Irish Journal of Psychological Medicine (2015), **32**, 205–208.
doi:10.1017/ipm.2014.56

ORIGINAL RESEARCH

Occupational stress and UN peacekeepers

J. Tobin*

Bloomfield Hospital, Rathfarnham, Dublin, Ireland

Background. Ireland has been actively involved in peacekeeping operations since the 1950s. The unique psychological stressors associated with this form of military activity have been under-recognised and under-researched.

Aim. The aim of this paper is to bring to the attention of mental health professionals, who have been caring for military and retired military peacekeeping personnel, the unique difficulties associated with peacekeeping and how they can impact upon the mental health of the peacekeeper.

Methods. The nature of peacekeeping is outlined. There is a short review of the limited literature on the mental health effects of this kind of military deployment. There is also an outline of the positive outcomes for the majority of those who have served as peacekeepers.

Results. Both the negative and the positive mental health outcomes depend on the particular mission. Each mission is different and the nature of a mission also changes over time. Post-traumatic stress disorder rates can vary from 3% to 15% of a peacekeeping cohort, depending upon the nature of the violence associated with the mission. The vast majority of peacekeepers have found their peacekeeping deployments as an enriching experience.

Conclusion. Peacekeepers are often witnesses as well as the victims of traumatic events. The restrictions placed upon their military role by the mission mandate can be a source of stress for them. Their mental health needs to be supported during the mission and after they have returned home.

Received 20 October 2013; Revised 05 August 2013; Accepted 16 September 2014; First published online 17 October 2014

Key words: Mandate, mission ambiguity, multiple missions, positive outcomes, powerlessness, PTSD, unique stressors.

Introduction

Since 1958, Irish soldiers have been involved in military deployment with the UN in many different parts of the world. They can have served as part of a battalion, a company or with a small group of colleagues. Most of the missions have been under Chapter 6 of the UN charter. This has been construed to be for peacekeeping. They have also served under Chapter 7, which is peace enforcement, such as the mission to East Timor in 2000. The ultimate aim is peace building and to prevent the resurgence of conflict, as well as to create the conditions necessary for sustainable peace in war-torn societies and to forward the process of democratisation.

As with all UN missions, they are restricted in the kind of actions and reactions they can perform by the mandate that set up the mission. Mandates are developed by the UN Security Council, and like all fractious committees, they develop a document that satisfies no one. Each mission is different from other missions, and the mission itself can vary a lot over time. UN interventions are supposed to occur when a conflict has moved into the post-conflict phase. On arrival in the allegedly post-conflict zone, the UN soldiers can find themselves sitting in the middle of an active conflict, despised by the various parties of the conflict and in some cases by the civilian population that the UN mission is mandated to protect. Soldiers that are trained to fight can be placed in a role where they are severely restricted in the retaliatory or defensive actions they can take. They are not under the command of the national government, but of the Secretary General of the UN and the Department of Peacekeeping Operations. As a result, the decisions in how they can operate are under the influence of bureaucrats as well as the Force Commander. Command structures are frequently confused as peacekeeping contingents often consist of representatives of different countries. As a result there is often little military interoperability. It is not unusual to find Irish soldiers asking what they are doing in this God-forsaken place and they can view their mission as futile. This can result in difficulties with frustration and anger.

Psychiatric problems occurring in peacekeepers have been recognised for a long time. In 1979, the Norwegians described 'Peacekeeper's stress syndrome' (Weisath, 1979). It is defined as rage, disillusion, frustration, feeling of impotence and helplessness, when confronted with violence and atrocities to which the peacekeeper is unable to respond. A variety of other psychiatric conditions have been noted such as: acute stress disorder, post-traumatic stress disorder (PTSD), conversion disorder/somatisation

* Address for correspondence: Dr J. Tobin, Bloomfield Hospital, Stocking Lane, Rathfarnham, Dublin 16, Ireland.
(Email: tobinjp3@gmail.com)

disorder, depression, alcoholism, drug abuse and survivor's guilt syndrome (Pearn, 2000). As has been noted in multiple studies, there is a dose–response correlation between exposure to traumatic events and subsequent sequelae.

There are five elements that have been identified as causes of psychological stress in peacekeepers deployed in peacekeeping operation:

1. *Isolation*. Being away from home. Limited communication. Feelings of being forgotten. There can be a loss of a sense of perspective about what is happening at home. Many erratic behavioural episodes are secondary to misperceptions of infidelities, family crises and being forgotten by friends, lovers and family.
2. *Ambiguity*. Ambiguity about the mission and its purpose. There are often ambiguous rules of engagement, poorly identified enemies and a feeling that the mission is meaningless.
3. *Powerlessness*. Lack of ability to influence the situation. Inability to protect the civilian population. Witnessing death, ethnic cleansing and atrocities. Being ordered not to intervene. This is exacerbated when the peacekeeper has formed personal relationship with the victims. The use of weapons has to be kept to an absolute minimum.
4. *Danger*. Attacks by local, regular and irregular formations. Limited availability of effective weaponry. Restraints on hitting back by engaging in active planned combat as opposed to reactive combat. Is peacekeeping a legitimate occupation for trained soldiers? It has more of a semblance of a policing action. Soldiers are trained psychologically to attack and defeat an enemy.
5. *Boredom*. Remaining in isolated posts. Lack of opportunity to demonstrate professional military abilities (Shigemura & Nomura, 2002).

To this list I would add humiliation. Soldiers who are trained to fight can be ridiculed for their lack of activity owing to the restrictions of the UN mandate by the local military formations and the civilian population. Often, the peacekeepers are placed in the mission area by the major world powers in order to be seen to have done something. Yet, they are denied the military and the political means to alter the situation. This can lead to a feeling of humiliation by the individual soldier and anger at the authorities for putting them in the situation. The traditional soldier expects war, but is forced into a passive role for which he or she is totally unsuited.

Non-recognition of their work and its associated dangers

There is a tendency to treat soldiers returning from peacekeeping missions as if they had been on a sunshine holiday. This can be a cause of anger and estrangement from their home community. This is aggravated by the rapid rate of modern travel and the failure of not providing peacekeepers with downtime or decompression, as is normally provided for combat troops being rotated home from areas of conflict such as Iraq or Afghanistan. Consequently, the opportunity to put their deployment experiences in perspective and obtain closure before facing home and family is lacking. Aggravating this is a failure of society to take note, record or provide news coverage for the dangers that their military are enduring in conflict and post-conflict zones. The only time that home news coverage appears to occur is when it is providing a photo opportunity for a government minister or other notables.

Scanlon in a 1996 lecture termed the phrase 'post-deployment stress syndrome' to account for the variety of symptoms that soldiers experience after operational deployment. These symptoms include physical, emotional, cognitive and behavioural components, which can persist for several months. My observation is that it takes about 3 months to lower the heightened state of emotional arousal that developed while serving overseas. In common with troops whose mission involves planned combat, peacekeepers have tended to utilise alcohol and illicit drugs to induce sleep and to help calm their level of arousal. Illicit drugs are usually freely available in conflict and post-conflict zones.

PTSD

A study of American peacekeepers in Somalia demonstrated that 8% of 3461 soldiers studied 5 months after deployment met the criteria for PTSD. There was no difference between the sexes (men = 7.9%; women = 8.8%). They also noted the protective effect of unit cohesion and good unit morale (Litz *et al*. 1997). Studies of PTSD among soldiers serving in combat missions in Iraq and Afghanistan have demonstrated a higher incidence of PTSD among female soldiers.

A Canadian study demonstrated a 15% incidence of PTSD during the peacekeeping operations in the former Yugoslavia in 1992–1993 (Passey & Crockett, 1995). This can be compared with the 15.2% of Vietnam War veterans (Everly, 1995). Overall, those missions in which there exists an identifiable peace tend to demonstrate the lowest rates of PTSD of around about 3%, and the more dangerous missions, especially those that are related to Chapter 7 enforcement, have a higher rate of PTSD of about 15%.

A Norwegian study of 16 000 former UNIFIL peacekeepers (Weisath *et al*. 1996) noted that the level of PTSD was higher among the 3.3% of soldiers that were repatriated for medical, social or disciplinary reasons. They noted that aggravating factors were lack of

https://doi.org/10.1017/ipm.2014.56 Published online by Cambridge University Press

military structure, working with multi-national teams, inappropriate military rank compared with the age of the soldier, investigating civilian casualties and being fired upon when unarmed. When the same investigators examined Norwegian UNIFIL peacekeepers in 2002, 6.6 years after deployment, the prevalence of PTSD was 5% (Mehlum & Weisaeth, 2002).

A Dutch study in 2005 noted that the PTSD prevalence among 3481 peacekeepers investigated 6 years after the mission, depended upon education level, marital status, previous exposure to war trauma, ethnicity, pre-existing psychological conditions, one's sense of locus of control and a feeling that the mission was without purpose and meaningless (Dirkzwager *et al*. 2005). However, they also recorded that 82% considered that the mission broadened their understanding of life and 52% believed that the mission resulted in an increase in their self-confidence.

A New Zealand study demonstrated that those at greater risk are the younger, the immature and those from dysfunctional family backgrounds. Yet, only 1% of their sample developed PTSD (McDonald *et al*. 1996).

A Canadian study of 473 UN peacekeepers demonstrated that those with PTSD and depression had a higher level of physical health-care requirements than those who suffer from PTSD or depression alone. This was despite being of a younger age group (Stapleton *et al*. 2006). This should come as no surprise as both PTSD and depression are associated with an increase in psychosomatic symptoms, so that a person demonstrating symptoms of both conditions would be more likely to have physical health concerns.

Other psychological sequelae

In all, 20% of Australian veterans of the UN peacekeeping force in Somalia had problems with anger control 15 months following their return home (Ward, 1997). One-third of American soldiers, who served in Somalia, met criteria for psychiatric caseness. The most common symptoms were depression, hostility, paranoid ideation and psychosis (Orsillo *et al*. 1996). In all, 29% of Canadian peacekeeping veterans had a depressive disorder 1–9 years after deployment (Richardson *et al*. 2006).

A study of Norwegian peacekeepers, who participated in missions from 1978 to 1995, had a standardised mortality rate of 1.4 for suicide when compared with the civilian population. There was a significant increase for suicide utilising firearms and carbon monoxide poisoning. It was more marked for those who were not in a stable relationship (Thoresen *et al*. 2003). A Finnish study of former peacekeepers demonstrated an increased risk of suicide among soldiers who were prematurely repatriated from the mission area (Ponteva *et al*. 2000). This may be influenced by the selection of personnel who were unsuited to the mission in the first place.

Multiple missions

I have observed that those who have served in multiple peacekeeping missions, especially veterans of UNIFIL missions, is that they can suddenly decompensate secondary to a small stressor that normally would not have been an upsetting event for them. They become very embarrassed by how they react. Symptoms of anxiety and depression are frequently evident. They are frequently tearful. I view such cases as secondary to multiple traumas, many, if not all, they took in their stride. However, a point is reached in which the soldier is unable to cognitively absorb another trauma, and the catastrophic reaction observed is really the result of the repeated exposure to previous stressful events. In 1995, the UN Peacekeeping Operations/Training Unit (United Nations, 1995) described a similar phenomenon. They noted that arising from the cumulative effect of occupational strain there could arise what they called 'flame out' that can lead to exhaustion and burn out.

Positive outcomes

Overall, deployment on peacekeeping missions has positive outcomes for those who partake in such experiences. Three consistent domains of positive changes have been recorded:

1. Improved self-concept. That is the perception of oneself as a stronger person, more mature and a more competent person.
2. Improved ability to form relationships within a social network.
3. A perception of personal growth and improved life priorities (Updegraff & Taylor, 2000).

The majority of Norwegian soldiers serving with UNIFIL in the Lebanon reported that their deployment experience had increased their self-confidence, expanded their political understanding, increased their stress tolerance and improved their military abilities (Mehlum, 1995). Similar results were found in a Danish study of UN peacekeepers. Increase in self-confidence was noted again, as well as an increased ability to manage stress in general (Bache & Hommelgaard, 1994). An examination of peacekeepers following deployment to Bosnia demonstrated that soldiers who identified more closely with the role of peacekeeper and who believed in the value of their mission were more likely to report perceived benefits from their role as peacekeepers and were less likely to report adverse psychological consequences (Britt *et al*. 2001). A Dutch study of 1046 peacekeepers

https://doi.org/10.1017/ipm.2014.56 Published online by Cambridge University Press

concluded that 10–25 years post-deployment, there was no more psychological distress than the Dutch population (Klaasens *et al*. 2008).

Conclusion

Psychological casualties arising from peacekeeping and peace enforcement missions do not compare to those soldiers who are involved in active combat. However, it is important to recognise that soldiers reporting from these missions may have been in a situation of escalating conflict either as witnesses or as active participants. Peacekeepers may have experienced a wide range of traumatic events and they are placed into an uncomfortable role, which has its own unique stressors. O'Brien made the observation that the presentation rate of psychiatric difficulties during war is quite low and that many soldiers develop difficulties after their service period is over. Owing to this phenomenon, estimating the actual rate of PTSD post-deployment should allow for delayed onset (O'Brien, 1994).

Peacekeeping and peace enforcement missions should include provisions for secondary intervention for those at risk, both in the mission area and at home.

Acknowledgement

I wish to thank Dr Ann Coughlan for her encouragement with this paper.

References

Bache M, Hommelgaard B (1994). *Danish UN Soldiers: Experience and Stress Reactions*. Defence Centre for Leadership: Copenhagen.

Britt TW, Adler AB, Bartone PT (2001). Deriving benefits from stressful events: the role of engagement in meaningful work and hardiness. *Journal of Occupational Health Psychology* **6**, 53–63.

Dirkzwager AJ, Bramsen I, van der Ploeg HM (2005). Factors associated with post traumatic stress among peacekeeping soldiers. *Anxiety, Stress and Coping* **18**, 37–51.

Everly GS (1995). Psychotraumatology. In *Psychotraumatology: Key Papers and Core Concepts in Post Traumatic Stress* (ed. G. S. Everly and J. M. Lating), pp. 3–8. Plenum Press: New York, NY.

Klaasens ER, van Veen T, Weerts JM, Zitman FG (2008). Mental health of Dutch peacekeeping veterans 10-25 years after deployment. *European Psychiatry* **23**, 486–490.

Litz BT, Orsillo SM, Friedman M, Ehrlich P, Batres A (1997). Post traumatic stress disorder associated with peacekeeping duty in Somalia for US military personnel. *American Journal of Psychiatry* **154**, 178–184.

McDonald C, Chamberlain K, Long N, Mirfin K (1996). *Psychological Effects of Peacekeeping Deployments on Military Personnel*. Massey University: Palmerston North, NZ, 77pp.

Mehlum L (1995). Positive and negative consequences of serving in a UN peacekeeping mission: a follow-up study. *International Review of Armed Forces Medical Services* **68**, 289–295.

Mehlum L, Weisaeth L (2002). Predictors of post traumatic stress reactions in Norwegian UN peacekeepers 7 years after service. *Journal of Traumatic Stress* **15**, 17–26.

O'Brien LS (1994). What will be the psychiatric consequences of the war in Bosnia? A bad war from the psychiatric point of view, leading to hidden pathology. *British Journal of Psychiatry* **164**, 443–447.

Orsillo SM, Weathers FW, Litz BT, Steinberg HR, Huska JA, Keane TM (1996). Current and lifetime psychiatric disorders among war zone related post traumatic stress disorder. *Journal of Nervous and Mental Disease* **184**, 307–313.

Passey DG, Crockett DJ (1995). *Psychological consequences of exposure to UN peacekeeping duties in the former Yugoslavia, Report of the Surgeon General*. National Defense: Ottawa, Canada.

Pearn J (2000). Traumatic stress disorders: a classification with implications for prevention and management. *Military Medicine* **165**, 434–440.

Ponteva M, Jormanainen V, Nurro S, Lehesjoki M (2000). Mortality after the UN service: follow-up study of the Finnish peacekeeping contingents in the years 1969-1996. *International Review of the Armed Forces Medical Services* **73**, 235–239.

Richardson JD, Elhai JD, Pedlar DJ (2006). Association of PTSD and depression with medical and specialist care utilization in modern peacekeeping veterans in Canada with health related disabilities. *Journal of Clinical Psychiatry* **67**, 1240–1245.

Shigemura J, Nomura S (2002). Mental health issues of peacekeeping workers. *Psychiatry and Clinical Neurosciences* **56**, 483–491.

Stapleton JA, Asmundson GJ, Woods M, Taylor S, Stein M (2006). Health care utilization by United Nations peacekeeping veterans with co-occurring self-reported, post traumatic stress disorder and depression symptoms versus those without. *Military Medicine* **6**, 562–566.

Thoresen S, Mehlum L, Moller B (2003). Suicide in peacekeepers: a cohort study of mortality from suicide in 22,275 Norwegian veterans from international peacekeeping operations. *Social Psychiatry Psychiatric Epidemiology* **38**, 605–610.

United Nations (1995). *Tips for Trainers: Stress Management for United States Peacekeepers*. DPKO/Training Unit: New York, NY, 37pp.

Updegraff JA, Taylor SE (2000). From vulnerability to growth: positive and negative effects of stressful life events. In *Loss and Trauma: General and Close Relationship Perspectives* (ed. J. H. Harvey and E. Miller), pp. 3–28. Brunner-Routledge: Philadelphia, PA.

Ward W (1997). Psychiatric morbidity in Australian veterans of the United Nations peacekeeping force in Somalia. *Australian & New Zealand Journal of Psychiatry* **31**, 184–193.

Weisath L (1979). *Psychiatric Disease and Stress Among UN Soldiers in South Lebanon (UNIFIL)*. Forsuarets Saniet: Oslo.

Weisath L, Mehlum L, Mortensen M (1996). Peacekeeper stress: new and different? *National Centre for PTSD Clinical Quarterly* **6**, 1.