reviewed. This includes both the theoretical and empirical reviews of concepts, theories and research about psychological distress and coping strategies.

Chapter three looks at the study's approach. It details the population, sample size, sampling techniques, and methods for gathering and analysing data. The data analysis, results, and discussions of the study are recorded in the penultimate chapter and the summary, conclusions, recommendation, as well as suggestions for further studies are talked about in the last chapter.

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CHAPTER TWO

LITERATURE REVIEW

This segment of the research looks at related literature and empirical work on concepts of peace support operations, psychological distress, and coping strategies. It also presents the theoretical and conceptual framework under-girding this study.

Theoretical Framework

Biopsychosocial theory

The biopsychosocial theory is an interdisciplinary concept that contends that social, psychological, and biological variables all have a big impact on people's health and happiness (Blascovich & Tomaka 1996). The old biomedical approach, which only focused on biological elements in understanding and treating sickness, was challenged by George Engel in the 1970s, and this theory was born as a result. According to this model, human health and illness are because of intricate interactions between factors that are biological, psychological, and social. These factors are seen as interconnected and influencing each other rather than operating in isolation. Here is a breakdown of the three components:

1. Biological Factors: These include genetic predispositions, physiological processes, and the functioning of bodily systems. Biological variables can influence a person's susceptibility to certain diseases or conditions and may influence their responses to treatment (Henderson & Baum, 2004). Biological factors can significantly relate to psychological distress. For example, the brain's chemical balance is very essential in controlling mood and emotions. Imbalances in

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neurotransmitters like serotonin, dopamine, norepinephrine can lead to conditions such as depression, anxiety, or bipolar disorder. Also, a person's genetic make-up can predispose them to certain mental health conditions. If there is a history of mental illness in the family, there may be a genetic component involved. Again, hormonal fluctuations, especially in men can contribute to psychological distress. Chronic illnesses, pain or physical disabilities can also cause psychological distress. The burden of managing a long-term health condition can lead to anxiety or depression. Certain medications can have psychological side effects, contributing to distress. Conversely, psychiatric medications are used to manage symptoms of psychological distress by targeting biological factors. (Gureje, Olley, Olusola & Kola, 2006)

2. Psychological Factors: These encompass a person's thoughts, emotions, beliefs, attitudes, and behaviours. Psychological factors can affect health outcomes by influencing coping mechanisms, stress levels, and adherence to medical advice (Wiese-Bjornstal, 2010). For example, psychological stress may exacerbate certain medical conditions. High levels of stress, whether from work, relationships, or life events, can trigger psychological distress. Prolonged exposure stressors can lead to conditions like anxiety and depression. Negative thought patterns, such as constant self-criticism, catastrophizing, or rumination, can contribute to psychological distress. These cognitive distortions can intensify feelings of sadness, worry of fear. Also, past harrowing incidents, like accidents, or combat fatigue may result in

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PTSD or other forms of psychological distress. Again, specific character features, such as perfectionism, neuroticism, or excessive self-criticism, can make individuals more vulnerable to psychological distress. Relationship problems, including conflicts, breakups, or social isolation, can be origins of emotional anguish (psychological distress). Healthy relationships as well as social support, on the other hand, can protect against psychological distress.

3. Social Factors: These include a person's family, community, financial level, culture, and availability of resources (Ungar, 2011). They also include the environment in which they reside. Social factors can impact health through various mechanisms, such as social support networks, education, living conditions, and healthcare access. Social factors are closely intertwined with psychological distress. Loneliness and social isolation are significant risk factors for psychological distress. Feelings of despair and anxiety might result from a lack of social ties. Major life occurrences like divorce, loss of a beloved, or job loss are social factors that can trigger psychological distress. The availability of social support during these times can significantly influence how individuals cope. Also, societal, and cultural norms and expectations can influence how individuals perceive themselves and others. Conforming to unrealistic or unhealthy expectations can lead to distress, especially in cases like body image dissatisfaction,

The biopsychosocial model emphasizes the importance of considering all three dimensions when assessing and treating an individual’s health concerns (Suls & Rothman, 2004). It recognizes that biological factors alone

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are often insufficient to fully explain the complexity of health and illness. By considering psychological and social factors, healthcare professionals can create a more thorough grasp of an individual's condition and provide more holistic and personalized care. The biopsychosocial model has had a significant impact on various fields, including medicine, psychology, and social work. It has influenced the development of integrated healthcare approaches and has led to a greater recognition of the importance interdisciplinary collaboration in healthcare settings (Evans, Baker, Berta, & Jan, 2014).

Transactional model of stress and coping theory

A psychological scaffold that describes how people perceive and react to stressful events is called the Transactional Model of Stress and Coping Theory, created by Richard Lazarus and Susan Folkman (Goldberger & Breznitz, 2010). This approach proposes that stress is a pulsating relationship between a person and their surroundings and is not only influenced by external events. The model places a strong emphasis on the cognitive evaluation process and the coping strategies people use to manage stresses.

Transactional Model consists of two primary components:

1. Transactional Process: Stress is viewed as a transactional process that happens between an individual and their environment. It involves a constant flow of communication and engagement of information between the person and the external circumstances they encounter (Aldwin, 2009).

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2. Cognitive Appraisal: this involves the individual's evaluation and interpretation of a potentially demanding situation. Lazarus and Folkman defined two categories of cognitive appraisal/assessment.
   a. Primary Appraisal: This relates to the assessment of whether a circumstance is unimportant, constructive, or stressful. If the condition is deemed stressful, it can be further categorized as a injury/loss (damage already done), danger (possible future harm), or challenge (possible future growth or gain).
   b. Secondary Appraisal: After determining a situation as stressful, secondary appraisal involves the assessment of an individual's coping resources and options for dealing with the stressor. It includes evaluating personal strengths, available support systems, and strategies that can be employed to manage or alleviate the stress.
2. Coping Strategies: Coping strategies are the efforts employed by individuals to deal with the demands of an agonizing circumstance. Lazarus and Folkman pinpointed some categories of coping strategies.
   a. Problem-focused coping: This type of coping involves efforts to directly alter or manage the stressful situation itself. It aims to change the source of stress or reduce its impact. Examples include problem-solving, seeking information, and taking action to resolve the issue.
   b. Emotion-focused Coping: This type of coping focuses on managing the emotional distress associated with the stressor. It aims to regulate emotional responses and reduce the negative

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impact of stress. Examples include seeking social support, using relaxation techniques, or engaging in activities to distract oneself from the stressor.

c. Avoidance coping: Sometimes, individuals cope by avoiding or distancing themselves from the stressor, this can be either adaptive (taking a short break to recharge) or maladaptive (avoiding the issue entirely, which can lead to long-term problems).

d. Adaptive Coping: These strategies involve adjusting one's thoughts and behaviours in a healthy and constructive manner. They promote resilience and effective stress management. Examples include seeking support, positive reframing, and acceptance of the situation.

e. Maladaptive coping: These mechanisms typically yield poor results in the long run and may even exacerbate stress or create new problems. Examples include substance abuse, denial, and self-destructive behaviours.

f. Social Coping: Relying on social connections and relationships for support and comfort is a common coping strategy. This can involve talking to friends or family, seeking advice, or simply spending time with loved ones.

g. Spiritual Coping: Some individuals turn to their faith, beliefs, or spirituality as a source of strength and comfort during challenging times. This can involve prayer, meditations, or engaging in religious practices.

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h. Humour Coping: using humour to lighten the mood and find amusement in difficult situations can be a helpful coping mechanism. It can provide a temporary break from stress.

i. Self-Care Coping: Engaging in activities that promote physical and mental well-being, such as exercise, proper nutrition, and relaxation techniques, can help individuals manage stress and build resilience.

j. Cognitive Coping: These strategies involve changing one's thought patterns and beliefs to manage stress. Techniques like cognitive reframing, positive self-talk, and challenging negative thoughts fall into this category.

k. Creating Coping: expressing oneself through creative outlets like art, music, writing, or other hobbies can provide a therapeutic way to process emotions and stress.

i. Professional Support: One crucial coping mechanism for overcoming complicated or ongoing stressors is to seek help from mental health specialists like therapists or counsellors.

The coping strategies are not fixed; they can change based on the perceived effectiveness of the mechanisms employed and the feedback received from the environment. The transactional model of stress and coping strategies theory recognizes that stress is a subjective experience, and individuals vary in their appraisal of events and coping responses. It highlights the involving nature of stress and coping, emphasizing the importance of the individual's interpretation and evaluation of stressors in determining their emotional and behavioural outcomes (Carver et al., 1986).

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Conceptual Review

The concepts of peace support operations, the variables under psychological distress and coping were presented in the aspect of the literature review. These concepts laid the foundation for the entire work.

Concept of Peace Support Operations

Peace support operations (PSOs) refer to international efforts and activities aimed at maintaining or restoring peace and stability in conflict-affected or fragile regions (Ivančík & Jurčák, 2014). These operations are typically carried under the umbrella of global organisations like the United Nations (UN) and involve various military, civilian and police components working together to achieve specific peacekeeping and peace-making objectives. There are two kinds of peace support operations, namely peace enforcement and peacekeeping.

Key concepts of peace support operations include:

Conflict Resolution and Avoidance: PSOs aim to tackle the underlying cause of hostility and prevent the escalation of violence (Kazanský & Andrassy, 2019).. They often involve diplomatic efforts to facilitate negotiations and dialogue between conflicting parties.

Peacekeeping: In order to monitor ceasefires, separate opposing fighting factions, and assist establish a secure environment for peace discussions, military, police, and civilian personnel must be sent to a conflict zone in order to conduct peacekeeping operations.

Peace-making: peace-making activities focus on actively mediating between conflicting parties, facilitating negotiations, and helping to broker peace agreements.

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Peacebuilding: once a conflict has been resolved, peacebuilding efforts focus on supporting the rebuilding of institutions. Infrastructure, and governance structures to establish a lasting and stable peace.

Humanitarian Assistance: PSOs often provide humanitarian assistance such as food, medicine, and shelter, to support the needs of civilian populations affected by conflict.

Legalism: PSOs work in order to uphold the law, human rights, and governance in post-conflict environments by helping establish functioning legal systems and institutions.

Disarmament, Demobilization, and Reintegration (DDR): PSOs assist in disarming belligerents, demobilizing armed groups, and reintegrating former fighters into society.

Conflict Management: PSOs help manage and mitigate conflicts by facilitating communication, promoting dialogue, and creating spaces for reconciliation among different groups.

Multinational and multidimensional: PSOs involve contributions from multiple nations and various components, including military, civilian, and police personnel. They often address political, security, humanitarian, and developmental aspects of conflict resolution.

Local ownership: successful PSOs require engagement and participation from local communities and governments to ensure that efforts are tailored to the specific context and needs of the region.

Coordination: Effective coordination among different actors, such as international organizations, host governments, and non-government organizations (NGOs), is crucial for the success of PSOs.

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Ghana's involvement in peacekeeping dates to its early years as an independent nation, in 1960, just three years after gaining independence, Ghana deployed its first contingent of peacekeepers to the United Nations Operation in the Congo (ONUC). This marked the beginning of Ghana's significant contributions to international peacekeeping efforts.

Ghana has continuously sent soldiers, police officers, and other people to many UN peacekeeping operations throughout the years, including those in Lebanon, Sierra Leone, Liberia, the Ivory Coast, and others (Banini, Powel, & Yekple, 2020). They have been instrumental in keeping these turbulent areas safe, assisting with the disarmament of fighters, providing aid to the needy, and supporting the establishment of law and order. Ghanaian peacekeepers have won accolades for their professionalism, commitment, and efforts to uphold stability and peace in areas impacted by armed conflict (Salihu & Aning, 2023). Ghana's active involvement in peacekeeping missions demonstrates its commitment to the determination of maintaining world peace and security to support stability on a global scale.

Concept of Peacekeeping

Global peace, stability, and security are maintained in large part through peacekeeping, which is a part of peace support operations and an integral part of diplomacy and the settlement of international conflicts. International organisations like the United States (US), international entities like the Economic Community of West African States (ECOWAS), the African Union (AU), or coalitions of willing states deploy peacekeeping missions to address conflicts, promote peace in areas that are experiencing or recovering from conflict, and protect civilians (Ayenagbo et al., 2012)

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Historical evolution:

The roots of modern peacekeeper can be linked to the creation of the United Nations in 1945. the UN's primary goal was to prevent future global conflicts by promoting diplomacy, cooperation, and international law. The United Nations Truce Supervision Organisation (UNTSO), the first UN peacekeeping force, was established in 1948 to keep an eye on the armistice between Israel and its neighbours (Theobald, 2014).

The nature of peacekeeping has changed over the years from the conventional observer missions to more complex operations that involve a combination comprising elements from the military, police, and civilian sectors. These missions vary in scope and mandate, ranging from monitoring ceasefires and buffer zones to supporting civilians. Countries that participate in peacekeeping include United Kingdom, France, China, India, and the United States of America, as well as, Pakistan, Bangladesh, Canada, Nigeria, Ethiopia, Netherlands, Sweden, Norway, Rwanda, and Ghana. (Krishnasamy, 2001)

Core principles

1. *The Parties' Agreement:* peacekeeping missions are created with the agreement of the countries involved in the conflict, reflecting the necessity of cooperation from a successful resolution.
2. *Impartiality and neutrality:* peacekeepers are expected to remain impartial, treating all parties fairly and equitably to build trust and facilitate negotiations.

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3. *Only use force when necessary to defend oneself:* the primary role of picture is to prevent violence, but they are authorized to use force only in self-defence or when protecting civilians.
4. *Defence of Peacekeepers:* the safety and security of peacekeepers themselves is paramount; they should be equipped to defend themselves against attacks.

Roles and Activities

1. *Conflict Prevention and Early Warning*: peacekeepers monitor potential conflict areas, identify early warning signs, and intervene diplomacy to prevent hostilities.
2. *Conflict Resolution and mediation*: they engage in diplomatic negotiations, dialogue facilitation, and mediation attempts to bring to the bargaining table, conflicting states.
3. *Protection of Civilians*: One of the most critical aspects, peacekeepers work to protect civilians from violence, displacement, and human right abuses, often establishing safe zones.
4. *Reconstruction and Development:* peacekeeping missions contribute to rebuilding infrastructure, governance systems, and institutions.

Despite its successes, peacekeeping faces several challenges such as security risks. Peacekeepers operate in volatile environments, exposing them to security threats from armed groups and insurgents. The issue of limited resources is also a challenge in peacekeeping. Adequate funding, personnel, and equipment are often lacking, affecting the effectiveness of missions. Again, the issue of complex conflicts cannot be overlooked. Conflicts today

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often involve multiple parties, making it difficult to identify clear lines of engagement.

Peacekeeping remains an essential tool in preventing violence and fostering stability in a world marked by complex conflicts. It exemplifies the potential of global collaboration, diplomacy, and nonviolence to address the most pressing issues facing humanity. As conflicts continue to evolve, the adaptability, innovation, and commitment of peacekeepers will be crucial in shaping a more peaceful and secure world for all.

Concept of Psychological Distress

Within the subject of cognitive health, psychological distress is a wide and all-encompassing principle. It also refers to a state of emotional and psychological suffering or discomfort experienced by individuals due to various stressors, challenges, or mental health issues. This distress can manifest across a spectrum of cognitive function, cognitive, emotional, and physical symptoms, impacting a person's overall well-being and functioning (Bass et al., 2020). One key concept of psychological distress is emotional suffering which involves intense and dismal emotions such as anxiety, sadness, fear, anger, or hopelessness. These emotions may be overwhelming and persistent. Individuals experiencing psychological distress may have difficulty concentrating, making decisions, or thinking clearly. Racing thoughts, ruminations, and irrational beliefs can also be part of cognitive distress.

Psychological distress can have physical symptoms, including headaches, muscle tension, fatigue, sleep disturbances, and gastrointestinal problems (Shiha & Aziz, 2021). These physical symptoms can be a result of

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the body's reaction to stressful events. The severity and duration of psychological distress can vary widely. Some individuals may experience short-term distress in response to a specific stressor, while others may endure chronic and persistent distress related to ongoing life challenges or mental health conditions. Various factors can contribute to psychological distress, including happenings in life (e.g., losing a loved one, job loss), traumatic experiences, chronic stress, mental health disorders (e.g., anxiety disorders, depression), and personal circumstances.

The concept of psychological distress in peacekeeping is no exception as it also encompasses a variety of emotional and psychological reactions, including depression, anxiety, stress and somatization, and other mental health issues. These reactions can arise from direct contact to violence, death of a colleague, the inability to intervene in certain situations, and the overall demanding nature of peacekeeping duties (Friedman, Warfe & Mwiti, 2203).

Peacekeepers are often far from their home countries and support systems, which can exacerbate feelings of isolations and stress. Inadequate access to mental health services and stigma surrounding seeking help may also contribute to psychological distress. Recognising and addressing psychological distress in peacekeeping is crucial to ensure the well-being of peacekeepers and their ability to effectively carry out their missions. Providing training, access to mental health resources, and proper debriefing after missions are some of the measures that can help mitigate psychological distress and support the mental health of peacekeepers (Di Razza, 2022).

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Concept of Coping Strategies

According to Endler and Parker (1990), coping is typically thought of as a way to deal with a stressful or bad event. Numerous categories have been established for coping mechanisms. These include maladaptive coping, which is avoidance-based coping (Folkman & Lazarus, 1980; Roth & Cohen, 1986), issue-focused coping, emotion-focused coping, and coping focused on the problem (problem-focused coping).

The five categories of active coping, planning, suppression of competing activities, restrained coping, and seeking social support are listed by Carver, Scheier, and Weintraub (1989) as issue centred coping strategies. In order to combat the stressor or lessen its consequences, active coping includes taking the necessary action. Consideration of the best way to manage the stressor is part of planning. Suppression of competing activities may be described as an effort to avoid being distracted by other occurrences. Waiting for the right moment to take action is what restraint coping entails, and asking for guidance, information, and support from others when you need emotional support is what restraint coping does.

In addition, positive reinterpretation, acceptance, denial, seeking out emotional support, and resorting to religious activities are all examples of emotion-focused coping strategies (Carver et al., 1989). The goal of positive reinterpretation is to control the distressing emotion. The capacity to acknowledge the truth of a difficult circumstance might be characterised as acceptance. While seeking emotional support refers to the act of looking for compassion, understanding, and moral support, denial is the adamant

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unwillingness to accept that a stressor exists. When under stress, people have a propensity to resort to their religion (Carver et al., 1989).

Disengagement from behaviour and thought, and attention on and expression of feelings are the three elements of maladaptive or less effective coping activities (Carver et al., 1989). The inclination to concentrate on and vent about the emotions that are upsetting one is represented by the first dimension, which is concentrating on and venting of emotions. While mental disengagement is a technique to divert oneself from thinking about the stressor, behavioural disengagement is characterised as diminishing one's attempt to deal with the stressor.

Coping strategies in peacekeeping involve techniques for managing stress, which can arise from exposure to conflict, trauma, isolation, and other challenging circumstances (Raju, 2014). These strategies may include implemented measures by higher command to help mitigate the somatic and emotional effects of stress. Building strong support networks among colleagues is crucial in peacekeeping missions. Peacekeepers often rely on their fellow team members for emotional support, sharing experiences, and providing a sense of camaraderie. Peer support can be vital coping strategy for managing stress and boosting morale. Adequate pre-deployment training equips peacekeepers with having the abilities and information needed to cope along the unique adversities of their missions. Training may include conflict resolution, cultural sensitivity, and self-defence skills, all of which contribute to better coping (Sharma & Sharma, 2012).

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Peacekeepers must be adaptable and flexible in rapidly changing environments. Coping strategies may involve the ability to quickly adjust to new situations, remain calm under pressure, and make sound decisions despite uncertainty. Prioritizing self-care is critical for peacekeepers. This includes getting adequate rest, maintain a healthy diet, and engaging in physical activity when possible. Proper self-care contributes to physical and mental resilience.

Coping strategies in peacekeeping are essential not only for the well-being of an individual involved but also for the overall success of peacekeeping missions. Effective coping techniques help peacekeepers manage psychological distress, maintain resilience, and carry out their duties effectively and often hostile environments. Training, support networks, and access to mental health resources all play crucial roles in fostering these coping strategies within the peacekeeping community (Saul & Simon, 2016).

Conceptual Framework

The conceptual framework demonstrates how psychological distress (Depression, Anxiety, Somatization as well as stress) matches unto the coping strategies of Military Personnel, and vice versa with demographics (age, gender, and marital status) predicting psychological distress. The conceptual framework provides a structured way to understand and analyse the relationships between various elements and concepts relevant to the study (Grant & Osanloo, 2014).

The central independent variable is psychological distress which is believed to have a significant impact on coping strategies among Ghanaian military peacekeepers in PSOs. The dependent variable, coping strategies is

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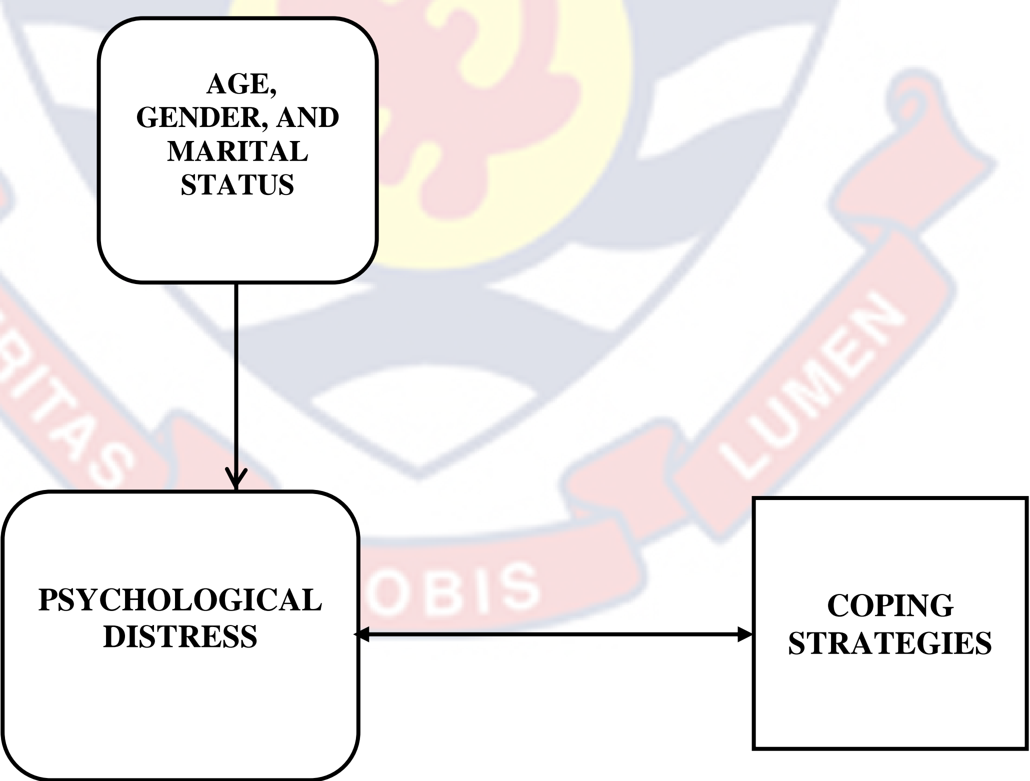
the outcome or effect being explained or predicted. Owing to the conceptual framework, it is possible to hypothesize that psychological discomfort may influence the coping mechanisms of Ghanaian military peacekeepers engaged in peace support operations. Prior investigations found support for the conceptual framework in the research. Nakkas, Annen and Brand (2016) looked at the applicants for military cadre's coping mechanisms and psychological suffering.

In summary, the conceptual framework provides a structured approach to understanding the connection amid psychological distress and coping strategies of Ghanaian military peacekeepers in PSOs and is grounded in established theories and prior research. This framework guides the research design, data collection and analysis, ultimately contributing to a deeper knowledge about the phenomenon being studied.



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Empirical Review

Psychological distress among soldiers

The ramification of peacekeeping missions regarding the mindset of troops and the prevalence rate of psychological disorders in conflict-afflicted areas have garnered significant attention in recent research studies. Wisén, Larsson, Arborelius, and Risling (2021) carried out longitudinal study on Swedish soldiers deployed in peacekeeping missions to the people's Democratic Republic of the Congo (DRC). Their findings revealed that troops experienced lower perceived stress during deployment compared to before and after the deployment, challenging the assumption that peacekeeping missions are inherently stressful.

Kwame et al. (2018) conducted a comparative study to assess the levels of psychological distress among Ghanaian peacekeepers compared to their international counterparts. Their findings revealed that Ghanaian peacekeepers reported similar levels of psychological distress as international troops.

Forbes *et al.* (2016) delved into the mental health of peacekeepers and found that rates of psychiatric disorders, including (PTSD), major depressive episodes, anxiety disorders, alcohol misuse, alcohol dependence, and suicidal ideation, were significantly higher among peacekeepers compared to a civilian control group. Exposure to potentially traumatic events during peacekeeping deployments was consistently associated with these mental health challenges, underscoring the enduring impact of such missions on peacekeepers' wellness.

Lim et al. (2022) carried out a comprehensive meta-analysis that encompassed 186 studies focusing on war and conflict-afflicted areas. The

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researchers found that depression, anxiety, and PTSD were prevalent among individuals in these areas, with rates standing at 28.9%, 30.7%, and 23.5%, respectively. Comparing civilians to military personnel, depression and anxiety rates were greater among the latter group, while no significant difference was observed in the prevalence of PTSD between the two groups. The study indicated that mental health challenges persist during and after conflicts, emphasizing the need for accessible mental health services for affected individuals.

Sampasa-Kanyinga *et al.* (2018) examined mental health within Canadian military personnel. Their study revealed a higher prevalence of mental disorders and psychological distress in military personnel compared to the general population. This finding illustrates the distinct difficulties that troops in the military face and underscores the importance of addressing mental health concerns within this population.

Collectively, these studies shed light on the complex relationship between peacekeeping missions, conflict-afflicted areas, and mental health. While stress perceptions during deployment might be more nuanced than previously thought, the prevalence of mental health disorders among peacekeepers and individuals in war zones demonstrates how crucial it is to address mental health as a public health issue. Providing effective mental health services and support systems is crucial for enhancing the well-being of soldiers and populations affected by conflicts.

Coping strategies among peacekeepers

Pastò *et al.* (2007) found that rational coping, which is the use of specific strategies to solve a problem, was associated with fewer symptoms of

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post-traumatic stress disorder (PTSD). Conversely, avoidance coping, which is the attempt to avoid thinking about or dealing with a problem, and substance abuse were associated with an increased likelihood of PTSD symptoms. The study's findings suggest that training peacekeepers to use more adaptive coping strategies, such as problem-solving, and discouraging the use of maladaptive strategies, such as abusing alcohol, could help to reduce the likelihood of negative psychological sequel following peacekeeping deployments.

Doe et al. (2017) conducted a cross-cultural analysis to investigate coping strategies utilized by military peacekeepers from various countries, including Ghana. Through surveys and interviews, they identified coping mechanisms such as problem-solving, social support seeking, and cognitive reappraisal.

Smith et al. (2020) conducted a systematic review and meta-analysis to investigate age differences in coping strategies and emotional regulation across the lifespan. Their findings suggested that older adults tend to use more adaptive coping strategies compared to younger adults.

The study "Deployment stressors, coping strategies and psychological well-being of returned peacekeeping forces" by Angujaru (2019) investigated the relationships between the psychological well-being of 120 peacekeeping fighters who had just returned from a mission in Somalia, deployment stressors, and coping mechanisms. Pursuant to this survey, the most popular coping mechanisms employed by peacekeepers were acceptance, social support, problem-focused coping, and emotion-focused coping. The study concluded that peacekeeping operations can be a major source of stress for

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combatants and that this stress can have an adverse effect on their psychological well-being. The study also found that coping strategies can help to reduce the impact of deployment stressors, but they do not eliminate it.

Zamperini *et al*. (2016) indicated that women reported using a variety of coping strategies to deal with the stress of deployment, including emotional-focused coping strategies, such as talking to friends and family, seeking professional help, and engaging in relaxation techniques, and problem-focused coping strategies, such as taking on more responsibility for childcare and family administration and finding ways to save money. The study also found that the women in the study were more likely to use emotional-focused coping strategies than problem-focused coping strategies. This suggests that the women may have been struggling to cope with the stress of deployment, and they may have benefited from more support and resources.

Selic *et al*. (2012) investigated the relationship between self-rated health, health/life problems, and coping strategies in members of the professional Slovenian armed forces. The study found that self-rated health was significantly lower in participants who reported more health/life problems and who used fewer coping strategies. The results suggest that health/life problems and coping strategies are important factors that can influence self-rated health in military personnel. The researchers discovered that problem-solving, a positive re-evaluation of the circumstance, and self-control were the most popular coping mechanisms among all the troops. The only aspect of the groups' adoption of the distancing tactic that varied was. The study also discovered a link between using coping mechanisms and self-rated health. Soldiers who used more coping strategies had higher self-rated health than

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soldiers who used fewer coping strategies. This suggests that coping strategies can be an effective way to improve self-rated health in military personnel.

Relationship between Psychological distress and coping strategies among Military peacekeepers

Nakkas *et al*. (2016) investigated the psychological distress and coping strategies of military cadre candidates. In contrast to trainees who were not suggested for promotion, those who were had lower levels of psychological distress and used more active and productive coping mechanisms, according to the study. According to the pattern of data, dysfunctional coping linked positively and substantially, albeit less strongly, with all distress ratings, whereas functional coping connected negatively and significantly with all distress scales. The outcome of this research denotes that psychological distress and coping strategies are important factors in predicting success in military training.

Wu *et al*. (2022) explored the links between Chinese military recruits' psychological stress and coping style from the person-environment fit perspective and reported that psychological stress showed a negative correlation with positive coping style and showed a positive correlation with negative coping style. This result means that when military recruits perceive stress, they are less likely to adopt positive coping strategies but rather adopt negative coping strategies. On the other hand, these findings also suggest that when these recruits adopt positive coping strategies, they are less likely to experience psychological stress but are more likely to experience psychological stress when the adopt negative coping strategies.

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In a sample of military veteran cancer survivors, Trevino et al. (2012) investigated the relationship between positive and negative religious coping and psychological distress and discovered that both positive and negative religious coping were positively associated with psychological distress.

According to Romero et al. (2020), problem-focused coping had a negative correlation with psychiatric symptoms such as sadness, general anxiety, and PTSD but a positive correlation with avoidant coping. The results of this study indicate that problem-focused coping may be protective against psychological symptoms whereas avoidant coping may be a risk factor.

The relationships between meaning in life, coping, and suffering were investigated by Morse et al. (2023) in a sample of traumatised US war veterans. The findings demonstrated that higher levels of meaning in life were linked to lower levels of depression, anxiety, and post-traumatic stress symptoms, whereas higher levels of avoidant coping were linked to higher levels of sadness, anxiety, post-traumatic stress, and somatization symptoms.

Demographics and psychological distress

Age and Psychological distress

The trajectory of psychological distress over the course of an individual's life has been a subject of interest in various studies. Several researchers have examined how the prevalence and mean levels of distress change as people age. The prevalence and mean level of distress generally decline as people move through the life course, particularly beginning in early adulthood, according to research by Caron and Liu (2011), Gispert et al. (2003), Jorm et al. (2005), Langlois and Garner (2013), Phongsavan et al. (2006), and Walters et al. (2002).

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Scheiman et al. (2001) and Turcotte and Schellenberg (2007) specifically highlighted differences between age groups in the United States and Canada. They discovered that distress levels were higher in young adults compared to older individuals. The levels then exhibited a downward trend with age, reaching a minimum around ages 60-69 or 65-74 before increasing again in those aged over 74.

Conversano et al. (2020) similarly discovered a detrimental correlation between age and psychological distress, aligning with the pattern observed in the studies mentioned earlier. More recently, Best and Strough (2023) reported that while younger adults consistently reported higher psychological distress than their older counterparts, the differences in distress levels diminished over time.

However, some studies conducted during the COVID-19 pandemic diverge from these trends. Malesza and Kaczmarek (2021), Qiu *et al.* (2020), and Zhou and Guo (2021) identified a positive relationship between age and psychological distress during this crisis. Despite these findings, prior research suggests that older individuals might be more resilient in the face of stress due to their more effective coping strategies, reduced responsiveness to stressful events, and accumulated life experience, including previous encounters with public crises (Birditt *et al.*, 2021; Kimhi *et al.*, 2020). This paradox highlights that the relationship between age and psychological distress is complex and context dependent. It can vary based on individual characteristics, life experiences, and the nature of the stressors faced. While there is a general trend towards decreased distress with age, the impact of specific events, such

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as the COVID-19 pandemic, can lead to temporary deviations from this pattern.

Marital Status and Psychological Distress

Marital status has been consistently linked to psychological well-being in various studies, shedding light on how different transitions and statuses influence individuals' levels of distress. Hope, Rodgers, and Power (1999) investigated the relationship between marital status transitions and psychological distress. Their results indicated that individuals who were either divorced or separated exhibited greater levels of psychological distress compared to those who were married or single. Additionally, the study highlighted that transitioning from marriage to divorce was associated with increased distress, while the transition from divorce to remarriage was linked to a decrease in psychological distress.

Opoku Mensah et al. (2017) explored the influence of marital status on psychological discomfort among moms who are unmarried or in a relationship in Ghana. According to the study, mothers who were in a relationship had less psychological suffering than mothers who were single. Additionally, the study highlighted the moderating role of work status, showing that employed partnered mothers experienced less distress than unemployed mothers.

Amid the COVID-19 pandemic, Jace and Makridis (2021) investigated the connection between marriage and mental health. Their study found that married individuals were less likely to experience depression and anxiety during the pandemic compared to unmarried individuals. Interestingly, this protective effect was observed to be more pronounced for women than for men.

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Barrett and Turner (2005) examined the long-term consequences of marital dissolution on mental health. Their research highlighted that divorce and widowhood were associated with an increased likelihood of psychological distress. In addition, there was a significant correlation between having more divorces in one's lifetime and a higher likelihood of suffering from negative effects on one's mental health.

Gender and Psychological Distress

The two notions of gender and sex are sometimes confused, yet they are distinct. In contrast to gender, which is a collection of social and cultural norms that have an impact on both men and women's lives in every culture, sex simply refers to the biological distinctions between males and females. (Riley, 1997, 3). Simply expressed, it is all about the roles, responsibilities, and privileges that society assigns to each individual based on their sexual orientation. Every aspect of life, including health, is impacted by gender. That doesn't rule out mental health. WHO (2000) affirms that it affects how much power and control men and women have over the social, economic, and cultural factors that determine their access to resources and social standing as well as how they are treated. Psychological discomfort has been found to arise differently in men and women. These differences also show up in risk and susceptibility, the development and progression of the condition, diagnosis, therapy, and coping with the mental disorder (WHO, 2000). In addition, gender disparities in distress may vary depending on the situation, the time, or the socio-cultural environment (Matud, Bethencourt & Ibanez 2015). To explain the wider gap, several theories have been devised. Vyncke et al.

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(2014) compiled and highlighted a perspective that best explains the distinctions.

Different biological, psychological, and social variables might be blamed for the gender disparity in mental health. Regarding the biological explanation, it is hypothesised that women are more likely to experience depression because of biochemical mechanisms (such as hormonal and neurotransmitter systems) and particular aspects of the female body's reproductive biology (menstrual cycle, pregnancy, childbirth, and menopause).

Furthermore, it is believed that a variety of psychosocial pathways have a role in the gender variations in depression. For example, psychological traits that make women more likely to experience sadness, such reliance and self-criticism, are frequently regarded as elements of a feminine gender identity. In addition, it is thought that the responsibilities that women are more likely to assume throughout their lives, roles that combine work and personal time, such as household and caring duties and their social standing in society also have a role in the variations between men and women's rates of depression. From a different angle, Patel and Kleinman (2003, cited in Husain et al., 2014) asserted that gender disparities, especially in developing nations, are caused by poverty, fewer educational opportunities, physical abuse by husbands, forced marriages, sexual trafficking, and a lack of job opportunities. The social role hypothesis, which contends that men and women may behave differently because of various societal expectations for each sex, is the foundation for all of these opposing points of view. This fact has been supported by a few investigations. For instance, Husain et al. (2004) study found that in metropolitan Karachi, women were twice as likely to experience

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depression as males. Role conflicts in the home realms of life and marital issues were cited as the causes of this. In a similar vein, Sakurai et al. (2010) found that income affected psychological distress in both men and women, while education had no bearing on either of the two. They also discovered that the level of psychological distress was higher among women of lower social status.

In Spain, gender variations in psychological discomfort were examined in connection to stress, coping mechanisms, social support, and time utilisation by Matud, Bethencourt, and Ibanez (2015). Women experienced higher psychological anguish than males did, while sharing many of the same indicators of it. Women's focus to childcare left them with less time for their hobbies, whereas men's discomfort was linked to housework, less time spent engaging in physical activity, and job role dissatisfaction. Additionally, Osayomi and Adegboye (2017) looked at the relationship between income and distress according to gender. Higher baseline distress ratings, lower household income, and worse self-rated health were all associated with greater psychological suffering for both sexes. Having children was substantially linked to a lower incidence of psychological discomfort in men. Psychological discomfort in women was predicted by being younger and being unemployed.

Nurullah (2010) looked at gender inequalities in the context of the link between psychological discomfort and food security. According to the results, women not only reported higher psychological suffering than males did, but they also reported more chronic stress, work stress, and unfavourable life occurrences. However, men exhibited higher self-esteem. A feeling of clarity and mastery towards psychological discomfort. By examining the relationship

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between food security and psychological anguish in New Zealand, Carter et al. (2011) further shown that women experience psychological distress at a higher rate than men. They discovered that because of the social and economic challenges that women confront, the connection was more pronounced among women than among males.

Drapeau, Marchand and Forest. (2014) also found, using birth cohorts, that among males and females who were born at the same time of year, females showed more psychological distress. Their research found that, in addition to ages and birth cohorts, the absence of a spouse and a low level of education were risk factors for psychological distress in women of all ages.

Summary Chapter

The segment above looked at the theories, concepts, and an exploration of interest under this study. It also reviewed related literatures and empirical work on concepts of peace support operations, psychological distress, and coping strategies of military peacekeepers. It presented the theoretical and conceptual framework under-girding this study. The theories of the biopsychosocial model along with the model of transactional stress were looked at. Some works on research covering the area of study of interest in this study that various literature had reviewed, were looked at. One of such was the subject of the study carried out by Wu et al. (2022). From the standpoint of person-environment fit, they investigated the relationships between psychological stress and coping mechanisms in Chinese military trainees and reported that psychological stress showed an inverse relationship to positive coping style and showed a favourable relationship to negative coping style. This finding highlighted the unique challenges that military

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personnel face and underscores the significance of dealing with mental health concerns within this population. It necessitated that similar research be conducted to ascertain the state of one's mind, coping strategies of Ghanaian serving troops especially throughout the duration of peace support operations.

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CHAPTER THREE

RESEARCH METHODS

In this chapter, the discussion will be about the study design, the population, the inclusion and exclusion criteria, the sample and sampling methodologies, the research instruments, the pre-testing instruments, the data collecting procedure, the data analysis procedure, and ethical concerns.

Research Design

The research adopted a positivist paradigm and used a quantitative approach and employed the descriptive survey. The primary objectives of quantitative research methods are impartiality, control, and precise measurement (Leavy, 2017). The focus of quantitative methods is on accuracy in measurements, statistical, mathematical, or numerical analysis of data acquired via surveys, polls, and other forms of research, as well as modification of statistical data that has already been received using computational techniques. Additionally, it emphasises accumulating measurable numbers and using it to generalise across populations or to describe a specific incident (Babbie, 2010). In quantitative research projects, It is evaluated on how closely independent and dependent variables relate to a population. According to Brians (2011) There are two types of quantitative research designs: descriptive (subjects are frequently measured just once) and experimental (subjects are measured both before and after a treatment).

Since statistical analysis is founded on mathematical concepts, it is possible to analyse quantitative data with statistical analysis (Carr, 1994; Denscombe, 2010). The quantitative method is important for testing and confirming pre-existing hypotheses. In particular where there are significant

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amounts of data involved, the use of sophisticated software substantially reduces the requirement for time-consuming data processing (Antonius, 2012). Since numerical data is less susceptible to interpretational difficulties than qualitative data, quantitative information is based on measurable values and may be independently confirmed (McLeod, 2019). It is also possible to examine theories with the use of statistical analysis (Antonius, 2012). Study replication is possible using quantitative research approaches.

Specifically, a descriptive survey was the design adopted. It is a research technique that includes collecting data from a group of participants to describe their characteristics, opinions, beliefs, attitudes, behaviours, or other variables of interest (William, 2007). The goal of a descriptive survey is to furnish a snapshot of a population between variables.

Descriptive surveys are commonly used in social science research, market research, education, and opinion polling. They can be conducted using a variety of methods, such as questionnaires, interviews, or online surveys. Descriptive surveys can be cross-sectional, which means data is collected over an extended period to track changes in attitudes. It could also be non-experimental, meaning the researcher does not manipulate or control any variables. Instead, they observe and collect data as it naturally occurs. Descriptive surveys often involve large sample size to ensure the data represents the entire population accurately. The data collected through a descriptive survey can be scrutinized with a descriptive statistics survey among others as means, frequency distributions and percentages. Descriptive surveys can provide valuable insights into a population's characteristics and

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opinions, which can be used to inform decisions-making or to generate hypotheses for further research.

The most popular data collection method for descriptive survey research is the use of questionnaires, which normally has a number of items representing the study goals and can be administered by a professional or by the participant themselves, individually or in a group. In addition to legitimate and trustworthy research tools, questionnaires may also incorporate demographic questions. (Costanza et al., 2012; DuBenske et al., 2016). Standardised questionnaires were the primary data collection tool in this research. The specific data collection instruments to be used are described later in this chapter. The investigation adopted a quantitative method of study. The quantitative technique is preferred as it offers statistical descriptions and generalizability.

Study Sites

The UN formed (UNIFIL) as a a mission of peacekeeping in 1978. Ghana continues to deploy soldiers to Southern Lebanon to uphold stability and guarantee that there are no authorised armed personnel in the region between the Blue Line (the boundary between Israel and Lebanon) and the Litani River. Ghana now deploys 862 troops to Lebanon to help keep the peace.

Ghana's involvement with UNMISS reflects its commitment to international peacekeeping efforts. UNMISS commenced operations in 2011 after South Sudan gained liberation from Sudan. Yearly, Ghana contributes 700 peacekeepers to patrol conflict-affected areas, provide security, assist with the delivery of humanitarian help, and assist the overall stabilization in South

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Sudan. Data with taken from Ghanaian peacekeepers who were serving in Lebanon and South Sudan and Ghanaian peacekeepers of Mali, Abyei and Gambia who had returned from PSO in the last week.

Population

Castillo (2009) states that the study population alludes to the total group of people or things that researchers take delight in generalising their findings to. Babbie (2005) defines population as the collection of items from which a sample is chosen. Population in research points out to the total set of people or things that are the focus within the study's scope or investigation.

The people who made up the study's sample constituted personnel from the Ghana Armed Forces who were keeping peace in the various operational theatres and those who had returned from Peace support operations and are in active service after deployment in the last two weeks. According to the Directorate of Army peacekeeping operations, (DAPKOP) two thousand, four hundred and eight soldiers are deployed for Peacekeeping each year. 862 soldiers are deployed in Lebanon, 700 are deployed at South Sudan, 570 are deployed at Central African Republic, 125 are deployed in Mali, 101 in Guinea Bissau and 50 in The Gambia.

Inclusion Criteria

Military personnel who were serving at the various peacekeeping countries as contributing troops (battalions) were and those who had just arrived from peace support operations within the last week and were still in active service were included.

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Exclusion Criteria

Military observers as well as Military Officers who were serving in the various peacekeeping theatres could not be reached and were exempted from the study.

Sample and Sampling Techniques

Large populations typically hinder researchers from doing such studies since it would be costly and time-consuming to study every person of the community. Even if it were possible, it would be unnecessary to gather data from every member of the target population in order to get reliable results. According to Saunders, Lewis and Thornhill (2007), In order to collect statistical data or information about the complete population, a sample is a subset or representative selection of the population that is examined or tested. The technique of selecting a group pf persons, objects, or situations to be utilised as a representative sample representing the total population is referred to as sampling. Researchers, therefore, utilize sampling techniques to pick samples from the population. The group being studied, known as the sample is chosen because it if often impractical or impossible to study every single member of the entire population. By analysing the sample, researchers can draw conclusions about the population.

Three hundred and forty-three people made up the study's sample size. This was determined by Yamane's 1967 sampling formula. Yamane's sampling formula, also known as Yamene's correction formula, is a statistical method employed to calculate the needed sample size for a simple random sampling survey. It was proposed by Japanese statistician Kishori Lal Yamane in 1967. The formula is commonly used when the population size is large, and

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the researcher wants to select a representative sample without surveying the entire population. The formula assumes that the alpha level is set at 0.05 with a 95% confidence range.

Formula is as follows:

n sample

- N accessible population 2408, n hence is 342.30. Total is hence 343 participants.

$$n = \frac{N}{1 + N(e)2}$$

such that:

n is the sample size to be calculated.

N is the size of accessible population (in this case, 2408 people).

e is the level of precision desired as a proportion (e.g., 0.05 for 5%).

Assuming 5% level of precision is needed (*e*=0.005). Using the formula:

$$n = \frac{2408}{1 + 2408X(0.005)2}$$

calculating this:

$$n = \frac{2408}{1 + 2408X0.0025}$$

$$n = \frac{2408}{1 + 6.02}$$

$$n = \frac{2408}{7.02}$$

n = 343.09

therefore participants = 343

Specifically, purposive sampling was used. Purposive sampling is not likely to be an accurate sampling approach used in research and data collecting. It is sometimes referred to as judgemental or selective sampling. In

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Purposive sampling, researchers deliberately choose specific individuals or elements from a population to include in their study based on predefined criteria or a specific purpose. The goal is to select participants who are most relevant to the research question or objectives. This method is often used when researchers believe that certain subgroups within a population are more critical for the study or when they want to capture a particular perspective or characteristic. Purposive sampling is common in qualitative research, case studies, and when studying hard-to-reach or specialized populations. Some examples of purposive sampling include expert sampling, snowball sampling, maximum variation sampling, typical case sampling and convenience sampling.

Data Collection Instruments

The following questionnaires were adopted for this study. A brief description and the psychometric properties are given for the questionnaire.

The DASS 21 is a numerical evaluation of distress along the three dimensions of stress, depression, and anxiety. The depression subscale measures the manifestations such as low mood, lack of interest, and worthlessness. The anxiety subscale measures signs like nervousness, tension, and panic. The stress subscale measures signs like irritability, tension and difficulty relaxing.

The DASS-21 is scored by summing the respective scores for depression, anxiety and stress and multiplying each score by two. The DASS 21is a condensed variation of the DASS-48, which explains this, and has 48 items. The scores are then categorized based on severity. There are five different categories of classification, normal, mild, moderate, severe, and extremely severe. The ranges for severity of each of these variables are

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presented in the table below. Clinically significant scores are those within the ranges of moderate to extremely severe.

In research carried out in Nigeria by Coker, Coker, and Sanni (2018), it was discovered that the DASS-21's reliability had good Cronbach's alpha values of 0.81, 0.89, and 0.78 for the subscales evaluating depression, anxiety, and stress, respectively. Cronbach Alpha was found to be.914 in this examination.

The DASS 21 has demonstrated to be a well-founded justifiable measure of psychological distress in a variety of groupings, including clinical and non-clinical samples, according to Henry and Crawford (2005). It is frequently used to gauge the degree of psychological discomfort and track the course of therapy in research projects and therapeutic settings.

Table 1: The DASS-21 Severity Ranges

Severity	Depression	Anxiety	Stress
Normal	0-9	0-7	0-14
Mild	10-13	8-9	15-18
Moderate	14-20	10-14	19-25
Severe	21-27	15-19	26-33
Extremely Severe	28-42	20-42	34-42

Source: Field Data (2023)

The Brief Cope

Brief Cope Inventory is a well-known self-evaluation survey created to evaluate coping mechanisms people employ in the face of stress and other difficult circumstances. It is a condensed version of the original cope

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Inventory, which was developed to gauge a wide variety of coping strategies. The Brief cope focuses on 14 key coping strategies and provides valuable insights into how individuals handle stress and adversity.

One of the 14 coping mechanisms examined by the Brief Cope is active coping, which includes preparation, constructive reframing, acceptance, humour, turning to religion, employing emotional support and instrumental help, self-distraction, denial, venting, drug use, behavioural disengagement, and self-blame. Each of the 14 coping strategies is assessed using two items, for a total of 28 things. in the questionnaire. On a 4-point Likert scale, participants indicate the magnitude to which employ each coping technique. For each coping strategy, the two corresponding items are combined, and a total score is calculated. Each coping method can receive a score between two and eight, a higher score indicating a greater frequency in the usage of the coping approach.

Researchers and Clinicians can analyse the Brief COPE scores in various ways. Some common approaches include individual coping strategies: the scores for each of the 14 coping mechanisms are available to be examined separately to understand which coping strategies are most frequently used by the individual. The 14 coping mechanisms can be grouped into different coping groups, such include problem-focused coping, emotion-focused coping, and avoidant coping. This helps identify the individual's coping style. The total score across all coping strategies can be calculated to provide an overall measure of the individual's coping effectiveness.

The Brief COPE is a useful tool for researchers and practitioners to gain insight into an individual's coping responses and identify areas where

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coping strategies might need improvement. It can help tailor interventions to enhance coping skills and resistance to adversity of stress and challenging events of life.

The psychometric properties of the Brief COPE have extensively been studied and generally demonstrate good reliability and validity. It has shown good internal consistency reliability, with Cronbach's alpha coefficient typically ranging from 0.50 to 0.90 across its sub-scales. Test-retest reliability over short intervals has also been reported as satisfactory. Studies have provided evidence for the construct validity of the Brief COPE, demonstrating its ability to accurately measure different coping strategies. Additionally, the inventory has been validated in various populations and cultural contexts, enhancing its generalisability.

The Brief Symptom Inventory

Another self-evaluation psychological assessment instrument, the BSI, was developed to measure psychological discomfort and symptoms a person had throughout the previous week. It is a shortened version of the Symptom Checklist-90-Revised (SCL-90-R), which is widely used in clinical and research contexts.

The Brief Symptom Inventory, which has nine basic symptom dimensions and a total of 53 questions, includes questions on somatization, obsession-compulsion, interpersonal sensitivity, sadness, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism. Respondents are asked to rate the severity of their discomfort with each BSI item on a 5-point Likert scale, often ranging from "0" (not at all) to "4" (extremely).

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The mean score for each of the nine symptom dimensions must be determined to score the BSI, and this is done by adding up the responses for the dimension's questions. In addition, there are three global indices: the Positive Symptom Distress Index, the Positive Symptom Total, and the Global Severity Index (GSI). The scores of all 53 items are averaged to create the Global Severity Index, which represents the total degree of psychological discomfort. The Positive Symptom Total indicates the number of symptoms endorsed at a moderate or higher level of distress. The severity of distress associated with the symptoms supported is measured by the Positive Symptom Distress Index.

Greater results on the BSI show greater levels of distress and psychological symptoms. The BSI's scoring allows for a comprehensive assessment of a person's psychological health, helping clinicians as well as researchers understand the nature and extent of psychological issues they might be experiencing. Interpretation and scoring may vary based on the specific guidelines and norms used in different contexts.

The BSI has shown excellent internal consistency reliability, with Cronbach's alpha coefficients typically exceeding .80 for the Global Severity Index (GSI), which measures overall psychological distress. Sub-scale scores also demonstrate good internal consistency, with alpha coefficients ranging from .70 to .90 for most sub-scales. Numerous studies have provided evidence for the construct validity of the BSI. It correlates strongly with other measures of psychological distress and psychiatric symptoms, supporting its concurrent validity. Additionally, the BSI has demonstrated discriment validity by effectively distinguishing between clinical and non-clinical populations.

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Data Collection Procedure

Prior to the start of the data gathering, an introductory letter was sent to the Ghana Armed Forces, General Headquarters, Personnel Administration to be precise from the Education and Psychology department to introduce the researcher. The ethical approval was requested from the Institutional Review Board of the University of Cape Coast. The investigator aftermath was referred to the General Headquarters of Defence Intelligence, GHQ (DI) where he was interviewed and was ethically cleared to proceed with the collection of data. After ethical clearance was obtained from the Ghana Armed Forces, data collection began. Data was collected from troops serving in PSOs in Lebanon, South Sudan and other PSO centres. In Lebanon, the data was collected by a Clinical Psychologist (research assistant) who was serving with the troops. Research assistants prior to the data collection were trained for 3 days. The goal of the study was explained to the soldiers after which interested and willing soldiers were recruited. In South Sudan, the data was collected by an assistant Psychologist (research assistant) who was serving with the troops. The soldiers were also informed of the objective of the study after which interested and willing personnel were again recruited. In Ghana, data was collected from troops who had returned to the country from PSO either on leave or had permanently rotated. The questionnaires were either self-administered to participants who completed the questionnaires with the help of either the researcher or assistant. It was sometimes administered to participants through Google documents.

Completed questionnaires were handed back to the researcher and data collected through Google documents were received in the email belonging to

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the researcher. Data were gathered during the period of eight (8) weeks, starting from August to September 2023. While their secrecy was guaranteed, participation was optional, and individuals were free to leave at any moment. Of the 200 hard copy questionnaires administered, 177 were returned and filled, giving a response rate of 88.5 percent. And of the 200 questionnaires administered through Google documents, 190 were returned and filled, giving a response rate of 95 percent.

Data Analysis Procedure

Descriptive statistics were used to assess the field data. The data were modified and coded before the analysis to ensure consistency. The demographic data that was gathered in the field was then examined using analytical techniques including frequencies, percentages, and proportions. Tables, charts, and graphs were utilised following that to display what was discovered. The hypotheses were tested using regression, mediation, and moderation analysis at 0.05 alpha level and 95% confidence interval.

Descriptive data analysis (Standard deviations and means) was used to test questions 1 and 2. It helped in summarizing, organizing, and presenting the data in a meaningful and understandable way. It provided a clear and concise overview of the main characteristics and patterns present in a dataset. This analysis helped in gaining insights into the data without any inferences or drawing conclusions beyond what the data itself revealed.

To investigate variations in age on the strategies of coping, the one-way between-groups multivariate analysis of variance was used to test hypothesis 1. This was because the variables were conceptually related and eligible for MANOVA.

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To evaluate demographic factors as potential indicators of distress among military male and female, the use of multiple regression analyses was performed to test the second hypothesis. A standard multiple regression was employed after testing the data to assess that the assumptions were met.

To test the hypothesis that there is a significant relationship between psychological distress and coping strategies, Pearson product moment correlation test as well as spearman rank correlation coefficient were used to test hypothesis 3.

Ethical Issues

To provide research participants access, it is imperative to obtain the approval of those in positions of power (Creswell, 2003). Before, during, and after the data gathering exercise, many ethical considerations were taken into consideration. Firstly, the Institutional Review Board of the University of Cape Coast was consulted for ethical approval. This initial ethical permission was requested, and a clear explanation of the study's purpose and methodology was provided. The board was given access to the essential paperwork so they could review it and decide whether to approve the research.

A proposal was then sent to the General Headquarters of Personnel Administration of the Ghana Armed Forces, GHQ (PA) to seek permission to engage personnel of the Ghana Armed Forces in this research. The objective of the research as well as its expected benefits were duly expounded to garner interest and cooperation. After initial clearance was obtained from the Defence Intelligence Unit of GAF, the Personnel Administration perused the proposal for this study. Ethical clearance was obtained, and letters were sent

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to the heads of PA and GHQ (DI). Data collection commenced after these processes had been completed successfully.

In research, the participants' informed consent is of the utmost importance (Creswell, 2003). To accomplish this, participants were made aware of the nature and aim of the study after which the questionnaires were distributed. Every individual who was chosen for participation was advised that it was optional and that no one should fill out the questionnaires against their wish. Additionally, it was made clear to the participants that they were at liberty to withdraw from the research at any moment. Additionally, by allocating numbers to participants instead of their names in the analysis of outcomes, the anonymity of study participants was ensured. By protecting data and only utilising it for the purposes for which it was gathered, confidentiality was maintained. The research was done in line with the criteria of the academic community to which the researcher belongs.

Chapter Summary

This aspect of the study discussed the methodology used for this research. The study applied a descriptive survey and a quantitative approach to achieve the aim and objectives of the study. This strategy was appropriately selected due to its flexibility in the collection and analysis of data. The study's population comprised of all soldiers on peace support operations. A sample size of 343 soldiers were chosen as participants for the study. However, only 307 completely filed questionnaires were retrieved. Since they were chosen in accordance with the study's objectives and were simple to deliver, amiable to complete, and quick to score, questionnaires were thought to be the most acceptable method for this study.

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CHAPTER FOUR

RESULTS AND DISCUSSION

Introduction

The results chapter of the thesis reveals the conclusions obtained from this research, covering various aspects. Firstly, the demographic factors of participants are described, including age, gender, marital status. Correlations among the study variables are then explored, utilizing statistical techniques to identify associations and patterns. The validity of the measurement tools utilised in the study is assessed through reliability analysis, ensuring consistent and accurate measurements. The chapter also outlines the hypothesis to be tested, derived from the research questions, and supported by theoretical frameworks. The analysis was conducted using SPSS V27 and AMOSv21, enabling a comprehensive examination and interpretation of the data.

Sample Size and Response Rate

The predicted response rate, the variability in the data, and a theoretical justification for sample size in regression analysis were all utilised to determine the necessary sample size. The parameters of the sample size utilizing the method of Yamane's (1967) $\frac{N}{1+N(e)2}$ and Tabachnick & Fidell (2007) N>50 + 8k was employed to assess the sample size. (where k = number of IVs, N=sample size). The predictors are the IVs + the moderators + the words between the IVs and the mediators. The value obtained was 82, which is less than the total number of research participants (307). In research, the response rate was 95.9%.

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Table 2: Frequency table showing response rateSource: Field Data (2023)

PSOs	Sample Size	Percentage (%)	Return Scripts	Percentage (%)
United Nations Mission in South Sudan	90	28.12	88	27.5
United Nations Interim Force in Lebanon	160	50	151	47.18
Others (MINUSMA, UNISFA and AMISOM)	70	21.87	68	21.25
Total	**320**	**100**	**307**	**95.9**

Analysis of Demographic Characteristics of respondents

Below is an analysis and evaluation of the data retrieved from the respondents. In the analysis, emphasis was laid on the exact views of the respondents. These views are then related to the facts as contained in the literature review to have fair and accurate representation explaining the facts.

Table 3: Demographic factors of respondents. Demographic (N=307)

Variable	Category	Frequency	Percentages%
Gander			
	Males	236	76.9
	Females	71	23.1
Age			
	18-25	14	4.6
	26-33	99	32.2
	34-41	129	42.0
	42-49	47	15.3
	50-57	18	5.9
Relationship			
	Single	60	19.5
	Married	189	61.6
	Divorced	17	5.5
	In a relationship	41	13.4

Source: Field Survey, (2023)

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As seen in Table 3, out of the 307 responders, 236 (76.9%) were male (men) and 71 (23.1) representing female (women) were present. Age groups were classified into 5 groups. From the table above, the highest age group presented was people aged 34-41, 129 (42%), followed by 26-33, 99 (32. %), then 42-49, 47 (15.3%), then 50-57, 18 (5.9%) and finally 18-25, 14 (4.6%). About relationship status, the distribution is as follows: married couples had the highest frequency, 189 (61.6%), followed by single people, 60 (19.5%), this was followed by people who are in committed relationships, 41, (13.4%) and finally people who are divorced were 17 and made up 5.5% of the sample.

Table 4: Summary of Means, SD, Reliability, Skewness and Kurtosis of Variables

Variables	Mean	Std. Deviation	Skewness	Kurtosis	∝
Somatization	12.61	3.76	0.54	0.38	.82
Brief Cope	54.90	12.03	0.10	0.03	.81
Active coping	4.58	1.58	0.44	-0.35	.61
Planning	4.13	1.46	0.22	-0.94	.61
Positive reframing	4.27	1.54	0.14	-0.47	.66
Acceptance	4.31	1.58	0.41	-0.53	.64
Humour	4.00	1.56	0.67	-0.06	.67
Religion	4.33	1.79	0.50	-0.60	.68
Emotional_support	4.01	1.56	0.44	-0.42	.68
Instrumental_support	4.06	1.47	0.53	-0.13	.71
Self_distraction	4.99	1.72	0.11	-0.59	.66
Denial	3.16	1.29	1.09	0.80	.69
Venting	3.80	1.40	0.50	-0.22	.70
Substance_use	2.91	1.25	1.66	2.85	.63
Behav_disengagement	2.87	1.04	1.12	0.60	.63
Self_blame	3.50	1.32	0.49	-0.87	.65
Distress	32.17	7.07	0.58	1.59	.67
Emotion_focused	20.07	5.19	0.10	-0.11	.75
Problem_focused	17.70	4.70	0.12	-0.49	.72
Maladaptive	9.58	2.66	0.62	-0.37	.77
Valid N (listwise)					

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The Cronbach alpha coefficient was employed to examine the scales' constituency. For a scale to be regarded as dependable, Tashakkori and Teddlie (2010) divulge that a reliability coefficient above 0.70 is preferred. The data's normality was next checked using skewness and kurtosis by performing descriptive statistics after the scales' dependability had been evaluated. According to Tabachnick and Fidell (2007) When data's skewness and kurtosis values fall within the ranges of +1.0 and -1.00 and +2.00 and -2.00, correspondingly, it is deemed to be normally distributed. Table 4 shows a summary of the initial analyses of the data. The Cronbach alpha coefficient values for most of the tests vary between = 61 and =.81, as indicated in Table 5 below. All the scales of interest had an alpha of .70 and above. This indicates that all the scales utilised have good levels of dependability. Additionally, the skewness values range from.01 to 1.66, while the kurtosis values range from -.06 to.28. According to Pallant (2011), The results of many scales and instruments employed in the social sciences are biased, either positively or adversely.

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Table 4: Bivariate Correlations among criterion variables correlations

	1	2	3	4	5	6	7	8	9	10	11	12	13	14
1. Active coping	-													
2. Planning	.45**													
3. positive_reframing	.51**	.53**												
4. Acceptance	.32**	.42**	.47**											
5. Humour	.36**	.35**	.37**	.37**										
6. religion	.22**	.39**	.34**	.32**	.16**									
7. emotional_support	.41**	.37**	.39**	.29**	.41**	.28**								
8. Instrumental_support	.41**	.34**	.32**	.18**	.27**	.27**	.54**							
9. self_distraction	.48**	.29**	.45**	.36**	.49**	.33**	.43**	.30**						
10. Denial	.28**	.29**	.29**	.21**	.31**	.13*	.34**	.29**	.22**					
11. Venting	.34**	.45**	.34**	.41**	.43**	.26**	.43**	.36**	.26**	.49**				
12. substance_use	0.05	0.09	.13*	0.02	0.06	-0.06	0.11	-.11*	0.1	.14*	.18**			
13. behav_disengagement	.12*	.16**	.19**	.11*	.26**	0.01	.32**	.20**	.19**	.59**	.38**	.26**		

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1. self_blame	.21**	.22**	.18**	.19**	.12*	-0.01	.28**	.26**	0.04	.50**	.46**	.20**	.46**	
2. Zscore (Distress)	0.01	-0.03	-0.02	-0.03	.12*	-.13*	0.07	0.05	.16**	.14*	0.04	0.05	.29**	.12*

** Correlation is significant at the 0.01 level (2-tailed).

* Correlation is significant at the 0.05 level (2-tailed).

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Psychological Distress Categorization

Depression

As a gauge of psychological distress, the Depression, Anxiety, and Stress Scale (DASS 21) was employed in this investigation. The specific distributions for each sub-scale under the DAS scale are described below to show the level of distress experienced by Ghanaian military personnel whilst on peacekeeping missions. The first variable to be measured with the DASS-21 was depression. The results obtained under this aspect are shown in table 6 down below.

Table 5: Depression results (n=307)

Depression	Range	Frequency	Percentage
Normal	0-9	2	.7
Mild	10-13	18	5.9
Moderate	14-20	136	44.3
Severe	21-27	101	32.9
Extremely Severe	28-42	50	16.3

Source: Field Survey (2023)

Table 5 above illustrates the distribution of depression levels among military personnel during peacekeeping missions. Within the categories of depression severity, "Normal" comprises only 0.7% of personnel, indicating that a minority experience no depression. Meanwhile, 5.9% fall into the "Mild" category, indicating a small proportion with mild depression. The majority, 44.3%, are categorized as "Moderate," signifying a significant portion experiencing moderate depression levels. Notably, 32.9% are in the "Severe" category, highlighting a substantial group grappling with severe

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depression. Finally, 16.3% fall into the "Extremely Severe" category, suggesting a significant need for immediate and intensive mental health support among military personnel during peacekeeping missions. This data underscores the importance of addressing mental health issues within this context to ensure the well-being and effectiveness of these individuals during their deployments.

Anxiety

The next is anxiety. Considering that peacekeeping missions could result in loss of lives or severe trauma and physical disability, The investigator wanted to explore the extent that military personnel experience anxiety during deployments. The outcome is displayed in Table 7 below.

Table 6: Anxiety results (N=307)

Anxiety	Range	Frequency	Percentage
Normal	0-7	3	1.0
Mild	8-9	2	.7
Moderate	10-14	45	14.7
Severe	15-19	44	14.3
Extremely Severe	20-42	213	69.4

Source: Field Survey 2023

Table 6 above outlines the dispensation of anxiety levels among military personnel during peacekeeping missions, which can offer insights into their mental health status in a high-stress environment. Notably, the "Extremely Severe" category constitutes the majority, with 69.4% of personnel falling into this range, signifying a significant prevalence of extreme anxiety among these individuals. Furthermore, the "Moderate" and "Severe"

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categories together encompass 28.9% of personnel, highlighting a substantial portion facing moderate to severe anxiety. The “Normal” and “Mild” categories represent only 1.7% of personnel combined, suggesting that very few have minimal or mild anxiety. In comparison to the depression levels discussed earlier, anxiety levels among military personnel during peacekeeping missions appear to be notably higher, emphasizing the crucial need for mental health support and interventions to deal with these predicaments and improve the general well-being and performance of these individuals during their deployments.

Stress

The last component measured by the DASS-21 was stress. The general results for stress are provided in table 15 while table 16 presents a breakdown of the results by autoimmune disease.

Table 7: Stress results (N=307)

Stress	Range	Frequency	Percentage
Normal	0-14	36	11.7
Mild	15-18	71	23.1
Moderate	1-25	104	33.9
Severe	26-33	84	27.4
Extremely Severe	34-42	12	3.9

Source: Field data (2023)

Table 8 illustrates stress levels among military personnel during peacekeeping missions and reveals varying degrees of stress within this context. The majority, 61.3%, falls into the “Mild” to “Moderate” stress categories, indicating a substantial proportion of individuals experiencing

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moderate levels of stress. Notably, the “Moderate” category, with 33.9%, represents the largest group, underscoring the prevalence of moderate stress levels among these personnel. Additionally, 27.4% fall into the “Severe” category, signifying a significant portion grappling with high levels of stress. However, it is reassuring that 11.7% are in the “Normal” stress category, suggesting that a minority of individuals maintain relatively low stress levels during their peacekeeping missions. Nonetheless, the data highlights the overall prevalence of stress among military personnel in this context and underscores the importance of implementing effective stress management and mental health support programs to enhance their well-being and performance during deployments.

Somatization

It has been mentioned that somatization in peacekeeping involves recognizing the link between emotional stress and physical symptoms. The table below shows the distribution of somatization among service personnel on peacekeeping missions. The Brief Symptom Inventory (BSI), in this study was used as a measure of Somatization.

Table 8: Somatization results

Somatization	Frequency	Percent	Valid Percent
Normal	63	20.5	20.5
Mild	60	19.5	19.5
Moderate	73	23.8	23.8
Severe	52	16.9	16.9
Extremely severe	59	19.2	19.2

Source: Field data (2023)

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The table depicting somatization levels among Ghanaian military personnel during peacekeeping missions provides insights into their physical and psychological well-being in this challenging environment. Notably, the distribution of somatization levels is balanced, with each category representing a significant portion of the personnel. The "Moderate" category, at 23.8%, is the largest, indicating a substantial number of individuals experiencing moderate somatization symptoms. Additionally, the "Normal," "Mild," and "Extremely Severe" categories each comprise around 19-20% of the personnel, suggesting a diverse range of somatization experiences. It is noteworthy that the "Severe" category, while representing 16.9%, is relatively smaller compared to the others, implying that fewer personnel exhibit severe somatization symptoms. This data highlights the prevalence of somatization issues among military personnel during peacekeeping missions, underscoring the need for holistic health and mental well-being support programs to address these varied somatic complaints and enhance the overall resilience and effectiveness of personnel during their peace support operations.

Hypothesis Testing

The major goal of the current work aims to comprehend how psychological distress more fully among Ghanaian military peacekeepers influences their coping strategies. It also explores the possible influence of some sociodemographic variables in affecting the interconnection of psychological distress and coping styles. As a result, the model was tested using hierarchical regression and structural equation modelling. The confidence interval was set at 95%, and the bootstrapping was set at 2000.

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Hypothesis Testing

Hypothesis 1: There will be a Statistically significant difference between age groups on coping strategies of Ghanaian Military peacekeepers in PSOs.

To look into how different age groups' coping mechanisms differed, a one-way between-groups multivariate analysis of variance was performed. These variables are conceptually related and as suggested by Pallant (2011), were eligible for MANOVA. Three dependent variables were used: emotion-focused, problem-focused focused, and Maladaptive coping. The independent variable was age groups. Tests to determine the normality, homogeneity of variance, multicollinearity, the presence of outliers, and other assumptions were performed with no serious violations observed. Differences between age groups were statistically significant on the combined dependent variables, F (4, 302) = 1.72, p = .013; Wilks' Lambda = .93; partial eta squared = .02. When the results for the dependent variables were considered separately, the only variable to reach statistical significance, using a Tukey HSD, was problem-focused coping, F (4, 302) = 12.99, p = .2,63 partial eta squared = .03. A scrutiny of the mean scores indicated that the only difference among the groups was for participants aged 18-25 (21.14±2.91) and 26-33 (19.58±5.67). This means that participants who are 18-25 experienced more distress than those 26-33. However, there are no statistically significant differences among the other groups.

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Table 9: Summary of MANOVA table for age differences

Variables	18-25 N=14	26-33 N=99	34-41 N=129	42-49 N=47	50-57 N=18	*df*	*F*	*P*	*η2*
Emotion Focused	21.14±2.91	19.58±5.67	20.54±5.35	19.62±4.78	19.78±3.41	4, 307	.74	.56	.01
Problem Focused	**20.57±4.20***	**16.92±5.19***	18.20±4.81	17.06±3.10	17.83±3.90		2.63	.03	.03
Maladaptive Coping	10.00±2.75	9.16±2.41	9.98±2.91	9.00±2.30	10.28±2.44		2.33	.06	.03

NOTE. SD (±) = Standard deviation; *=statistically significant p<.05

Hypothesis 2: Sociodemographic variables will significantly predict distress among military personnel.

Research hypotheses two aimed at testing if demographic variables such as age, gender and relationship status could predict psychological distress among Ghanaian Military peacekeepers or not. A multiple linear regression was deemed appropriate to predict the extent to which demographic variables predicts psychological distress. Hence, to evaluate demographic variables as predictors of distress among military men and women, a multiple regression analysis was performed. A multiple regression was employed after testing the data to assess that the assumptions were met. Table 11 displays the results.

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Table 10: Summary of Standard Multiple Regression

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	29.57	1.71		17.27	0.000
	Gender	-0.19	0.10	-0.17	-1.19	0.053
	Age	0.92	0.44	0.12	2.09	0.038
	Relationship	0.69	0.47	0.86	1.46	0.144

a Dependent Variable: Zscore (Distress)

Source: Field data (2023)

Table 11 indicates results on a multiple linear regression analysis conducted to predict psychological distress based on demographic variables (gender, age and relationship status). The table shows that a significant regression equation was found. The model explained 19% of the variance in distress significant portion of the variance (R^2= .19, F (3, 303) =3.81, p = .000). Gender was not a significant predictor of distress (B=-.17, p=.053). Age, was however, a positive predictor of distress (B=.12, p= .038). Conversely, relationship status was not a significant predictor of distress ((B=.09, p=.144).

Hypotheses 3: There is a significant relationship between psychological distress and coping strategies of Ghanaian military peacekeepers in peace support operations.

Research hypotheses three aimed at testing if there was a significant relationship between psychological distress and coping strategies among Ghanaian military peacekeepers in peace support operations. Pearson Product Moment Correlation analysis was conducted to identify any possible

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relationships between the variables, psychological distress and coping strategies. The Pearson correlation coefficient was appropriate for this analysis since both variables are quantitative in nature and normally distributed. Table 12 displays the findings of the analysis.

Table 11: Correlation between psychological distress and coping strategies

		Psychological distress	Coping Strategies
Pearson Correlation	Psychological distress	1.000	.087
	Coping Strategies	.087	1.000
Sig. (2-tailed)	Psychological distress	.	.127
	Coping Strategies	.127	.

**. Correlation is significant at the 0.01 level (2-tailed).

Source: Field Survey (2023)

Table 11 presents the correlation analysis between psychological distress and coping strategies. The correlation analysis revealed that there was no statistically significant relationship between psychological distress and coping strategies, r=.087, p=.127. Hence, no relationship exists between psychological distress and coping strategies.

Further, research hypotheses three aimed at testing if there was a significant relationship between psychological distres (somatization) and coping strategies among Ghanaian military peacekeepers in peace support operations. Spearman rank correlation coefficient was conducted to identify any possible relationships between the variables, psychological distress (somatization) and coping strategies. The Spearman rank correlation

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coefficient was appropriate for this analysis since somatization was ordinal in nature or ranked. Table 13 displays the findings of the analysis.

Table 12: Correlation between psychological distress and coping strategies

		Somatization (Binned)	Coping Strategies
Spearman's rho	Somatization (Binned)	1.000	.198
	Coping Strategies	.198	1.000
Sig. (2-tailed)	Somatization (Binned)	.	.000
	Coping Strategies	.000	.

**. Correlation is significant at the 0.01 level (2-tailed).

Source: Field data (2023)

Table 12 presents the correlation analysis between psychological distress (somatization) and coping strategies. The correlation analysis revealed that there was a statistically significant relationship between somatization and coping strategies, r=.198, p=.000. This represents a weak positive relationship between somatization and coping strategies. This means that as somatization increases, coping strategies also increases and vice-versa.

Discussion on Findings

To allow for a clear delineation of the outcomes, the study's findings have been arranged in this chapter, objective by objective.

Discussion on Descriptive Statistics

The descriptive that are discussed in this section are psychological distress and coping strategies. The variables will be looked at in isolation and then the respective association will be drawn.

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The components of psychological distress as stated in this study comprise depression, anxiety, stress, and somatization. Of the 307 participants, 32.9% experienced severe depression while 16.3% experienced extremely severe depression. For anxiety, 14.3% of the participants experienced severe anxiety while 69.4% experienced severe anxiety. 27.4% of participants experienced severe stress while 3.9 experienced extremely severe anxiety. For somatization, 16.9% of participants experienced severe somatization, while 19.2% experienced extreme severe somatization. These results indicate that there is a clinically significant score of psychological distress among participants.

Psychological Distress among Military Peacekeepers

The high prevalence of psychological distress among Military Peacekeepers observed in this study aligns with the existing body of literature. Previous research on military personnel deployed in high-stress environments, such as peacekeeping missions, consistently reports elevated levels of psychological distress (Adler et al., 2013; Hoge et al., 2004). This is congruent with the central tenets of the Biopsychosocial theory, which underscores the interplay of biological, psychological, and social factors in influencing mental health (Engel, 1977). The biopsychosocial model which is a holistic framework that views psychological distress as the result of complex interactions between biological, psychological, and social factors suggests that understanding and addressing psychological distress require considering multiple dimensions. The biological factors include genetic predispositions, neurological and biochemical processes, and physical health. The psychological factors encompass an individual’s thoughts, emotions, and

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behaviours. The social factors refer to the environment and interpersonal relationships, social support, socioeconomic status, cultural influence etc. the biopsychosocial model emphasizes the dynamic interactions among these three dimensions. For instance, chronic stress from social factors can trigger biological responses (e.g., elevated cortisol levels) that, over time, impact psychological state can influence their social interactions and biological responses.

Ghanaian Military Peacekeepers in peace support operations, confronted with the challenges of combat zones, separation from loved ones, and the trauma of witnessing violence, are subject to a complex web of stressors that can contribute to their psychological distress. In essence, applying the biopsychosocial theory to peacekeeping allows for a more comprehensive understanding of the challenges and well-being of individuals involved in these missions. It underscores the importance of addressing not only physical health and mental health but also the social context in which peacekeepers operate to promote their overall well-being and mission effectiveness.

Coping Strategies Employed by Military Peacekeepers

The coping strategies identified in this study, including problem-focused coping, emotion-focused coping, and maladaptive coping, resonate with the broader literature on coping among military populations. Military personnel often rely on a range of coping strategies to manage the unique stressors they encounter (Lazarus & Folkman, 1984). Adaptive coping strategies, such as problem-focused and emotion-focused coping, are recognized as essential tools for enhancing resilience and well-being (Skinner

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et al., 2003). However, the prevalence of maladaptive coping strategies, as highlighted in this study, underscores a critical area for intervention. Maladaptive coping strategies, such as substance abuse, denial, or avoidance, can exacerbate psychological distress and hinder effective adjustment (Skinner et al., 2003). It is worth knowing that while these coping strategies may provide temporal relief or distraction, they often lead to more significant long-term issues, such as worsening mental health, strained relationships, addictions, and physical health problems. Seeking support from friends, family, or professionals and developing healthier coping strategies is essential for overall well-being.

The high-stress nature of peacekeeping missions already puts soldiers at risk for psychological distress, and maladaptive coping can increase that risk. This finding emphasizes the need for targeted interventions informed by the Transactional Model of Stress and Coping theory, which posits that individuals under high distress may resort to less adaptive coping strategies (Lazarus & Folkman, 1984).

Relationship between Psychological Distress and Coping Strategies

The observed positive weak relationship between psychological distress and somatization as a component of psychological distress supports the tenets of the Transactional Model of Stress and Coping theory. This theory alludes that persons facing high levels of somatization (distress) may employ high adaptive coping strategies to manage overwhelming stressors (Lazarus & Folkman, 1984). The reliance on maladaptive coping mechanisms such as substance abuse, avoidance, escapism, and denial in response to elevated distress levels underscores the importance of early intervention and support

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programs targeting coping skill development. Maladaptive coping mechanisms can have a wide range of negative side effects on an individual's physical, mental, and social well-being. For instance, it often exacerbates mental health issues, such as depression, anxiety, and post-traumatic stress disorder (PTSD). Many maladaptive coping strategies, such as substance abuse, and overeating, can lead to physical health problems like obesity, cardiovascular disease, liver damage, and more. Maladaptive coping behaviours, such as substance abuse, can also lead to addiction, making it difficult for individuals to stop these harmful habits. Other Maladaptive coping mechanisms can lead to social isolations, relationship strain, financial problems, legal issues, decreased work, increased stress, loss of control, and self-harming behaviours.

Interestingly, a lack of a significant relationship between psychological distress and emotion-focused or problem-focused coping strategies merit further exploration. This finding suggests that Military Peacekeepers may not always effectively utilize adaptive coping strategies even when experiencing distress. It is possible that the unique stressors of peacekeeping missions require tailored coping interventions that align more closely with the nature of these missions.

Socio-demographic characteristics as predictors of psychological distress

The results revealed that overall, sociodemographic characteristics indeed play a significant role in predicting psychological distress. Contrary to some expectations, gender, as indicated by males and females, was not found to be a significant predictor of distress. This debunks other literature that opined that women are more likely to suffer psychological distress than men. The finding is however consistent with recent study suggesting that

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psychological distress can affect both male and female military personnel equally (Castro et al., 2006). Gender-neutral interventions and support programs may be appropriate for addressing distress within military populations. Age emerged as a notable predictor of psychological distress. Specifically, being between the ages of 26-33 and 34-41 was associated with higher distress levels. This finding suggests that older military personnel may have developed more effective coping mechanisms over time, or they may be better equipped to handle the stressors of peacekeeping missions. It underscores the importance of considering age-related differences in the design of support programs for younger military personnel (Nash, 2007). Relationship status also did not play a significant role in predicting distress levels. Being single was not a significant predictor, but being married or divorced were both associated with higher distress levels. These findings align with previous research highlighting the unique stressors faced by married and divorced military personnel, particularly related to family responsibilities and separation (De Burgh, 2019). It underscores the importance of providing targeted support and resources for military personnel in different relationship statuses.

Chapter Summary

The penultimate chapter of this thesis presented the findings obtained from the study, covering various aspects. Firstly, the features of the participants' demographics were described, including age, gender, marital status. Correlations among the study variables were then explored, utilizing statistical techniques to identify associations and patterns. The scales utilised in the study's reliability analysis were assessed through reliability analysis,

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ensuring consistent and accurate measurements. The chapter also outlined the various hypotheses tested, derived from the research questions, and supported by theoretical frameworks. The analysis was conducted using SPSS V27 and AMOSv21, enabling a comprehensive examination and interpretation of the data.

The results showed that Ghanaian military peacekeepers experienced psychological distress during peace support operations. The results also found a statistically significant relationship between somatization (psychological distress) and coping strategies among these military peacekeepers.

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CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

The Summary, Findings, and Suggestions are presented in this chapter. The results of the study provided the basis for the conclusions and suggestions. The investigator hopes that all field stakeholders will use the study's results, conclusions, and suggestions to inform practise and guide future policy decisions.

Summary

General Overview of the Study

The present study aimed to investigate psychological distress and coping strategies among Ghanaian Military Peacekeepers in Peace support Operations in line with five primary objectives to:

1. Measure the levels of psychological distress among Ghanaian military peacekeepers in PSOs.
2. Investigate the coping strategies employed by Ghanaian military Peacekeepers in PSOs.
3. Investigate the difference between age groups in coping strategies of Ghanaian military peacekeepers in PSOs.
4. Investigate the relationship between psychological distress and coping strategies of Ghanaian military peacekeepers in PSOs.
5. Discover if sociodemographic characteristics (age, gender and marital status) will predict psychological distress among Ghanaian peacekeepers in PSOs.

It was decided to use the descriptive research design. This is because the design makes it possible to collect data from a broader population, offering

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both descriptive and inferential information on the study's primary variables. With regards to the nature of the study, it was only open to Ghanaian Military Peacekeepers engaged in Peace Support Operations as well as those who had just returned from Peace Support Operations and were still in active duty. Participants ranged in age from 23 to 57. Participants for this study were chosen through purposive sampling. A total of 307 participants were engaged in this study. Questionnaires that included standardised measures were the primary tools for gathering data. Prior to the start of data collection, all protocols, including ethical concerns, were followed. Means and standard deviation were utilised to examine the data. For hypothesis 1, one-way MANOVA was employed, and for hypotheses 2 and 3, standard multiple regression and Pearson product moment correlation as well as Spearman rank correlation coefficient were used respectively.

Key Findings

The study revealed that Ghanaian Military peacekeepers experience clinically significant psychological distress (depression, anxiety, stress, and somatization) while serving in peace support operations. Specifically, between the ages of 26-33 and 34-41 was associated with lower distress levels.

On the type of coping strategies, the study implored that maladaptive coping strategies such as substance abuse, denial and overeating were prevalent among these military peacekeepers, compared to emotion-focused and problem-focused coping strategies.

The results revealed that demographic characteristics indeed play a significant role in predicting psychological distress. Contrary to some expectations, gender, as indicated by males and females and relationship status

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were not found to be significant predictors of distress unlike age which was a significant predictor.

Conclusions

The findings of this thesis showed that the availability and severity of psychological distress is directly related to coping strategies of Ghanaian Military peacekeepers in peace support operations. The psychological distress and coping strategies of Ghanaian peacekeepers are vital aspects of their experiences during Peace Support Operations. These men and women, while serving in challenging and often high-stress environments, face range of psychological stressors that can impact their mental wellbeing. However, their ability to cope with these stressors is essential not only for their personal welfare but also for the success of peacekeeping missions.

Ghanaian military peacekeepers, like their counterparts from around the world, exhibit a remarkable resilience in the face of adversity. They employ a variety of coping strategies, both adaptive and maladaptive, to navigate the unique challenges of their missions. These strategies are shaped by individual difference, cultural factors, and the demand of their roles. Efforts to support Ghanaian Military Peacekeepers in managing psychological distress during peace support operations must be multifaceted. Training and education programs should emphasize the importance of recognizing and addressing mental health concerns. Encouraging the use of adaptive coping mechanisms, such as seeking social support from higher command and peers, engaging in stress-reducing activities such as recreational activities, and practicing mindfulness, can enhance their resilience and overall well-being.

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Furthermore, it is imperative that organizations responsible for deploying and supporting peacekeepers prioritize mental health services. These include providing access to mental health professionals, creating stigma-free environments, and fostering a culture of open communication about mental health challenges. Ghanaian peacekeepers play a vital role in international peacekeeping efforts, and their psychological well-being is not only a matter of individual concern but also a critical factor in the effectiveness of peacekeeping missions. By acknowledging the psychological distress, they may experience and by offering support and resources to enhance their coping strategies, Ghana as well as the broader international community (UN, AU, ECOWAS) can ensure the well-being of these dedicated individuals while continuing to contribute to global peace and security.

Recommendations

The following are the recommendations arising from the findings of the study:

1. Pre-deployment Training and Education: There should be the development and implementation of pre-deployment training programmes that specifically focus on stress management, resilience-building, and mental health awareness by the Military High Command. There should also be the need to incorporate cultural sensitivity training to help the Ghanaian Peacekeeper understand and navigate the cultural nuances of the country/region they serve in.
2. Access to Mental Health Professionals: Military High Command and Organization responsible for Peace Support Operations should ensure that all Ghanaian peacekeeping contingents have access to mental health

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professionals, including psychologists and psychiatrists, who can provide assessments, therapies, counselling, and treatment when needed. There also should be the establishment of a robust telehealth infrastructure to provide ongoing mental health support, particularly in remote or austere deployment locations.

3. Peer Support Programmes: Military High Command should foster a culture of peer support among Ghanaian peacekeepers. Establish peer support programs and encourage open conversation about mental health challenges. Some Peacekeepers should be selected and trained as peer support volunteers who can provide immediate assistance and referrals to mental health professionals.
4. Adaptive Coping strategies: There should be the integration of training on adaptive coping strategies, such as mindfulness, relaxation techniques, and problem-solving skills, into the standard curriculum of peacekeepers by the Military High Command. The use of stress-reduction activities like physical exercise, art therapy, and journaling should be encouraged.
5. Psychological screening: There also should be the implementation of psychological screenings for Ghanaian peacekeepers before, during, and after deployments to identify potential mental health concerns early by the Military High Command and The United Nations. The screening data should be used to tailor interventions and support services effectively.
6. Research and Data Collection. There should be the need to encourage research on the mental health of Ghanaian peacekeepers to better

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understand the unique stressors they face and the effectiveness of interventions by the Military High Command. Data on coping strategies and psychological outcomes should be collected to continually refine support programs.

Suggestions for Further Studies

This research has improved comprehension of understanding psychological and coping strategies of Ghanaian military peacekeepers in peace support operations. However, it is suggested that;

1. Longitudinal studies that follow Ghanaian peacekeepers over an extended period, tracking changes in their psychological distress levels, coping strategies, and mental health outcomes before, during, and after deployments may be studied. This can help identify trends and factors contributing to their mental well-being over time.
2. Alternatively, comparative studies that may compare the experiences of Ghanaian peacekeepers to those from other countries serving in similar peace support operations may be studied in future research. The need to investigate whether cultural, organizational, or other factors influence their psychological distress and coping mechanisms may be helpful.
3. Lastly, an appraisal of the efficacy of mental health and coping interventions tailored at the needs of Ghanaian peacekeepers may be essential in future studies. Assessing which strategies, such as training programs or peer support in initiatives, may yield the most significant improvements in psychological well-being.

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APPENDICES

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APPENDIX A

UNIVERSITY OF CAPE COAST

DEPARTMENT OF EDUCATION AND PSYCHOLOGY

MEASURING TOOLS

PSYCHOLOGICAL DISTRESS (DASS 21)

Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you **over the past week**. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

0 Did not apply to me at all.

1 Applied to me to some degree, or some of the time.

2 Applied to me to a considerable degree or a good part of time.

3 Applied to me very much or most of the time.

SER	STATEMENTS	0	1	2	3
1(s)	I found it hard to calm down				
2 (a)	I was aware that my mouth felt dry				
3 (d)	I couldn't seem to experience any positive feeling at all				
4 (a)	I experienced breathing difficulty (e.g. excessively rapid breathing, breathlessness in the absence of physical exertion)				
5 (d)	I found it difficult to take the initiative to do things on my own				
6 (s)	I tended to over-react to situations than I normally would do				
7 (a)	I experienced trembling (e.g. shaking in the hands or body)				
8 (s)	I felt that I was using a lot of nervous energy due to pressure				
9 (a)	I was worried about situations in which I might panic (lose control) and make a fool of myself (look foolish)				
10 (d)	I felt that I had nothing to look forward to (to hope for)				
11 (s)	I found myself getting tensed or worried				
12 (s)	I found it difficult to relax				
13 (d)	I felt sad and depressed (lose interest in even usual things)				
14 (s)	I could not tolerate anything that interfered with what I was doing				

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15 (a)	I felt I was close to panic (fear/lose control)				
16 (d)	I was unable to become enthusiastic (happy/excited) about anything				
17 (d)	I felt I was not worth much as a person (I felt I was not much useful as a person)				
18 (s)	I felt that I was rather easily offended				
19 (a)	I was aware of the action of my heart in the absence of physical exertion (e.g., sense of heart rate increase, heart missing a beat)				
20 (a)	I felt scared (afraid) without any good reason				
21 (d)	I felt that life was meaningless (pointless)				

Brief COPE Inventory

These items seek to find out on how you've been managing your stress or your general health during the previous few months.

Pick the suitable answer that applies to you	I haven't been doing this at all (1)	I’ve been doing this a little bit (2)	I've been doing this a medium amount (3)	I've been doing this a lot (4)
1. I’ve been turning to work or other activities to take my mind off things				
2. I’ve been concentrating my efforts on doing something about the situation I’m in				
3. I’ve been saying to myself "this isn't real."				
4. I’ve been using alcohol or other drugs to make myself feel better				
5. I’ve been getting emotional support from others				
6. I’ve been giving up trying to deal with it.				
7. I’ve been taking action to try to make the situation better.				
8. I’ve been refusing to believe that it has happened.				
9. I’ve been saying things to let my unpleasant feelings escape.				
10. I've been getting help and advice from other people.				
11. I've been using alcohol or other drugs to help me get through it.				
12. I’ve been trying to see it in a				

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different light, to make it seem more positive.				
13. I've been criticizing myself				
14. I've been trying to come up with a strategy about what to do.				
15. I've been getting comfort and understanding from someone.				
16. I've been giving up the attempt to cope				
17. I've been looking for something good in what is happening				
18. I've been making jokes about it				
19. I've been doing something to think about it less, such as going to movies, watching TV, reading, daydreaming, sleeping, or shopping.				
20. I've been accepting the reality of the fact that it has happened.				
21. I've been expressing my negative feelings.				
22. I've been trying to find comfort in my religion or spiritual beliefs.				
23. I've been trying to get advice or help from other people about what to do.				
24. I've been learning to live with it.				
25. I've been thinking hard about what steps to take				
26. I've been blaming myself for things that happened.				
27. I've been praying or meditating.				
28. I've been making fun of the situation.				

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Brief Symptom Inventory (BSI)
"Here I have a list of problems people sometimes have. As I read each one to you, I want you to tell
me HOW MUCH THAT PROBLEM HAS DISTRESSED OR BOTHERED YOU DURING THE PAST 7
DAYS INCLUDING TODAY. These are the answers I want you to use. *[Hand card and read answers.]* Do you have any questions?"

0 = Not at all
1 = A little bit
2 = Moderately
3 = Quite a bit
4 = Extremely

DURING THE PAST 7 DAYS, how much were you distressed by:

1.	Nervousness or shakiness inside	0	1	2	3	4
2.	Faintness or dizziness	0	1	2	3	4
3.	The idea that someone else can control your thoughts	0	1	2	3	4
4.	Feeling others are to blame for most of your troubles	0	1	2	3	4
5.	Trouble remembering things	0	1	2	3	4
6.	Feeling easily annoyed or irritated	0	1	2	3	4
7.	Pains in the heart or chest	0	1	2	3	4
8.	Feeling afraid in open spaces	0	1	2	3	4
9.	9. Thoughts of ending your life	0	1	2	3	4

DURING THE PAST 7 DAYS, how much were you distressed by:

10.	Feeling that most people cannot be trusted	0	1	2	3	4
11.	Poor appetite	0	1	2	3	4
12.	Suddenly scared for no reason	0	1	2	3	4
13.	Temper outbursts that you could not control	0	1	2	3	4
14.	Feeling lonely even when you are with people	0	1	2	3	4
15.	Feeling blocked in getting things done	0	1	2	3	4
16.	Feeling lonely	0	1	2	3	4
17.	Feeling blue	0	1	2	3	4
18.	Feeling no interest in things.	0	1	2	3	4

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0	= Not at all
1	= A little bit
2	= Moderately
3	= Quite a bit
4	= Extremely

DURING THE PAST 7 DAYS, how much were you distressed by:						
19. Feeling fearful	0	1	2	3	4	
20. Your feelings are easily hurt	0	1	2	3	4	
21. Feeling that people are unfriendly or dislike you	0	1	2	3	4	
22. Feeling inferior to others	0	1	2	3	4	
23. Nausea or upset stomach	0	1	2	3	4	
24. Feeling that you are watched or talked about by others	0	1	2	3	4	
25. Trouble falling asleep	0	1	2	3	4	
26. Having to check and double-check what you do	0	1	2	3	4	
27. Difficulty making decisions DURING THE PAST 7 DAYS, how much were you distressed by:	0	1	2	3	4	
28. Feeling afraid to travel on buses, subways, or trains	0	1	2	3	4	
29. Trouble getting your breath	0	1	2	3	4	
30. Hot or cold speels. **31.** Having to avoid certain things, places, or activities because	0	1	2	3	4	
they frighten you	0	1	2	3	4	
32. Your mind going blank	0	1	2	3	4	
33. Numbness or tingling in parts of your body	0	1	2	3	4	
34. The idea that you should be punished for your sins	0	1	2	3	4	
35. Feeling hopeless about the future	0	1	2	3	4	
36. Trouble concentrating	0	1	2	3	4	

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0 = Not at all
1 = A little bit
2 = Moderately
3 = Quite a bit
4 = Extremely

DURING THE PAST 7 DAYS, how much were you distressed by:					
37. Feeling weak in parts of your body	0	1	2	3	4
38. Feeling tense or keyed up	0	1	2	3	4
39. Thoughts of death or dying	0	1	2	3	4
40. Having urges to beat, injure, or harm someone	0	1	2	3	4
41. Having urges to break or smash things	0	1	2	3	4
42. Feeling very self-conscious with others	0	1	2	3	4
43. Feeling uneasy in crowds	0	1	2	3	4
44. Never feeling close to another person	0	1	2	3	4
45. Spells of terror or panic	0	1	2	3	4
DURING THE PAST 7 DAYS, how much were you distressed by:					
46. Getting into frequent arguments	0	1	2	3	4
47. Feeling nervous when you are left alone	0	1	2	3	4
48. Others not giving you proper credit for your achievements	0	1	2	3	4
49. Feeling so restless you couldn't sit still	0	1	2	3	4
50. Feelings of worthlessness	0	1	2	3	4
51. Feeling that people will take advantage of you if you let them	0	1	2	3	4
52. Feeling of guilt	0	1	2	3	4
53. The idea that something is wrong with your mind	0	1	2	3	4

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APPENDIX B

UNIVERSITY OF CAPE COAST

DEPARTMENT OF EDUCATION AND PSYCHOLOGY

INFORMED CONSENT FORM

Title: Psychological Distress and Coping Strategies of Ghanaian Military Peacekeepers in Peace Support Operations.

Principal Investigator: Peter Owusu-Darkwah

Address: Department of Education and psychology, College of Education Studies.

General Information Concerning Research

The primary goal of this investigation is to gain understanding of the psychological suffering Ghanaian Military Peacekeepers experience during Peace Support Operations and their coping strategies. The study will include Peacekeepers serving in the various Peacekeeping theatres and those who have returned either on leave or have permanently been rotated in the last two weeks. The DASS 21 Scale, Brief COPE (PTLDS) (Carver, 1997), and the Brief Symptom Inventory (BSI) would be employed to assess the levels psychological distress and the types of coping mechanisms Military Peacekeepers engage in. In order to learn more about the level of your wellbeing following Peace Support Operations, you are chosen as a potential participant in this study. This will help the Military High Command know the psychological distress personnel encounter during PSO, their coping mechanisms, and possible help in their managing aftermath.

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Study Procedures

I will begin by asking you to join the study. If you agree to take part in this study, you will have to fill out various questionnaires under the supervision of my research assistants and me. For participants who might not be able to converse in English, translations of the questions into their native tongues will also be made available.

Risks Involved

The discomforts, injuries, or threats to you during involvement are no higher than those you encounter in regular contact with other people. None of the inquiries are intended to be upsetting. Due to individual variations, it is extremely regrettable if there are times when you feel uneasy, humiliated, or inconvenienced, and you are free to leave the interview.

Benefits of Participation

Your participation in this research study won't directly benefit you in any way. Your involvement in this study is expected to have a positive impact on Ghanaian military personnel generally, especially those who engage in peace support missions. When dealing with soldiers who go on PSOs, the Military High Command will be better able to make educated judgements about their mental health.

Confidentiality

The results of this study's records will be kept secret as required by law. In any reports or publications deriving from the study, no specific names will be used. Each questionnaire will be assigned a code and stored separately from any participant names or other forms of direct identification. Only on this permission form will your initials be visible. Research data will always be stored in locked folders. The files will only be accessible to researchers, and no one else will be able to view the data without your permission.

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Voluntary Involvement and Right to Exit the Research

Participation in this study is entirely up to you. You have the option to abstain completely. If you decide to take part in the study, you are free to change your mind at any moment and stop taking part without suffering any consequences. You won't incur any fees or lose any advantages you might have otherwise received if you leave the study.

Withdrawal of Participation by Researcher

If the researcher thinks that your involvement in completing the study survey has disturbed you in some manner, he or she may decide to drop you from the study.

Contact Information for Further Information

Please get in touch if you have any inquiries concerning the study with Mr Peter Owusu-Darkwah (024-833-5349). Though your legal rights would be upheld, and privileges entitled to study participants, kindly feel free to contact the supervisor of this study should there be any violations or perpetrations to the contrary.

Prof Mark Kwaku Owusu Amponsah

Email: mamponsah@ucc.edu.gh, mclaureen2014@gmai.com

Contact no: +233 205 055 973/ +233 242 524 710

CONSENT

I have read and comprehend the justification given to me. After receiving satisfactory answers to all of my inquiries, I willingly decide to take part in this study. A copy of this permission form has been sent to me. I have read the above material and have decided to participate in the study, and by signing below, I certify that I have done so and that I have understood the information on this form.

Signature ______________________________ Date _______________

Research Participant

Signature ______________________________ Date _______________

Interviewer

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APPENDIX D

INTRODUCTORY LETTER

UNIVERSITY OF CAPE COAST
COLLEGE OF EDUCATION STUDIES
FACULTY OF EDUCATIONAL FOUNDATIONS
DEPARTMENT OF EDUCATION AND PSYCHOLOGY

Telephone: 03320-91697
Email: dep@ucc.edu.gh

UNIVERSITY POST OFFICE
CAPE COAST, GHANA

19th April, 2023

Our Ref:

Your Ref:

The Director
Public Relations Officer
Ghana Armed Forces
Accra

Dear Sir/Madam,

THESIS WORK
LETTER OF INTRODUCTION
MR. PETER OWUSU-DARKWAH

We introduce to you Mr. Peter Owusu Darkwah, a student from the University of Cape Coast, Department of Education and Psychology. He is pursuing a Master of Philosophy degree in Clinical Health Psychology, and he is currently at the thesis stage.

Mr. Darkwah is researching on the topic: **"PSCHOLOGICAL DISTRESS AND COPING STRATEGIES AMONG GHANAIAN MILITARY PEACE KEEPERS IN PEACE SUPPORT OPERATIONS."**

He has opted to collect or gather data at your institution/establishment for his thesis work. We would be most grateful if you could provide him the opportunity and assistance for the study. Any information provided would be treated strictly as confidential.

We sincerely appreciate your co-operation and assistance in this direction.

Thank you.

Yours faithfully,

Prof. Mark O. Amponsah
HEAD

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APPENDIX E

APPROVAL FROM GHQ (PA), GHANA ARMED FORCES

RESTRICTED

Personnel Administration
General Headquarters
Ghana Armed Forces
BURMA CAMP

Accra 776474

GHQ/6363/PS1

23 June 23

Head
Faculty of Educational Foundations
College of Education Studies
University of Cape Coast
Cape Coast

REQUEST TO CONDUCT ACADEMIC RESEARCH
MR OWUSU-DANKWAH PETER

I refer to your letter dated 19 April 2023 requesting for authority for Mr Owusu-Dankwah Peter to conduct academic research with the Ghana Armed Forces on the topic ***"Psychological Distress and Coping Strategies among Ghanaian Military Peacekeepers in Peace Support Operations"***. I am directed to convey the approval of Ghana Armed Forces for him to conduct the research.

I am to request that he contact the units relevant for his required information and should be guided by military regulations which spell out information or materials whose unauthorized disclosure could be detrimental to the interest of the Ghana Armed Forces and the nation as a whole. Furthermore, I am to request that a copy of his completed research work be forwarded to this Department for retention.

Respectfully submitted, please.

MK ASUKA
Colonel
for Director General Human Resources

RESTRICTED

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