Review Paper

Is Peacekeeping Peaceful? A Systematic Review

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Objective: To systematically review the literature on the association between deployment to a peacekeeping mission and distress, mental disorders, and suicide.

Methods: Peer-reviewed English publications were found through key word searches in MEDLINE, PsycINFO, Scopus, and Embase, and by contacting authors in the field. Sixty-eight articles were included in this review.

Results: Some studies have found higher levels of postdeployment distress and posttraumatic stress disorder (PTSD) symptoms. Most studies have not shown an increased risk of suicide in former peacekeepers. Correlates of distress and PTSD symptoms included level of exposure to traumatic events during deployment, number of deployments, predeployment personality traits or disorder, and postdeployment stressors. Perceived meaningfulness of the mission, postdeployment social supports, and positive perception of homecoming were associated with lower likelihood of distress.

Conclusions: Most peacekeepers do not develop high levels of distress or symptoms of PTSD. As postdeployment distress is consistently shown to be associated with high levels of exposure to combat during deployment, targeted interventions for peacekeepers who have been exposed to high levels of combat should be considered.

Can J Psychiatry. 2010;55(7):464-472.

Clinical Implications

- Peacekeepers exposed to significant combat or atrocities such as human massacres are at increased risk for self-reported distress and PTSD symptoms.
- The association between peacekeeping and suicide is inconsistent, and, where present, relatively weak.
- A range of predeployment, deployment, and postdeployment factors mediate or moderate distress among peacekeepers.

Limitations

- The studies included in the review used variable methodology in assessment of psychopathology.
- Cross-sectional studies are limited owing to retrospective recall bias, and there were few prospective studies.
- Information on intercountry differences in selection of service members and health care systems available to service members was not available and might affect the prevalence of distress among peacekeepers.

Key Words: peacekeeping, military, distress, suicide

There is a dose–response relation between combat stressors and the subsequent risk of self-reported distress and mental disorders. ^{1,2} The stresses of peacekeeping and their consequences have received less attention.

Peacekeeping refers to a military intervention in a conflicted area authorized by the UN Security Council. Many service members from different countries have participated in both UN- and NATO-based peacekeeping missions. Since 1948, there have been more than 60 UN peacekeeping operations around the world.³ Hundreds of thousands of soldiers from more than 120 different countries have been deployed on peacekeeping missions. According to the UN, more than 2400 UN peacekeepers have died while serving on a peacekeeping mission during the last 60 years.³

The main objectives of peacekeeping missions are to ease tensions and provide humanitarian aid in regions where civil conflict and outright war is ongoing.⁴ Peacekeepers' duties include monitoring activities of conflicting parties, maintaining the safety of noncombatants, ensuring delivery of humanitarian aid, and assisting in building infrastructures. During peacekeeping missions, soldiers often find themselves in life-threatening situations.⁵ However, peacekeepers are required to maintain strict impartiality, and the use of weapons should be limited to the absolute minimum.⁶

There are 3 different forms of military presence in conflict areas: observer missions, peacekeeping operations, and peace enforcement operations. In the first form, UN observer groups are unarmed, are deployed to monitor ceasefires, and assist the conflicting parties. In the second form, peacekeeping operations are military interventions following a peace agreement between parties in conflict. The aims of the peacekeeping operations vary, but in most cases the tasks are to prevent recurrence of hostilities and to support peaceful interaction. In the third form, peace enforcement operations aim to stop an aggressor; the term is used when no peace agreement exists.

Since the end of the Cold War, civil wars within countries have dramatically increased due to previously suppressed religious and political conflicts. Although there has been a clear increase in the number of peacekeepers deployed, and potentially high levels of exposure to violence during peacekeeping duties, there is a dearth of literature studying the mental health consequences of peacekeeping. Former Canadian General Romeo Dallaire published his autobiography, *Shake*

Abbreviations used in this article

NATO North Atlantic Treaty Organization

PCL PTSD Checklist

PTSD posttraumatic stress disorder SMR standardized mortality ratio

UN United Nations

Hands with the Devil: The Failure of Humanity in Rwanda,⁸ on his deployment to Rwanda as a peacekeeper. Dallaire wrote explicitly about the atrocities he witnessed as thousands of people were killed in a civil war in Rwanda. His book has received international attention, suggesting that peacekeeping duties in highly conflicted areas may be associated with a range of negative outcomes.⁸ It is not known whether the experiences of Dallaire are representative of other peacekeepers in Rwanda and (or) peacekeeping operations in general. Our article aims to provide the first systematic review of the literature on the association between deployment to peacekeeping operations and distress, mental disorders, and suicidality.

Method

The methodology of our review followed the search strategy outlined by Stroup et al. A systematic review of English articles was conducted in 4 databases: MEDLINE (from 1980 to 2009), PsycINFO (from 1806 to 2009), Scopus (from 1823 to 2009), and Embase (from 1980 to 2009). Search terms used in each of the 3 databases included peacekeeping in combination with the following words: distress, depression, PTSD, alcohol, disability, anxiety, quality of life, and suicide. This search resulted in: 63 abstracts in MEDLINE, 302 in PsycINFO, 92 in Scopus, and 62 in Embase, with significant overlap between the databases. Published authors in the field were contacted, and references were hand searched to ensure that all relevant articles were included in the present review.

Two authors independently reviewed the abstracts to determine eligibility for inclusion in the study. All studies that examined distress, mental disorders, quality of life, and suicide among soldiers deployed to peacekeeping operations were included. Publications that focused on the following: mental health problems related to combat deployments, mental health consequences of peacekeeping on families of peacekeepers, commentaries on peacekeeping, and the reliability and validity of psychological instruments among peacekeepers were excluded. A total of 68 studies were included. 6,10–82

Results

Table 1 (available from author) provides a summary of the literature on the association between peacekeeping operations and distress. It is important to note that most studies used self-report measures to assess distress and PTSD symptoms that are not designed for making a diagnosis of mental disorders.

Peacekeeping and Distress

The literature is mixed as far as whether deployment to peacekeeping operations is associated with increased levels of self-reported distress. Several studies have found no increase in levels of distress or mental health problems among peacekeepers.²⁹ Early studies of UN peacekeepers, in

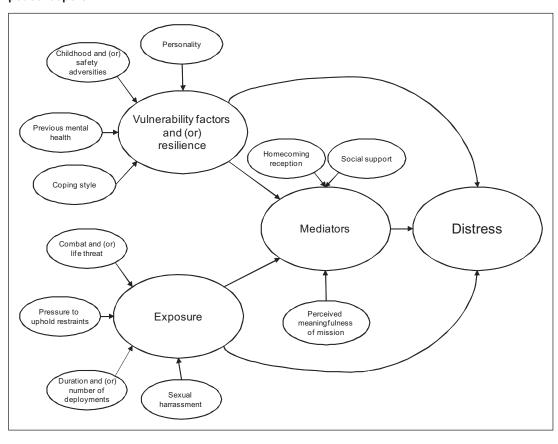


Figure 1 Empirically based model of risk and protective factors of distress among peacekeepers

areas where peace had already been established, found that only small proportions of peacekeepers were psychologically distressed.³⁰ This stress was often related to boredom, frustration, and role conflict among soldiers trained for active combat duty.³¹ However, psychological distress was not usually long-lasting.³² Another study³³ examined Swedish peacekeepers at 4 time points (before deployment, immediately after deployment, 6 months postdeployment, and 1 year after deployment) and found no significant change in distress.

Studies³⁴ from a large sample of United Kingdom service members found that Gulf War veterans had significantly higher levels of distress, and poorer quality of life in comparison both with Bosnia peacekeepers and with era controls. However, peacekeepers from Bosnia were not found to have an increase in distress³⁵ or impaired physical functioning³⁴ in comparison with era controls. Only one study has compared the levels of distress among peacekeepers with UN military observers.³⁶ This study demonstrated that UN observers had significantly higher levels of distress and PTSD symptoms than peacekeepers.

In contrast, a range of cross-sectional studies across different nations have noted substantial levels of distress among former peacekeepers. ^{6,37,38} A large cohort of American veterans returning from peacekeeping duty in Somalia was assessed

about 5 months after return from deployment. ³⁸ Reports from this dataset demonstrated the prevalence of probable PTSD, using self-reported data based on the PCL, ⁸³ to be 7.9% in men, and 8.8% in women, ³⁸ and about 30% of the sample met threshold for a mental disorder based on the self-report Brief Symptom Inventory. ⁸⁴

Asmundson et al³⁹ examined a large sample of Canadian veterans, and found that peacekeepers were significantly more likely to have self-reported depressive and PTSD symptoms than nondeployed personnel. In this large sample, symptoms of PTSD were directly and indirectly (via depression) associated with poor health status.³⁹ Overall, this sample had a probable PTSD diagnosis in 13.0% of peacekeepers and subthreshold PTSD in another 10.6%.⁴⁰ Similarly, Australian peacekeepers were assessed 15 months after returning from Somalia on a range of self-report measures including the General Health Questionnaire,⁴¹ with at least one-fifth having significantly elevated levels of mental health-related distress.

Our group also examined a population-based sample of active Canadian Forces personnel (n = 8441) with interview-based assessment of mental disorders using the Composite International Diagnostic Interview.⁴² This study found that 35% of the soldiers had been deployed to a peacekeeping

mission. Peacekeeping was positively associated with PTSD, self-perceived need for information, and long-term restriction in physical activities (significant odds ratios ranging from 1.26 to 2.47).⁴³

The concept of delayed-onset PTSD has been controversial.⁸⁵ One study in the field by Gray et al⁴⁴ used a prospective longitudinal design to estimate the prevalence of delayed-onset PTSD among peacekeepers. They found that a significant proportion (6.5% of the sample) did not meet criteria for PTSD at 4 months postdeployment, but later met criteria for PTSD at 18 months. The possible mechanism of delayed-onset PTSD has been reviewed recently⁸⁵ but remains not well understood.

Peacekeeping and Suicidality

Besides increased distress, there has been increasing concern about suicide risk among soldiers. Kaplan et al⁴⁵ recently demonstrated that US veterans are at increased risk for death by suicide in comparison with the general population. These reports are contrary to previous studies that have demonstrated a lower likelihood of suicide among service members and veterans. ^{46–48} Consistent with the purposes of our paper, we will focus specifically on studies examining suicide among peacekeepers.

The first studies that examined the question of suicide in peacekeepers were conducted by Hansen-Schwartz et al⁴⁹ and Hall.⁵⁰ Hall⁵⁰ reported a cluster of 3 suicides among US peacekeepers within the first month of deployment to a mission in Haiti. Hansen-Schwartz et al⁴⁹ found 4 suicide cases in a contingent of 3859 Danish soldiers in which the expected rate would have been 3 cases. In this study, among the 4 suicides, 2 occurred within 1 month prior to deployment, and 2 occurred within 1 year postdeployment.

Michel et al51 examined suicide rates among 39 768 Swedish military personnel who had served in NATO or UN peacekeeping missions between 1960 and 1999. They found that peacekeepers had a significantly lower likelihood of death by suicide, compared with the general population (SMR = 0.67; 95% CI 0.58 to 0.77). In contrast, Ponteva et al⁵² examined suicides among Finnish soldiers deployed to several peacekeeping operations (deployed between 1969 and 1999), and found higher rates of suicide, compared with control subjects. Wong et al⁵³ extended this line of work by examining 66 deaths by suicide in all Canadian soldiers between 1990 and 1995, with 2601 control subjects randomly selected from an electronic military database. They found that 36% of the 66 soldiers who died from suicide had been deployed to a peacekeeping mission. In the overall sample, exposure to peacekeeping was not associated with an elevated rate of suicide. However, among a subsample of air force personnel, exposure to peacekeeping was associated with elevated risk of suicide (OR 3.43; 95% CI 1.42 to 8.41). To date, we were unable to find any other study that has been done to replicate this

finding that peacekeeping air force personnel are at higher risk for suicide.

A large study⁵⁴ examined rates of death by suicide in 22 275 Norwegian male veterans involved in 1 or more 6-month deployments with a UN or NATO peacekeeping operation. The period of inclusion was from 1978 to 1995, and the soldiers could have been involved in missions to Lebanon, the former Yugoslavia, the Persian Gulf, or Somalia. SMRs were calculated based on the ratio between the observed number of cases, and the expected number of cases (based on national averages). An increased SMR of 1.40 (95% CI 1.1 to 1.8) for suicide was found among former peacekeepers, compared with suicide rates in the general population. The methods of suicide differed between peacekeepers and those in the general population. SMR for suicide by firearms (SMR = 2.14; 95% CI 1.5 to 2.9) and by carbon monoxide (SMR = 2.29; 95% CI 1.5 to 24.7) were also significantly elevated for peacekeepers compared with the general population.

Only 2 studies have examined the relation between peace-keeping and risk for suicidal ideation. Both of these studies, one from a Canadian sample and the other from a Norwegian sample, have noted that exposure to traumatic events during deployment is associated with an increased likelihood of suicidal ideation. ^{55,56}

Empirically Based Model of Distress and Suicide Among Peacekeepers

The aforementioned review, while characterized by mixed results, suggests that distress and possibly suicide are elevated in people deployed to peacekeeping missions. Figure 1 illustrates an empirically derived model of distress and suicide related to peacekeeping operations. Below, we describe the empirical basis for the model.

Dimensions of Deployment Associated With Distress Among Peacekeepers

Combat and Traumatic Events Exposure. The strongest and most consistent risk factor for distress among peacekeepers is traumatic exposure, including direct combat exposure. ⁵⁷ Litz et al³⁸ examined US peacekeepers after deployment to Somalia and found that the level of combat exposure during the peacekeeping mission was associated with an increased risk of PTSD. Our group examined Canadian peacekeepers and found that exposure to combat and witnessing atrocities such as massacres were significantly associated with several mental health problems, ^{43,55} including PTSD. Bramsen et al⁵⁸ used longitudinal data from Dutch peacekeepers to demonstrate that exposure to traumatic events was associated with self-reported distress and PTSD symptoms.

Pressure to Uphold Restraints. Litz et al³⁸ demonstrated that pressure to uphold restraints (that is, minimize use of firearms) was associated with a higher likelihood of self-reported PTSD symptoms among peacekeepers

returning from Somalia. They used structural equation modelling to demonstrate that this dimension of peacekeeping had a unique effect on PTSD symptoms after adjusting for combat exposure.

Duration and Number of Deployments. Beyond the experience of soldiers within a particular deployment, there has also been an expanding body of literature on the impact of duration of deployment and number of deployments in relation to soldiers' emotional distress. Lazarus and Folkman⁵⁹ describe that the duration of the stressor that a person endures may be associated with a higher likelihood of distress if the stressor is associated with exhaustion. However, if the person habituates to the stressor, and has a sense of mastery, then over time there would be a decrease in the levels of distress. Further, novelty may be an important determinant of whether an event is stressful, particularly if there is potential for harm or danger. 59 Thus Lazarus and Folkman⁵⁹ hypothesize that soldiers deployed for their first time may have the highest levels of distress. To date, the data to support this hypothesis are weak. As the number of deployments increases, the stress associated with each deployment may decrease. Adler et al¹¹ used a large sample of American soldiers deployed to the former Yugoslavia to demonstrate that longer duration of deployment and first-time deployments were associated with the highest levels of self-reported PTSD and depressive symptoms among men but not women. In contrast to Adler et al's study, 11 which did not find an association between an increased number of deployments and distress, studies by Richardson et al^{60,61} demonstrate that, among Canadian peacekeepers, an increasing number of deployments was associated with higher rates of PTSD. Longer duration of deployment was also associated with increased levels of stress among Italian peacekeepers in Bosnia.62

Physical Health Problems. Although physical injury during deployment to combat missions has been demonstrated to be associated with postdeployment PTSD, ^{63,64} there is a dearth of specific information on this issue in peacekeepers. In a sample of Canadian peacekeeping veterans, physical health problems were associated with self-reported PTSD and depressive symptoms. ⁶⁰ In this sample, PTSD and depression were associated with increased medical and psychological services. ^{65,66} However, these health problems could have occurred prior to or during the deployment. Another study ⁷⁰ in a treatment-seeking sample of veterans demonstrated a strong link between PTSD and depression and chronic pain.

Deployment Without an Established Peer Group. Bartone et al⁷¹ used a mixed methods qualitative and quantitative study and suggested that deployment to peacekeeping operations without an established peer group may be a risk factor for distress. Greenberg et al⁷² also examined this hypothesis among a UK sample of peacekeepers and did not find an association between deployment to a peacekeeping operation without the established peer group and risk for PTSD symptoms.

Sexual Harassment During Deployment. One study among US peacekeepers from Somalia demonstrated an association between sexual harassment during deployment and PTSD symptoms both in men and in women.⁷³ Further replication of this study is required.

Predeployment Vulnerability and Resilience Factors

Personality Factors. Two studies have specifically examined personality factors in relation to distress using a longitudinal design. First, Bramsen et al⁵⁸ examined a sample of Dutch peacekeepers deployed to Somalia who completed a short form of the Minnesota Multiphasic Personality Inventory before deployment to examine the link between predeployment personality and postdeployment PTSD symptoms among peacekeepers deployed to Somalia. 44 Exposure to traumatic events during deployment and predeployment personality traits (that is, negativism and psychopathology) were associated with postdeployment PTSD symptom severity. Second, Michel et al⁷⁴ found that the presence of a baseline diagnosis of a personality disorder was associated with a greater likelihood of distress at follow-up and greater likelihood of reporting traumatic events during deployment. In another longitudinal study⁸⁶ among Swedish peacekeepers in Kosovo, baseline trait anxiety levels interacted with trauma exposure during deployment to increase the risk of postdeployment distress.

Coping. One longitudinal study⁷⁵ of US peacekeepers has demonstrated that an active coping style, in contrast to passive methods of coping, moderates the impact of work stress on psychological symptoms. Another study⁷⁶ in former Dutch peacekeepers demonstrated that certain coping strategies, such as wishful thinking and accepting responsibility, were associated with increased PTSD symptoms. In contrast, problem-focused coping behaviour was associated with a lower likelihood of PTSD symptoms.⁷⁶

Previous Mental Health Problems. Ward⁴¹ demonstrated that among Australian peacekeepers (n = 117), preenrolment contact with a psychiatrist and psychologist was associated with postdeployment distress.

Childhood Maltreatment. Belik et al⁷⁷ examined the relation between childhood maltreatment and suicidality in a large representative sample of the Canadian military. After adjusting for presence of common mental disorders, exposure to childhood maltreatment was associated with increased likelihood of suicide attempts.

Mediators and Moderators of Distress

Meaningfulness of Mission. Litz et al⁶ developed a measure to examine the positive aspects of peacekeeping missions that operationalized concepts of humanitarianism and pride during the peacekeeping mission. In structural equation models, positive aspects of the peacekeeping mission were associated with a decreased risk of self-reported PTSD symptoms

among veterans from a peacekeeping mission in Somalia. Similarly, Britt et al^{78,79} used a longitudinal design among US soldiers to show that a positive sense of meaningfulness in the mission was associated with a lower risk of self-reported distress.

Homecoming Reception. Bolton et al⁸⁰ examined an American sample of soldiers returning from Somalia, demonstrating that the person's positive perception of their homecoming reception was associated with a lower likelihood of PTSD symptoms.

Social Supports. Bolton et al⁸⁰ reported that self-disclosure of traumatic events to family and friends postdeployment was associated with lower levels of PTSD symptoms. Similarly, Greenberg et al⁷² found that UK peacekeepers that spoke about their experiences during deployment had lower levels of distress than those who did not speak of their experiences. However, because these studies are cross-sectional, causal inferences cannot be made.

Treatment Seeking

A large body of literature suggests that peacekeeping operations and PTSD among peacekeepers are associated with mental health service use, ⁵⁵ perceived need for treatment, ^{55,67,68} as well as general medical service use. ^{60,65} Much of the data have come from Canadian veteran samples and active military samples. Forbes et al ⁶⁹ compared clinical presentations of Australian peacekeepers to Vietnam veterans and found more severe levels of reexperiencing symptoms and anger among peacekeepers in comparison with Vietnam veterans. However, treatment outcomes did not differ between peacekeepers and Vietnam veterans.

Discussion

To our knowledge, our review is the first to systematically examine the literature on the mental health consequences of peacekeeping operations. There are 3 main findings from our review. First, the vast majority of peacekeepers do not develop mental health problems or high levels of distress. Second, some studies have demonstrated that service members deployed to peacekeeping operations are significantly more likely to report distress, compared with nondeployed service members. Third, most studies have not shown a link between peacekeeping deployments and suicide. Importantly, the role of psychopathology in relation to suicide among peacekeepers is unclear and needs to be further explored.

There are several possible reasons to explain the differences across studies. The most likely explanation is that peacekeepers in different studies have different levels of exposure to conflict during deployment and different levels of organizational and social support during and after deployment. Second, there may be differences across nations in recruitment and selection of soldiers (that is, preexisting risk factors may differ). Third, there are substantial differences in the way

PTSD symptoms, distress, and suicide, were measured across studies examined here. Nevertheless, these findings underscore the importance of careful monitoring for mental health problems among peacekeepers returning from deployments with high levels of conflict.

Among mental disorders, there has been a strong focus on postdeployment PTSD. There has been increasing attention to other disorders such as major depression, alcohol abuse, panic disorder, and generalized anxiety disorder. A key limitation of most of the literature on this topic is the use of self-report instruments rather than interview-based assessments of mental disorders. Although self-report paper and pencil instruments, such as the PCL and the General Health Questionaire, are reliable screening tools, recent empirical data have suggested that these instruments might overestimate the prevalence of mental disorders. 87 Conversely, some studies have shown that soldiers may underreport symptoms owing to fear of stigmatization. To tease these confounding factors apart, there is a need for systematic evaluation of peacekeepers across countries using the same methodology. To examine the epidemiology of mental disorders across different countries, the World Health Organization has conducted mental health surveys in 28 countries using a similar sampling design, and face-to-face interviews. 88-90 A similar cross-national initiative is required among peacekeepers to delineate true differences in mental disorders, and suicidality across nations, compared with differences, owing to the methodology of assessment.

Further, the prevalence rates of mental disorders reported in peacekeeping samples are generally comparable with the prevalence rates reported in studies in the general population. 90 To date, there are no studies in the literature that have directly compared prevalence of mental disorders among a peacekeeping sample with the general population. Further studies in this area of inquiry are needed. Although there is emerging evidence for protective factors among peacekeepers, many of the studies have not been replicated and the cross-sectional methods used preclude cause and effect interpretations. Nevertheless, positive appraisal or a sense of meaningfulness of the mission, a positive homecoming reception, pride, self-disclosure, social support, active coping style, and perceived job control all appear to be associated with lower levels of distress. Further systematic evaluations of possible protective factors are required.

Besides deployment and postdeployment-related risk and protective factors, little information is available on predeployment risk factors. Although predeployment personality factors are associated with postdeployment, there is a need to examine a history of childhood adversity, genetic factors, and prior history of mental illness as possible risk factors for deployment-related mental health problems in this population. At present, there is a need for empirical evidence to support any predeployment interventions that could

improve the coping of soldiers in the context of stressful deployments.

Finally, although numerous authors have proposed that the stressors of peacekeeping deployments differ from those of combat operations, there is no empirical evidence to support this hypothesis. Bartone et al⁷¹ and Litz et al^{6,38} have found that a sense of powerlessness and witnessing atrocities and massacres are key traumatic stressors among peacekeepers. However, it is possible that exposure to combat and other trauma may be the strongest factors, irrespective of the sense of powerlessness in not being able to use weapons during deployments. Systematic comparisons of soldiers undergoing deployment to combat operations and peacekeeping operations are required to delineate whether the stressors of peacekeeping deployments do in fact meaningfully differ from combat operations. Further, there is only one study⁶⁹ that compared clinical response of peacekeeping related to PTSD with combat related to PTSD Vietnam veterans. It found no differences in clinical response. However, this was a small study, and further larger studies are required in this area.

Conclusions

Although there is some evidence that exposure to high levels of combat and atrocities during peacekeeping deployment is associated with postdeployment distress, most peacekeepers do not develop postdeployment distress or morbidity. Predeployment personality factors, and postdeployment social supports also seem to mediate or moderate the level of postdeployment distress among peacekeepers. There is a need for prospective evaluations of mental health problems among peacekeepers using standardized face-to-face interviews across countries. Such work would pave the way for development of targeted psychological interventions that may prevent mental health problems in peacekeepers following deployment. Finally, given the data suggesting that most peacekeepers suffering with mental illness do not receive care, 55,68,91 there is a need for systematic efforts to overcome stigma and other barriers to care.

Acknowledgements

Preparation of this article was supported by Canadian Institutes of Health Research grants (63186, 152348, 184490, and 181467), and a National Institute of Health K24 Award (MH64122). The authors acknowledge Briana Melia and Rae Spiwak for their assistance with manuscript preparation. We thank the following authors for their input: Brett Litz, Per-Olef Michel, Simon Wessely, Deniz Fikretoglu, Dave Pedlar, Carl Castro, Lars Mehlum, and Don Richardson.

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Manuscript received May 2009, revised, and accepted December 2009.

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Résumé : Le maintien de la paix est-il paisible? une revue systématique

Objectif: Mener systématiquement une revue de la documentation sur l'association entre le déploiement à une mission de maintien de la paix et la détresse, les troubles mentaux, et le suicide.

Méthodes: Les publications en anglais révisées par les pairs ont été repérées grâce à des recherches par mots clés dans MEDLINE, PsycINFO, Scopus, et Embase, et en communiquant avec des auteurs qui ont publié sur le stress du maintien de la paix. Soixante-huit articles ont été inclus dans cette revue.

Résultats: Certaines études ont constaté des niveaux plus élevés de détresse post-déploiement et de symptômes de trouble de stress post-traumatique (TSPT). La plupart des études ne font pas état d'un risque accru de suicide chez les anciens soldats du maintien de la paix. Les corrélats de la détresse et des symptômes de TSPT comprenaient le niveau d'exposition à des événements traumatiques durant le déploiement, le nombre de déploiements, les traits ou les troubles de la personnalité pré-déploiement, et les stresseurs post-déploiement. Le sens perçu de la mission, les soutiens sociaux post-déploiement, et la perception positive du retour chez soi étaient associés à une probabilité plus faible de détresse.

Conclusions: La plupart des soldats du maintien de la paix ne développent pas de niveaux élevés de détresse ou de symptômes de TSPT. Comme la détresse post-déploiement se révèle de façon constante être associée à des niveaux élevés d'exposition au combat durant le déploiement, des interventions ciblées pour les soldats du maintien de la paix qui ont été exposés à des niveaux élevés de combat devraient être envisagées.