

Editorial

Peacekeepers deserve more mental health research and care

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Summary

United Nations peacekeeping personnel face numerous stressors due to their challenging deployments. Past studies have had inconsistent results regarding whether or not their deployment experience affects their mental health outcomes. Further studies are required to ascertain the associations between their outcomes and factors before, during and after their peacekeeping missions.

Declarations of interest

None.

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United Nations (UN) peacekeeping operations aim to develop conditions for lasting peace among conflict-torn nations. The main objectives of UN peacekeeping operations are to maintain peace and security, facilitate the political process, protect civilians, assist in disarmament, demobilise former combatants, protect and promote human rights, and assist in restoring the rule of law. Since 1948, 71 UN operations have been carried out. As of 31 October 2015, 16 operations were ongoing with a total of 124 142 personnel from 124 countries including 105 609 uniformed personnel, 5315 international civilian personnel, 11 476 local civilian personnel and 1742 UN volunteers.¹

Although every peacekeeping mission is different, the operational characteristics (and mental health consequences) have similarities to those of humanitarian assistance, disaster relief and combat missions.² Missions in chaotic areas can be extremely harsh and challenging. Many missions involve human violence, past or present. The peacekeepers are potentially exposed to life-threatening situations. A total of 3406 fatalities have occurred in all UN peace missions since 1948 (this includes fatalities for all UN peacekeeping operations, as well as political and peacebuilding missions).¹ Unlike in combat missions, the peacekeepers are prohibited from using force except for defence of the mandate and themselves.³ Seet & Burnham⁴ analysed the cause of 1559 personnel deaths during 49 UN peacekeeping missions between 1948 and 1998; they reported that the relative risk of death from all causes and from hostile acts increased during missions providing or supporting humanitarian assistance. Finally, yet importantly, the national and/or international

political stream can also affect the psychosocial context of peacekeeper deployment.

Stressful experiences of peacekeeping operations raise concerns of mental health consequences to peacekeepers. Although the history of UN peacekeeping missions spans decades, research on peacekeepers is relatively uncommon. Most studies tend to be reported from Western countries, although non-Western studies are also emerging.^{5–7} Previous studies show a wide range of mental health outcomes, such as post-traumatic stress disorder (PTSD), depression, substance use, increased hostility and suicide.^{2,3,8,9} A meta-analysis of peacekeeper studies reported that the pooled PTSD prevalence rate was 5.3% with an extremely wide range (from 0.05 to 25.8%).⁸ Conversely, another review reported an equivocal association between peacekeeping deployment and subsequent psychological distress.⁹ In order to interpret this inconsistency, various factors need to be taken into account (e.g. personnel selection, methodological differences, variety of peacekeeping roles and potential hazards).

In this journal, Forbes *et al*¹⁰ provide a substantial contribution to this area of research. Their study examines current and lifetime psychiatric disorders – namely, PTSD, depression, generalised anxiety disorder, alcohol misuse and suicidal ideation – among 1025 peacekeepers from Australia. This group was compared with an Australian community sample, and it was revealed that the peacekeeping group had remarkably higher rates of current psychiatric disorders than did the community group. These outcomes were associated with both lifetime and deployment-related trauma exposure.

The study by Forbes *et al* has several strengths worth emphasising. First, this study rigorously evaluated a large number of participants using structured clinical interview, thereby ensuring that the reliability of the study is higher than those studies employing self-report or semi-structured interview formats. Second, this study provides data on the long-term mental health outcomes of peacekeepers. Third, the study participants are peacekeepers deployed on various UN missions. Many of the past studies have analysed a specific deployment owing to selection bias. Finally, this study used large-scale civilian comparison data, allowing the authors to compare the mental health outcomes of peacekeepers with those of the general population.

This study reemphasises the need to enhance our understanding of mental health-related factors before, during and after peacekeeping missions and to provide long-term mental healthcare to former and present peacekeepers. In a military context, there have been decades of debate on whether or not mental health screening will help to decrease the number of traumatised soldiers. An American study¹¹ shows the effectiveness of pre-deployment mental health screening to reduce mental health issues, medical evacuations from the front line for mental health reasons and suicidal ideation. For peacekeepers, it will be helpful to elucidate the relations between personnel selection, pre-deployment mental status, pre-deployment trauma exposure and post-deployment mental health. The same goes for the effect of post-deployment life events, as already reported by Michel *et al*,¹² among others.

In this study,¹⁰ associations between peacekeeping missions' societal context and mental health outcomes were not covered, but it is hoped that future studies will address this topic. Peacekeepers' mental health consequences are associated with recognition (or lack thereof) by their home country, their gratification in their mission role and their pride in serving their country.^{2,3,9} These factors will likely also be related to the peacekeepers' psychological resilience. The societal perception of peacekeeping missions will also be important for future missions involving imperceptible agents, such as infectious diseases or nuclear disasters. After the 2011 Fukushima nuclear power plant disaster, the electric company was heavily criticised for management issues. When we conducted a study of these workers, social criticism was a key determinant of their post-disaster mental health.¹³

Given these discussions, we propose two future directions in this field of research. First, previous peacekeeping studies have focused on mental health impacts among the uniformed personnel.¹⁴ Although there is a small body of literature regarding civilian humanitarian relief workers,^{15,16} there are no studies dedicated solely to evaluating the mental health consequences of non-uniformed personnel in peacekeeping operations (15.7% of total UN peacekeeping personnel).¹ It may not be easy to study these non-uniformed personnel, but these individuals will also be impacted by UN peacekeeping operations and may show different patterns of mental health disorders, both in direct relationship to the deployment and over their lifetimes.

Second, a possible future direction is the development of a prospective UN Peacekeeping Operations Health Registry, which, by its very nature, would be multi-national and multi-cultural. In light of the ongoing UN peacekeeping operations, this should yield a wealth of knowledge regarding prevalence of illnesses, including mental illnesses, in such operations on a lifetime basis from multiple countries as well as help develop best practices for prevention and intervention in specific countries and cultures.

As a conclusion, this study by Forbes *et al* contributes to our understanding of the peacekeepers' inner struggles and future needs for research and care that they deserve. This paper will encourage future studies, from both Western and non-Western countries, to understand the underlying psychosocial dynamics present in the peacekeepers.

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First received 21 Dec 2015, final revision 21 Mar 2016, accepted 22 Mar 2016

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