

# NEW VOICES IN PUBLIC POLICY

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## Mental Health Stresses and Services for Military Peacekeepers

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## ***Introduction***

Peacekeeping operations are a fairly new field in the modern world, especially when compared to the thousands of years of war humans have perpetrated and suffered. In 1968, Will and Ariel Durant noted that “in the 3,421 years of recorded history, the world has only known peace during 268 of them.”<sup>1</sup> The current state of the world does not make it likely for the number of years of peace to ever increase.

Since the field is still in its infancy, very little research has been done to study the strains placed on military peacekeepers while working under hostile conditions. When beginning to study peacekeeping missions and their demands on the peacekeepers involved, it is important to note that “each operation is unique; the degree of difficulty, length, scale, outcome and local opposition are just some factors that characterize a specific mission.”<sup>2</sup> Indeed, some missions can be completed quickly with few casualties while others seem interminable.

The complexity of missions and the threats to peacekeepers are compounded in a post-Westphalian world in which most conflicts are intrastate in nature. At this time, peacekeepers must enter areas where peace may be tenuous or where violence is still ongoing. Lamerson and Kelloway write “whereas peacekeeping operations have always contained the potential for danger, recent deployments [under what may be unstable conditions,] “virtually guarantee that peacekeepers will come under fire from belligerents.”<sup>3</sup> In fact, 1,219 individuals have been killed while servicing peacekeeping operations for the United Nations.<sup>4</sup>

With the danger involved and the need for advance training to handle intricate operations, most missions must be undertaken by soldiers from various global armed forces. However, at this time little information has been gathered on the effects felt by the men and women who

serve in such a capacity. The focus of this research will be on military peacekeepers, and will seek to explore the common stresses in peacekeeping operations, the reactions or conditions that result from such stresses, and the mental health services provided to peacekeepers in the armed services.

### ***Stresses in peacekeeping operations***

A variety of stresses can understandably be found in all phases of peacekeeping operations, whether during pre-deployment, deployment, or post-deployment. The weeks or months of training in the pre-deployment phase often coincide with increased levels of anxiety and psychological distress.<sup>5</sup> The most common stressors before deployment include “preparation in terms of training, taking care of personal business, and anticipation of the deployment.”<sup>6</sup>

Deployment stresses are plentiful and wide-ranging. Although most soldiers will cope well with the demands of their role as a peacekeeper, there are times when the pressure can become overwhelming. Work-related problems may include role conflict, ambiguity of mission, and lack of recognition for duties performed.<sup>7</sup> Stressors in the environment may include separation from home, poor living conditions, and safety threats.<sup>8</sup>

Role conflict is one of the hardest issues for a soldier to address. Dag Hammarskjöld, the second Secretary General of the UN, noted in a well-known comment that “peacekeeping is not a soldier’s job, but only a soldier can do it.”<sup>9</sup> This sentiment embodies the specific dilemma that “[a]lthough service members are perceived to have the only set of unique skills that can enable successful performance on peacekeeping missions, peacekeeping operations do not fully fall under the purview of what should be expected from service members.”<sup>10</sup> If a soldier’s usual job

specialty is not well-matched for their role as a peacekeeper, the soldier may feel ineffective, that their work is insignificant, and the mission is meaningless.

Role conflict can be further complicated when the rules of engagement are limited. Often, military peacekeepers will “experience a conflict between a stated mission (i.e., the provision of humanitarian assistance) and the fundamental need to defend one's life.”<sup>11</sup> Even though these men and women are trained for combat, mission “directives may explicitly prohibit the trained response to return fire when attacked.”<sup>12</sup> The fact that they are often attacked by the same people to whom they are offering assistance makes the situation worse.<sup>13</sup>

In some cases, peacekeeping operations can look almost like war, however, “unlike war, they lack a focal enemy and, oftentimes absent clearly defined mission objectives, are typically conducted in an environment that is not well defined.”<sup>14</sup> This ambiguity can surround the mission itself, the soldier’s duties, and the rules of engagement imposed on the peacekeepers. The uncertainty that then surrounds daily life in a mission can become a potent stressor.

The disconnect created between the aggressive nature of trained soldiers and the objective to bring about peace and stability has occasionally caused hostile transgressions.<sup>15</sup> As both the tenets of neutrality and the rules of engagement tend to limit the actions that can be taken, peacekeepers must at times suppress basic survival instincts.<sup>16</sup> It has been supposed that in the extreme, “this cognitive dissonance may [have led] to such calamitous behaviors as the torture and murder of a Somali youth by members of the elite Canadian Airborne Regiment (CAR) or the strangling of an 11-year old Albanian girl by an American paratrooper during his deployment in Kosovo.”<sup>17</sup> Fortunately, these incidents are very few in number and have not tarnished the reputation of all missions.

The principles of neutrality and impartiality will also, at times, present stresses in a mission. The restraint needed to maintain “neutrality between two or more warring parties taxes the mental apparatus of the individual peacekeeper, thereby also possibly increasing the risk of psychiatric effects.”<sup>18</sup> In fact, many soldiers have stated one of the most severe stresses felt in-theater was not one to their own safety, but observing violent acts, sometimes against civilians and children, which they were helpless to prevent.<sup>19</sup> The discord between what a soldier thinks he should do versus what he must do is inconsistent with the rules of Western society when, for example, that soldier is prohibited from providing food aid to the starving because such aid could be construed as “taking sides.”

Though servicemen certainly do not expect a luxurious experience while on a mission, the environments in which they live on a daily basis can produce both high- and low-level stresses. Such low-level stresses due to poor physical conditions might include: wet beds, infrequent showers, lack of privacy, hostile climate, or looting of food and supplies.<sup>20</sup> On the other hand, high-level stresses may include exposure to the threats of shootings, explosions, or hostage situations. There are also frequent humanitarian aspects of a mission in which a soldier may observe grave illness, physically or psychologically wounded people, and abject starvation.

Though few studies have been conducted, compelling evidence from initial research shows the threat of danger, not surprisingly, is top of mind for many peacekeepers. In one report, “79 percent of Australian soldiers deployed to Rwanda believed they were in danger of being killed.”<sup>21</sup> In a survey of Danish soldiers sent to the former Yugoslavia, “the majority (54%) of these peacekeepers reported that their worst experience was when they felt their life was threatened.”<sup>22</sup>

Hostage situations are not uncommon either: “In a survey of Norwegian peacekeepers in South Lebanon, 9 percent reported having been held hostage,” plus “8 percent of Dutch peacekeepers deployed to Bosnia reported having been held hostage.”<sup>23</sup> In some of the most severe cases, peacekeepers have been held captive in life-threatening situations.<sup>24</sup>

Although it may not produce an immediate life threat, soldiers are subjected to other major stressors such as rioting, mobs, or observing death and destruction.<sup>25</sup> The frequent witnessing of death, injury or dismemberment can be classified as a threat to mental and spiritual stability.<sup>26</sup> Such atrocities can challenge observers at their most basic level, which “entails a qualitatively different kind of stress that is an important factor to consider” when considering the pressure a soldier may be experiencing.<sup>27</sup> It should be anticipated, then, that individuals living under these conditions are at higher risk for the occurrence of a medically-definable stress reactions.<sup>28</sup>

Although the environmental factors that surround a mission seem to be the most pressing while in-theater, peacekeepers, like anyone else, may carry stresses with them from outside of the mission. These stresses from home may involve everyday problems with relationships, health, or finances. Long periods of separation from home and loved ones can cause challenges that “range from practical constraints, such as difficulty communicating back home or getting access to news, to the psychological isolation that comes from living in a foreign environment.”<sup>29</sup>

It seems a fairly obvious solution to provide frequent contact with home to help alleviate this stress; however, there are opposing viewpoints that quick access to family members through phone or internet could be highly beneficial or emotionally hazardous to soldiers.<sup>30</sup> On the positive side, such contact could “could boost morale, resolve family problems before they got

out of hand at home, relieve boredom, [and] reduce isolation.”<sup>31</sup> On the other hand, there are often excessive expenses involved with such communications and there is a risk of a soldier receiving bad news from home, possibly putting him or her into a hazardous state of mind.<sup>32</sup> In any case, it is imperative to note that stressors from the home may leave individuals more susceptible to stressors while in-theater.<sup>33</sup>

When a soldier returns home post-deployment, there are still problems to be addressed. Troops are often returned home rather quickly after departing from a mission. This rapid reintegration back into society is also a stress factor as it does not offer the opportunity to readjust to life on the base or to family roles.<sup>34</sup> Soldiers are not given ample time to begin shaping their outlook on their deployment experience and to re-assimilate to civilian life.<sup>35</sup> Consequently, “conflicted emotions about the tour, generalized hostility, feelings of psychological isolation from others, and feelings of helplessness and powerlessness are not uncommon among returned peace support personnel, at least in the short term.”<sup>36</sup>

Though it may seem that way, not all mission experiences are completely negative. In one study, the majority of peacekeepers (82%) concluded their experiences have broadened their outlook.<sup>37</sup> More than 50 percent also said their deployment provided them with life-long friends and boosted their self esteem.<sup>38</sup> The rewards soldiers feel from such an experience and the “sense of purpose that arises from being part of a cohesive and organized military structure[may help to] mitigate the potentially traumatizing effects of exposure to the negative elements of peacekeeping.”<sup>39</sup>

### *Reactions to stresses in peacekeeping*

The immense and varied stress factors imposed on a military peacekeeper can wear on anyone and can be relatively minor, as with general anxiety, or severe, as with suicidal thoughts or actions. While the psychological consequences of war may be instantaneous, gradual or long-lasting, the media typically generally only pays attention to “war-induced disorders...at the outbreak of war, and immediately afterwards, with very little in the way of sustained long-term follow-up.”<sup>40</sup> It is probably because of this shortsightedness that the research in existence is so scarce, and there is little transfer of knowledge from one conflict to another.

Still, some historical progress in the areas of trauma and stress reactions by soldiers exists. During World War I, “‘shell shock’ was coined to describe reactions to combat situations; medical authorities believed that the symptoms were a result of the concussive effects of shell explosions.”<sup>41</sup> If a soldier showed symptoms without any physical injury, it was often thought the soldier was trying to avoid the front line. As a result, treatment usually consisted of shame, derision and the command to endure all circumstances.<sup>42</sup> In World War II, “terms such as war neurosis, combat exhaustion, and fight fatigue were used to describe cases of combat stress.”<sup>43</sup> Although physicians no longer believed the soldiers with these symptoms were trying to avoid duty, this was supplanted with the idea that affected individuals were psychologically fragile.<sup>44</sup>

More recently, some efforts have been made to study the consequences of stressors on peacekeepers, particularly because of similarities between peace operations and war. So far, research has found many peacekeepers tend to adapt well during their deployment, but the impact of trauma on others “can be associated with suffering from serious psychopathology such



as post-traumatic stress disorder (PTSD), depression, suicide, alcohol abuse or dependence, generalized anxiety disorder, adjustment disorders and poor overall physical health.”<sup>45</sup>

The somatic reactions to stress exposure can also include “increased headaches, stomach upsets, sleep disturbances, and increased frequency of minor upper respiratory ailments.”<sup>46</sup> These effects may be deemed insignificant physical disturbances; however, more serious conditions, such as hypertension, have also been recorded.<sup>47</sup>

Traumatic situations in peacekeeping missions can lead to very serious psychological disorders that need to be addressed efficiently and effectively. However, Yoder states that “politicians, negotiators, peacebuilders [sic], and the general public alike tend to think of trauma healing as soft, a warm fuzzy” that has little to do with the needs of a soldier.<sup>48</sup>

The factors that cause trauma to individuals may vary greatly, and an outsider cannot effectively determine whether a situation may be overwhelming to someone else. In short, what one may consider stressful, another may consider greatly traumatic. Any number of factors, including “age, previous history, degree of preparation, the meaning given to the event, how long it lasts, the quality of social support available, knowledge about how to deal with trauma, genetic makeup, and spiritual centeredness,” may predispose an individual to deeming an event trauma.<sup>49</sup>

There are several types of trauma and not all are produced by an isolated incident, but can be the result of “living under abusive or unsafe conditions that are long-term and continuous.”<sup>50</sup>

Another type of trauma, common to peacekeepers, is secondary or vicarious trauma, which “refers to the effects experienced by rescue workers, caregivers, and others who respond to catastrophes and attend to direct victims first-hand.”<sup>51</sup> Finally, one rarely discussed form of trauma involves actively participating in causing harm to another while in the line of duty or

taking part in illegal activity.<sup>52</sup> This may, in fact, be the hardest trauma to heal as “research suggests that the traumatic effects of harming others, intentionally or unintentionally,” may cause a reaction more severe than what is experienced by survivor themselves.<sup>53</sup>

One of the worst effects of trauma is flashbacks, or intrusive memories in which any factor similar to one during the traumatic event can result in a sudden, vivid reproduction of that trauma.<sup>54</sup> As a result, survivors try to avoid situations that may trigger certain memories and will sometimes even retreat from their normal lives.<sup>55</sup> At the cerebral level, “neuroscientists believe trauma disrupts the orbitofrontal cortex functioning, leaving us susceptible to what interpersonal neurobiology expert Daniel Siegel calls ‘low-mode’ (lower brain) states.”<sup>56</sup> When this occurs, coherent thought is not possible and one may be overwhelmed by emotion or impulse.<sup>57</sup>

A widespread psychiatric condition resulting from trauma is posttraumatic stress disorder (PTSD). There have been a few studies conducted that show a wide range—between 3 percent and 20 percent—of peacekeepers suffer from PTSD.<sup>58</sup> The rate of incidence of PTSD may be “related to the nature and frequency of potentially traumatic events, which vary tremendously within each peacekeeping mission, from benign observer operations (for example, in Sinai) to highly dangerous peace-enforcement missions (such as the Somalia and Bosnia missions).”<sup>59</sup> While some research suggests that women are about two times more likely to develop PTSD than men, other studies state that there is no significant difference between men and women in the rate of occurrence.<sup>60</sup>

Besides being subjected to threatening situations, other variables shown to be associated with PTSD include “a lower level of education, being single, having experienced more potentially traumatic situations during deployment, having had no control over the situation

during deployment, reporting more feelings of powerlessness, and using professional help during deployment.”<sup>61</sup> Other pre-trauma risk factors include a family history of mental illness, prior trauma, and abuse as a child.<sup>62</sup>

The number of deployments can also increase the risk for PTSD: a 10.92% rate of PTSD for veterans deployed once and 14.84% for those deployed multiple times clearly shows the devastating impact deployment can have on one’s mental health.<sup>63</sup> And although it does not accurately reflect the rate of incidence, “current data suggest that approximately 10 percent of armed forces personnel deployed for combat, peacekeeping, or humanitarian disaster relief seek treatment for...[PTSD] following their tour of duty.”<sup>64</sup> In addition to these numbers, between 10 percent and 25 percent of individuals who do not have PTSD will experience other symptoms not severe enough for an official diagnosis.<sup>65</sup>

There is an irrefutable link between PTSD and depression, as Richardson, Naifeh, and Elhai report: “[M]ore than 50 percent of PTSD patients have diagnosable major depressive disorder.”<sup>66</sup> Two explanations for this association suggest that a history of depression could be a major risk factor for PTSD, or on the other hand, that PTSD may increase the chance for depression.<sup>67</sup> A vicious cycle can be formed from the link between these conditions: PTSD may contribute to depression, which may contribute to poor health, which may lead to further depression.<sup>68</sup>

Combat stress reaction (CSR) is more common but not as severe as PTSD. This psychological disturbance will occur when a soldier is “unable to marshal effective coping mechanisms to deal with the threatening stimuli.”<sup>69</sup> Some symptoms of CSR may include

psychic numbing, anxiety, guilt about functioning, depression, psychosomatic reactions, and psychotic-like states.<sup>70</sup>

CSR can cause a soldier to improperly manage or remove himself from a dangerous threat, leaving him “inundated by feelings of utter helplessness and anxiety.”<sup>71</sup> These intense emotions may leave a soldier predisposed to similar reactions in later deployments. Although not every peacekeeper who has CSR will have a similar reaction under comparable circumstances, any sort of stress reaction does leave a soldier more open to CSR with further deployments.<sup>72</sup>

A stress reaction is so common in soldiers performing peacekeeping duties that a disorder has been named for it, now known as peacekeeper’s stress syndrome or UN soldiers’ stress syndrome.<sup>73</sup> This syndrome is characterized by “rage, delusion and frustration, [and] feelings of impotence and helplessness when confronted with violence and atrocities to which the peacekeeper is unable to respond.”<sup>74</sup> The symptoms involved in the syndrome may include persistent physical, psychological or behavioral elements.<sup>75</sup> Although not yet fully recognized by the psychiatric community, this syndrome is a “conceptually useful term to help explain soldiers’ reactions to operational experiences.”<sup>76</sup>

It should be noted that all stress reactions do not necessarily denote a psychological problem or behavior that requires monitoring. In fact, exposure to stressors and reactions to stress in deployment can, as in daily life, bring about a strengthening of character.

### ***Services for stresses in peacekeeping***

Again, though research in the area is somewhat lacking, there is enough evidence to see that the stressors peacekeepers experience can cause moderate to severe psychological disturbances. In one study, a full “12 percent of the peacekeepers contacted a professional health

care worker during their deployment for problems they attributed to their peacekeeping experience.”<sup>77</sup> Similarly, after returning from their mission, “between 5percent and 9percent of Kosovo and Bosnia peacekeepers reported needing help with externalizing problems (i.e., controlling their anger/hostility), internalizing problems (for example, depression), and PTSD and stress related symptoms.”<sup>78</sup> Clearly, there is a need for mental health aid before, during and after deployment for those peacekeepers to deal with their emotional distress.

In the pre-deployment phase, fully explaining the mission and elucidating the rules of operation may be the most important steps the armed services can take to help reduce future incidents of stress reactions.<sup>79</sup> Imparting knowledge of the mission country’s “culture and the organizational culture of the UN peacekeeping forces can help to alleviate the experience of confusion and role ambiguity on arrival,”<sup>80</sup> Pre-deployment briefings can “serve important psychological functions because the information imparted can establish or realign expectations; this in turn may reduce uncertainty and anxiety.”<sup>81</sup>

Just recognizing stress itself as a danger helps personnel recognize issues to be confronted while employed.<sup>82</sup> Since 1994, the UN has conducted Mission Readiness Workshops in order to address “philosophical, practical and psychological concerns related to peacekeeping service.”<sup>83</sup> The workshops and a mission booklet are made available to anyone taking part in a UN mission.<sup>84</sup>

Peacekeepers who seek out mental health care during their deployment may actually be at higher risk of problems upon return home, so early help can be crucial.<sup>85</sup> During a mission, first-level care “may consist of a short-term hiatus from stressful situations focusing on physiological

needs such as rest and food.”<sup>86</sup> Fellow soldiers and leaders are the first lines of defense in helping medical professionals recognize early symptoms of stress.<sup>87</sup>

If needed, second-level care “may require the soldier’s transfer to a CSC (combat stress control) unit co-located with the nearest field hospital.”<sup>88</sup> These units can only service small numbers of soldiers at a time, but they do allow for individual and group counseling, as well as training in coping skills.<sup>89</sup> One report showed a success rate of 85 percent for CSC units rehabilitating soldiers and quickly returning them to duty.<sup>90</sup>

Evacuation for further treatment is sometimes needed for individuals who are at risk for harming themselves or others, or who have acute psychological problems.<sup>91</sup> As a mission ends, evacuations for mental health reasons may increase because “fewer psychological support resources remain and a more relaxed attitude about returning soldiers home may exist.”<sup>92</sup>

At this time, post-deployment services are the most readily available. The majority of military organizations involved in peacekeeping “provide post-theater treatment, often restricted to diagnosed PTSD,” but at this time mental health services are increasing for other commonly seen conditions.<sup>93</sup>

Some branches of armed services in the United States “have used one of the most comprehensive redeployment screening programs: this large-scale initiative screens for major trauma events, risk factors, and adjustment problems and provides an individual follow-up clinical interview as necessary.”<sup>94</sup> One effective method, yet to be put into widespread use, is individual psychotherapy, which “assists returning peacekeepers in dealing with the aftermath of trauma and with the tasks of reintegration into post-mission roles,”<sup>95</sup> In some cases family or group therapy may be offered, but availability is limited .

Formalized debriefing prior to post-deployment has become a fairly controversial method in recent years. In 2000, the Surgeon General of the United Kingdom stopped the practice after research showed that a single session of debriefing produced no positive effect and was at times damaging.<sup>96</sup> Although “two-thirds of peacekeepers...were in favor of formal psychological debriefing on return home,” there is adequate “evidence that formal psychological debriefings and medical/welfare interventions are not required by all.”<sup>97</sup> More recently, the suggestion has been to restrict these types of interventions to extremely high-risk groups rather than using an all-purpose approach for peacekeepers.<sup>98</sup>

Although most service members make use of informal networks of peers and family members to vent their post-deployment stresses, and more highly distressed individuals utilize healthcare professionals, still others in need do not seek help at all. Relevant research has targeted all veterans and not specifically military peacekeepers, but the findings may be generalized. One study among World War II veterans showed that “59 percent of the highly exposed respondents with a current PTSD did not seek professional help in the three years preceding the study.”<sup>99</sup> In addition, the National Vietnam Veterans Readjustment Study showed that “78 percent of the veterans with a current PTSD did not currently receive mental health care services, while 38 percent of them never did so.”<sup>100</sup>

One reason for not seeking treatment may be the “significant military-instilled mental health stigma.”<sup>101</sup> In one case, a military chaplain felt this stigma kept him from coming forward and talking to professionals about his operation stress injury for years because he observed that many servicemen who did so were released from duty to the Department of Veterans Affairs.<sup>102</sup>

Other reasons that treatment is not pursued include cost, distance, and lack of information on where to obtain services.<sup>103</sup>

One of the most critical tools in processing stress is simple—talking to someone else about the matter. In fact, symptoms of stress may continue “if those who have been exposed to critical events are unable to ‘process’ what has happened to them.”<sup>104</sup> As reported by Yoder, trauma specialists state that “acknowledging and telling the story counteracts the isolation, silence, fear, shame, or ‘unspeakable’ horror” associated with traumatic events.<sup>105</sup>

In a recent survey, responses indicated that “two-thirds of peacekeepers spoke about their experiences.”<sup>106</sup> The following table illustrates those with whom peacekeepers discussed their experiences.

<i><b>Group or individual spoken to</b></i>	<i><b>Pct.</b></i>
Military friends or peer group in same deployment	98%
Spouse or partner	95%
Other family member	76%
Military friends or peer group not in same deployment	60%
Civilian friends or peer group	52%
Chain of command	15%
Medical services	8%
Welfare services	8%

As shown, most spoke to informal networks, such as peers, families or friends, while fewer spoke to military chain of command or medical professionals.<sup>107</sup> Greenberg et al. argue there is a link between “speaking about peacekeeping experiences and lower distress levels...which suggests that the age old dictum ‘it’s good to talk’ may indeed be true, [there needs to be a recognition that] whilst social support may have positive impacts on health, it may



only do so if it is perceived by the individual as being positive.”<sup>108</sup> It should also be noted that while most found solace in speaking to family or friends, those who were severely distressed did seek help from professionals.<sup>109</sup>

For some, the benefits of informal networks are not an option because service personnel may not live near a network of friends or family. In such cases, the “military should do all they can to promote a sense of community and facilitate stable interpersonal relationships in order to maintain the informal networks.”<sup>110</sup>

For those who need and seek professional help versus help through informal networks, there are currently some programs in place for active service members. However, it should be noted that many former soldiers are living as civilians removed from the military community and, therefore, “it is important that primary care physicians and psychiatrists become knowledgeable about the emotional impact of peacekeeping deployment, inquire about military service, and screen for possible PTSD.”<sup>111</sup>

When speaking of assistance while in-theater, Richardson, Naifeh and Elhai purport that “mental health support [may] vary somewhat across nations but usually consists of medical officers, medical assistants, mental health specialists (e.g., mental health nurses, social workers), and priests or chaplains.”<sup>112</sup> Sometimes psychiatrists deploy with a mission, but they “more commonly serve in supervisory and consultation capacities, making scheduled visits during tours or in cases of emergency.”<sup>113</sup>

Canada has developed Operational Stress Injury Social Support (OSISS) groups for both enlisted servicemen and vets.<sup>114</sup> The purpose of the OSISS peer groups is to “offer a connection

to their band of brothers which allows them to grasp that they ‘don’t have to go through it alone’ upon their return home.”<sup>115</sup>

The United States Army has recently made great efforts to combat stress issues by publishing several pamphlets, guides, and presentations on deployment-related stress and suicide prevention. The “Redeployment Health Guide: A Service Member’s Guide to Deployment-Related Stress Problems” discusses CSRs, PTSD, adjustment disorders and where to find help for all of the above.<sup>116</sup> The “Suicide Prevention Training Tip Card” gives advice to soldiers and leadership on how to recognize the warning signs and risk factors for suicide.<sup>117</sup> Plus, the “ACE (Peer) Suicide Intervention Program” teaches soldiers to “ask, care, [and] escort” a buddy if that soldier is showing signs of suicidal thoughts or actions.<sup>118</sup>

Are these efforts enough? The way wars are waged has changed dramatically in recent years; accordingly, so have postwar peacekeeping missions. Although not a peacekeeping effort, the U.S. Army has reported the suicide rate of soldiers in Iraq is “five times that seen in the Persian Gulf War and 11percent higher than during Vietnam.”<sup>119</sup> In 2008, the RAND Corporation published a study stating that approximately 20 percent of service men and women who were in Iraq or Afghanistan reported symptoms of PTSD or depression, but only half were treated.<sup>120</sup>

With no national draft in place, the U.S. military is stretched thin with two wars to fight and multiple peacekeeping missions around the world. This means soldiers are asked to repeatedly deploy with little regard for their mental health and psychological safety. What the military owes these volunteers is a thorough mental health screening pre- and post-deployment, as well as mandatory monthly check-ups while in-theater.

## *Conclusion*

In conclusion, though the area is understudied as of yet, there seems to be a clear-cut role for mental health professionals in maintaining the health of peacekeepers worldwide. There also seems to have been an unfortunate lag in military understanding or willingness to address these needs. In 2009 alone, the U.S. has already seen two incidents—one at a CSC in Baghdad and one at Fort Hood, Texas—in which combat stress or the threat of deployment seem to have taken a violent turn toward fratricide. This horrific trend can only be expected to continue if drastic measures are not taken to revitalize current programs and increase timely implementation of new programs.

Considering the current global situation, with troops in Iraq, Afghanistan, and across the globe, it is urgent that future studies suggest the best course of treatment for peacekeepers before departure and upon return home. As Yoder summarizes the dilemma, the nature of ongoing conflict and violence in the world leads to a “circular question: if healing must wait for an outbreak of security and peace, and if unhealed trauma contributes to cycles of victimhood and violence, can there be peace without healing? Can there be healing without peace?”<sup>121</sup>

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### Notes

<sup>1</sup> Carl Andrew Castro, "Considerations When Conducting Psychological Research During Peacekeeping Missions: The Scientist and the Commander " in *The Psychology of the Peacekeeper: Lessons from the Field*, ed. Thomas W. Britt and Amy B. Adler (Westport, CT: Praeger, 2003), 25.

<sup>2</sup> Jun Shigamura and Soichiro Nomura, "Mental Health Issues of Peacekeeping Workers," *Psychiatry and Clinical Neurosciences* 56 (2002): 489.

<sup>3</sup> C.D. Lamerson and E.K. Kelloway, "Towards a Model of Peacekeeping Stress: Traumatic and Contextual Influences," *Canadian Psychology* 37, no. 4 (1996): 195.

<sup>4</sup> Thomas W. Britt and Amy B. Adler, "The Psychology of the Peacekeeper: An Introductory Framework," in *The Psychology of the Peacekeeper : Lessons from the Field*, ed. Thomas W. Britt and Amy B. Adler (Westport, CT: Praeger, 2003), 3.

<sup>5</sup> Megan M. Thompson and Luigi Pasto, "Psychological Interventions in Peace Support Operations: Current Practices and Future Challenges," in *The Psychology of the Peacekeeper: Lessons from the Field*, ed. Thomas W. Britt and Amy B. Adler (Westport, CT: Praeger, 2003), 224.

<sup>6</sup> Amy B. Adler, Brett T. Litz, and Paul T. Bartone, "The Nature of Peacekeeping Stressors," in *The Psychology of the Peacekeeper: Lessons from the Field*, ed. Thomas W. Britt and Amy B. Adler (Westport, CT: Praeger, 2003), 162-63.

<sup>7</sup> Ibid., 157.

<sup>8</sup> Ibid., 156-57.

<sup>9</sup> Britt and Adler, "The Psychology of the Peacekeeper: An Introductory Framework," 79-80.

<sup>10</sup> Ibid., 79-80.

<sup>11</sup> Lamerson and Kelloway, "Towards a Model of Peacekeeping Stress: Traumatic and Contextual Influences," 198.

<sup>12</sup> Ibid.

<sup>13</sup> Ibid.

<sup>14</sup> Volker C. Franke, "The Social Identity of Peacekeeping," in *The Psychology of the Peacekeeper: Lessons from the Field*, ed. Thomas W. Britt and Amy B. Adler (Westport, CT: Praeger, 2003), 32.

<sup>15</sup> Christian Moldjard, Lars Kristian Fossum , and Are Holen, "Coping with Peacekeeping Stress." In *The Psychology of the Peacekeeper: Lessons from the Field*, ed. Thomas W. Britt and Amy B. Adler (Westport, CT: Praeger, 2003), 171 }

<sup>17</sup> Franke, "The Social Identity of Peacekeeping," 32.

<sup>18</sup> Lars Weisaeth, "The Psychological Challenge of Peacekeeping Operations," in *The Psychology of the Peacekeeper: Lessons From the Field*, ed. Thomas W. Britt and Amy B. Adler (Westport, CT: Praeger, 2003), 49.

<sup>20</sup> Adler, Litz, and Bartone, "The Nature of Peacekeeping Stressors," 157-58.

<sup>21</sup> Ibid., 159.

<sup>22</sup> Ibid.

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- <sup>23</sup> Ibid.
- <sup>24</sup> Weisaeth, "The Psychological Challenge of Peacekeeping Operations," 220.
- <sup>25</sup> Adler, Litz, and Bartone, "The Nature of Peacekeeping Stressors," 159.
- <sup>26</sup> Ibid., 160.
- <sup>27</sup> Ibid., 152.
- <sup>28</sup> Weisaeth, "The Psychological Challenge of Peacekeeping Operations," 220.
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