

# Coping With the Impact of Working in a Conflict Zone: A Comparative Study of Diplomatic Staff

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**Objectives:** Diplomats as a result of their work in conflict zones are "at risk" of exposure to intense psychological stressors. This study investigated the mental and physical health of diplomats working in a war zone. **Methods:** The study used a comparative retrospective cohort design. Mental and physical health outcomes were compared for two groups of United Kingdom diplomats: those who had completed postings in Iraq and/or Afghanistan, and those deployed overseas to nonhardship posts. **Results:** Diplomats posted to Iraq and Afghanistan and individuals who experienced trauma had significantly more symptoms of posttraumatic stress disorder. There were no significant differences between the groups in levels of general psychiatric morbidity, fatigue, and alcohol misuse. **Conclusions:** Although personnel who went to war zones or suffered trauma were more psychologically symptomatic, the increased burden of symptoms was not associated with frank illness.

Over recent decades, the negative effect of conflicts upon the mental health of soldiers has attracted increasing media and scientific attention.<sup>1-3</sup> However, many nonmilitary personnel such as diplomats, aid workers, and private security personnel also work in conflict zones, and to date, few studies have examined the effects of conflict upon the mental health of these groups. The United Kingdom's governmental effort to negotiate and achieve international postconflict restoration work is coordinated by the Foreign and Commonwealth Office (FCO) and the conflicts in Iraq and Afghanistan, in particular, have seen FCO staff living in conflict zones for extended periods. Given the high-profile role of FCO staff, the relative lack of research to have examined their mental health is somewhat surprising.

Conflict zones provide an environment that is threatening to both life and mental health.<sup>1,4,5</sup> However, it is still somewhat unclear how the interplay of exposure to traumatic events is related to other vulnerability factors in the development of posttraumatic stress disorder (PTSD). Although most people do not become ill after exposure to traumatic events, there is a well-demonstrated relationship between trauma exposure and the incidence of PTSD.<sup>4,6</sup> Furthermore, it appears that the factors that lead to people developing PTSD may be less important than the nature of the trauma itself or postincident factors such as the provision of social support.<sup>4</sup>

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## Learning Objectives

- Demonstrate familiarity with previous studies of the psychological effects of working in conflict zones, including studies in military and non-military personnel.
- Outline the new findings on posttraumatic stress disorder (PTSD) symptoms in UK diplomats posted to Iraq or Afghanistan.
- Discuss the findings in context of the ongoing debate over the relative importance of traumatic experiences versus other vulnerability factors in the development of PTSD.

Several recent studies on the health of soldiers, reservists, and peacekeepers have considered the psychological and physical stress of working in conflict zones.<sup>2,7-9</sup> Results have been mixed; some studies suggest that for regular personnel in the United Kingdom military, deployment to the Iraq war has not, so far, been associated with significantly worse health outcomes. However, some military subgroups have been found to have worse mental health after deployment including both combat troops and reservists.<sup>2</sup> Furthermore, psychological symptoms are not only found in United Kingdom military personnel after deployment, but also affect those who have been deployed but have not been involved in active combat.<sup>10</sup> Findings from the United States have also found a link between deployment and poor mental health status including PTSD, depression, substance misuse, unemployment, and divorce.<sup>5,11</sup>

Another important issue, which the military research has considered, is the length of deployment. For example, it appears that for military personnel, longer deployments may be detrimental for personnel's mental health and increased reporting of physical symptoms.<sup>8</sup> Those deployed for 13 months or more in the past 3 years were more likely to fulfil criteria for PTSD, score as cases on the general health questionnaire, and report multiple physical symptoms. The prevalence of all psychological symptoms was higher among those deployed for 13 months or more and consistently associated with problems at home during and after deployment. Furthermore, PTSD was associated with a mismatch between expectations about the duration of deployment and the reality.<sup>8</sup> Similar findings have been found in US military research studies.<sup>12</sup>

There has been only limited research carried out on FCO diplomats working overseas. Unaccompanied employees are at increased risk of illness and traumatic injury when compared with accompanied employees, and employment status, gender, marital status, and region of posting are associated with the development of illness or injury.<sup>13</sup> A report from the US Office of Medical Services (for the US Department of State) on diplomatic staff who had recently returned from Iraq suggests that diplomats have been affected by their service there more than other staff in routine overseas postings. United States diplomats, deployed to Iraq, commonly reported insomnia, "easy to startle" responses, irritability and anger outbursts, numbness and emotional distance, trouble concentrating, and problems relating to their relationship with a spouse or partner<sup>14</sup>; the authors of the report suggested that at least 40% of state department diplomats who have served in danger zones suffer some symptoms of posttraumatic stress.

Although there is a considerable body of research, which has examined individual's reactions to extreme events, this data may not be directly applicable to those who live under the constant threat of being in a war zone, as is the case for diplomatic staff in the Middle East. Modern wars do not have a "front line" behind which personnel can remain safe, and novel tactics such as the use of suicide bombers and improvised explosive projectiles place all personnel, military or otherwise, in harm's way. Thus, all personnel who work in conflict areas, including diplomatic staff, can be regarded as being "at risk" of exposure to intense psychological stress as a function of their work. This study therefore aimed to (a) assess the mental health of diplomats working in Iraq or Afghanistan and diplomats working on overseas postings in nonhardship countries, (b) investigate whether deployment to Iraq or Afghanistan leads to poorer mental health when compared with those on overseas postings, (c) examine the relationship between exposure to trauma and mental health outcomes, and (d) investigate whether longer postings to Iraq and Afghanistan are associated with more adverse mental health outcomes.

## METHODS

The study used a comparative retrospective cohort design and was based on the methodology used by a team of researchers who had examined the health of United Kingdom armed forces personnel.<sup>2,8</sup> The study compared mental and physical health outcomes in two groups of diplomatic personnel. Those who had completed a posting in Iraq and/or Afghanistan (I/A group) and diplomats who had neither worked in Iraq or Afghanistan nor been on a hardship posting (overseas group). The FCO maintains a list of posts, which are designated as hardship postings, calculations are made by the FCO on the basis of employment conditions abroad and take into account a variety of criteria including climate, pollution, isolation, health, security, and social tension.

The I/A group comprised diplomats who had been on a posting to Iraq and/or Afghanistan between January 2003 and June 2008. The overseas group comprised diplomats who had never worked in Iraq or Afghanistan nor been on a hardship posting (as defined by the FCO). The I/A group inclusion criteria included all diplomats who had been on a posting to Iraq and/or Afghanistan and for the overseas group included all diplomats who had completed an overseas posting in the past 5 years. Exclusion criteria for both groups included anyone under active psychological treatment and/or diplomats who had been in the FCO for less than 1 year. Personnel were also excluded from the overseas group if they had been to Iraq or Afghanistan or on a hardship posting in the last 5 years. The two groups were matched for demographic details such as age, seniority, gender, and level of education. The study received approval from Royal Holloway, University of London ethics committee. A total of 358 participants were identified by the FCO.

We devised and piloted a 17-page questionnaire booklet for each group on the basis of the King's College London study.<sup>2</sup> Participation in the study was entirely voluntary and participants were told that the researchers were independent of the FCO. The questionnaire included standardized questionnaires and consisted of six sections: (1) background information: demographics, grade, current job, and directorate; (2) posting information: length of posting, expectations, preparation, experience on deployment (including potentially traumatic experiences), experiences after deployment, and previous deployments; (3) information on current health and mental health history; (4) information on lifestyle: risk taking, alcohol consumption, and smoking; (5) meaning in life; and (6) additional information.

The questionnaire used a number of standardized measures to examine a broad construct of psychological health: symptoms of common mental disorder were measured with the General Health Questionnaire 12 (GHQ-12),<sup>15</sup> and the 12-item Chalder Fatigue Scale (CFS) was used to measure fatigue.<sup>16</sup> Cases on both measures were

defined as individuals with a score of four or more. Symptoms of PTSD were measured using the 17-item PTSD Checklist—Civilians Questionnaire (PCL-C)<sup>17</sup>; we used two cutoffs, 44 (sensitive) and 50 (specific).<sup>17,18</sup> Alcohol consumption and harmful use were measured using the Alcohol use Disorders Identification Checklist (AUDIT),<sup>19</sup> a 10-item questionnaire, the generally accepted cutoff point of the scale for identifying a potential alcohol problem is eight.<sup>20</sup> Caseness was scored as eight and a positive score for diplomats was taken as 12 (a mid-point between the conventional cutoff and the military cutoff).<sup>21,22</sup>

The questionnaire also asked questions about the posting experience. Appraisal of posting experience included whether the posting was (1) a positive (defined in terms of reports of pride, fondness, or accomplishment) or negative experience (defined in terms of reports of confusion, regret, or anger); (2) professionally rewarding; and (3) personally rewarding. Exposure to trauma included fearing death, being shot at, coming under indirect fire, seeing people wounded or killed, giving aid to wounded, handling bodies, experiencing hostility from civilians, and sustaining an injury that needed treatment. Diplomats were also asked whether they would volunteer for the same posting again.

Data was collected from June 16, 2008, to July 31, 2008. Potential participants were contacted by e-mail a week after a letter providing information about the study had been sent to all participants. The first set of questionnaires was e-mailed to both groups on June 16, 2008; both groups were sent a follow-up e-mail on June 23, 2008. Finally, all those who had not responded were e-mailed individually encouraging them to take part in the study. Participants either completed the questionnaire online and e-mailed the researcher a copy or completed it by hand and used the free FCO internal mail system to return the questionnaire.

Data from the questionnaire were analyzed using SPSS (Statistical Package for Social Sciences, IBM, Chicago, Illinois) version 14 for Windows. Before analysis, data were double entered and screened for accuracy, missing values, and normality of distribution. Where participants had put more than one answer to a question, answers were ranked. If participants had not fully answered all questions on a standardized measure, the participant was not given a score for that measure and was not included in related analyses. Parametric tests were used to analyze the data, as normality assumptions were met. To check for confounding variables, a Pearson's correlation was carried out between length of posting and time since posting; and psychological well-being and a *t* test was carried out to see if there was an association between relationship status and well-being scores. No significant differences were found. The homogeneity of the groups was determined by chi-squared tests for categorical scores (all chi-squared analyses used Pearson's chi-squared test) and independent *t* tests for continuous variables. All correlations used Pearson's product correlation and, in accordance with standard scientific practice, we took the level of significance as 5%.

## RESULTS

Of the 358 individuals identified, 149 diplomats fitted the criteria for the I/A group and 209 diplomats fitted the criteria for the overseas group. The overall response rate was 81%. In the I/A group, the response rate was 97% and in the overseas group, the response rate was 69%. The study therefore comprised 289 participants; 144 (49.8%) were posted to either Iraq or Afghanistan (81 males, 62 females) and 145 (50.2%) had been on an overseas posting (88 males, 57 females). Within the I/A group, 99 of the respondents answered that their most recent posting had been to Iraq and 44 to Afghanistan. One respondent in this group did not specify where their most recent posting was to.

The groups did not differ significantly on age, gender, level of education, or grade (Table 1). The only significant demographic difference was that overseas participants were significantly more

TABLE 1. Demographics Split by Group

	Overseas Group Frequency (%)	I/A Group Frequency (%)
Gender		
Male	88 (60.7)	81 (56.6)
Female	57 (39.3)	62 (43.4)
Age	41.89 (8.12)	39.34 (10.06)
Range	(27–58)	(24–64)
Relationship status		
In a relationship	120 (82.8)	89 (61.8)
Not in a relationship	25 (17.2)	55 (38.2)
Education		
Degree or above	83 (57.2)	84 (58.3)
Up to A levels	62 (42.8)	60 (41.7)
Grade		
A	20 (13.8)	22 (15.4)
B	25 (17.2)	42 (29.4)
C	32 (22.1)	25 (17.5)
D	39 (26.9)	37 (25.9)
SMS	29 (20)	17 (11.9)

SMS indicates senior management.

likely to be in a relationship than I/A participants ( $\chi^2_1 = 15.85, P < 0.001$ ).

No significant differences were found between the groups in participant's enthusiasm for going on a posting; however, there was a significant difference between the reasons cited by each group for going ( $\chi^2_4 = 25.34, P < 0.001$ ). In the overseas group, the most cited motivator for going on a posting was career advancement, whereas the I/A group stated that adventure was their main motivation followed by career advancement (Table 2). Diplomats in the I/A group also worked significantly longer hours per week (Table 3) when compared with the overseas group ( $\chi^2_7 = 126.05, P < 0.001$ ).

A significant difference was found between groups on how they defined their posting experience ( $\chi^2_5 = 13.80, P < 0.001$ ). "Accomplishment" was the most cited posting description in the overseas group, followed by "fondness," whereas accomplishment, followed by "pride," was the most cited description for the I/A group. Significantly more participants in the overseas group reported that they would volunteer again ( $\chi^2_1 = 13.80, P < 0.001$ ) and significantly more participants in the I/A group reported that their posting was personally rewarding ( $\chi^2_1 = 12.54, P = 0.001$ ). There were no other significant differences between groups (Table 2).

Within the whole sample, caseness on the GHQ was 22.2%; on the PCL 2.1% (cutoff score of 44) and 0.3% (cutoff score of 50); on the CFS, caseness was 28.2%; and on the AUDIT, 30.5% (cutoff score of 8) and 9% (cutoff score of 12). A chi-squared comparison in caseness between the groups on the standardized measures (GHQ, PCL-C, CFS, and AUDIT) showed that the differences in proportions between groups was not significant for any of the measures. Mean ratings of psychological well-being (measured by the GHQ, PCL-C, CFS, and AUDIT) were calculated for each group and an independent *t* test was used to compare the GHQ, PCL-C, CFS, and AUDIT scores for the I/A group and overseas group. Diplomats posted to Iraq or Afghanistan scored significantly higher than those in the overseas group on the PCL-C ( $t_{285} = 2.15, P < 0.05$ ); however, no other significant differences were found (Table 4).

Further analysis of the sample considered if exposure to trauma was associated with increased symptoms of PTSD. Scores on the PCL for those in the sample who had experienced trauma were compared with those who had not for each question. Fearing

TABLE 2. Between-Group Comparison of Enthusiasm and Motivation Before Posting and Posting Appraisal

	Overseas Group Frequency (%)	I/A Group Frequency (%)
Enthusiasm for posting		
I wanted to go	138 (95.8)	130 (90.3)
I agreed to go	5 (3.5)	13 (9)
I did not want to go	1 (0.7)	1 (0.7)
Motivation for going on posting		
Career advancement	67 (46.5)	40 (28.8)
Adventure	15 (10.3)	42 (30.2)
Money	12 (8.3)	10 (7.2)
Get away	15 (10.3)	5 (3.6)
Other	35 (24.1)	42 (30.2)
Professionally rewarding		
Yes	107 (74.3)	115 (79.9)
No	37 (25.7)	29 (20.1)
Personally rewarding		
Yes	109 (76.2)	131 (91.6)
No	34 (23.8)	12 (8.4)
Description of posting		
Positive	121 (85.8)	120 (83.9)
Negative	20 (14.2)	23 (16.1)

TABLE 3. Between Group Comparison of Hours Worked Per Week

Hours Worked Per Week	Overseas Group Frequency (%)	I/A Group Frequency (%)
Less than 40	14 (9.7)	1 (0.7)
40–49	61 (42.4)	12 (8.3)
50–59	52 (36.1)	24 (16.7)
60–69	14 (9.7)	40 (27.8)
70–79	3 (2.1)	31 (21.5)
80–89	0 (0)	23 (16)
90–99	0 (0)	8 (5.6)
More than 100	0 (0)	5 (3.5)

death ( $t_{283} = 1.75, P = 0.002$ ), being shot at ( $t_{283} = 3.18, P = 0.002$ ), coming under indirect fire ( $t_{283} = 2.34, P = 0.002$ ), seeing people wounded or killed ( $t_{258} = 3.36, P = 0.001$ ), and sustaining an injury that needed treatment ( $t_{280} = 2.73, P = 0.007$ ) were all significantly associated with increased PTSD symptoms. The odds ratio were significant for being shot at OR 20 (3.4 to 115.2) and seeing people wounded or killed OR 6.4 (1.3 to 33.4). No other significant differences were found.

Experiences of trauma differed between the two groups. When compared with the overseas group, significantly more people in the I/A group feared death ( $\chi^2_1 = 108.15, P < 0.001$ ) and were shot at ( $\chi^2_1 = 33.79, P < 0.001$ ) while on their posting. In the I/A group, 89 participants stated they had had a traumatic experience; as expected, these participants scored significantly higher on the PCL-C, ( $t_{140} = 4.44, P < .001$ ) when compared with those in the I/A group who did not have a traumatic experience. A correlation between length of deployment for participants posted to Iraq or Afghanistan and well-being measures (GHQ, PCL-C, CFS, and AUDIT) showed that there was no association between length of posting and well-being scores.

**TABLE 4.** Caseness on Well-Being Measures\*

	Overseas Group Frequency (%)	I/A Group Frequency (%)
<b>GHQ</b>		
Caseness	30 (21.4)	33 (22.9)
Noncaseness	110 (78.6)	111 (77.1)
<b>CFS</b>		
Caseness	41 (29.1)	37 (27.2)
Noncaseness	100 (70.9)	99 (72.8)
<b>PCL-C (a)</b>		
Caseness	2 (1.4)	4 (2.8)
Noncaseness	143 (98.6)	138 (97.2)
<b>PCL-C (b)</b>		
Caseness	0 (0)	1 (0.7)
Noncaseness	145 (100)	141 (99.3)
<b>AUDIT (a)</b>		
Caseness	38 (29.7)	33 (31.4)
Noncaseness	90 (70.3)	72 (68.6)
<b>AUDIT (b)</b>		
Caseness	8 (6.2)	12.4 (9)
Noncaseness	120 (93.8)	92 (87.6)

CFS indicates Chalder Fatigue Scale; GHQ, General Health Questionnaire; PCL, PTSD Checklist—Civilians Questionnaire.

\*Caseness cutoff scores: PCL-C(a) = 44, PCL-C(b) = 50, AUDIT(a) = 8, AUDIT(b) = 9.

## DISCUSSION

The article reports a number of key findings from the results of the first representative study of the United Kingdom diplomatic staff posted to conflict zones. Firstly, we found that diplomats posted to Iraq and Afghanistan reported significantly more symptoms of PTSD (as measured by the PCL-C) than diplomats on overseas postings; experiences of trauma were higher for this group, which may account for higher PCL scores. Secondly, diplomats who reported higher levels of exposure to trauma, such as coming under fire or who feared being killed also reported higher levels of PTSD symptoms whether or not they had been to Iraq or Afghanistan. These differences may be explained by the larger degree of trauma in the I/A sample; however, although diplomats who reported more exposure to trauma reported significantly more PTSD symptoms, there was no significant difference in PTSD caseness. Indeed, only four participants (2.1%) reported sufficient PTSD symptoms likely to be clinically significant, providing further support for the importance of other vulnerability factors in the development of PTSD. We found no evidence to suggest any significant differences between the two groups on levels of psychiatric morbidity. Lastly, we did not find that those who deployed to I/A for longer reported worse mental health. These results suggest that deployment to conflict zones does not necessarily lead to deterioration in mental health.

## LIMITATIONS

As with all retrospective studies that use a self-report method of data collection, causal inferences could not be drawn about the relationships between variables; therefore, the direction of the effects found cannot be ascertained. This also makes it very difficult to rule out situational variables and confounding variables that may have contributed to any associations found at the time. Although there is no reliable way of clarifying whether psychological distress levels (as indicated by the GHQ, PCL, and CFS) was as a result of their posting, the results found can be taken as being valid indicators of association. Future prospective studies are required to examine whether distress

levels are caused by deployments rather than merely being associated with them. This will require having access to baseline data before service personnel are sent on operations.

Another important limitation is that because the FCO sends only a limited number of personnel to I/A each year, to ensure that we had a sufficiently large sample size, some of our participants may have returned home 5 years ago whereas others would have returned home just weeks or months before completing the questionnaire. Therefore, the effect of recall bias was hard to ascertain and would have been likely to vary between respondents.

## COMPARISON WITH THE KNOWN LITERATURE

The finding that diplomats in Iraq and Afghanistan showed higher levels of PTSD symptoms than their overseas counterparts is similar to findings for US diplomats, reservists in Iraq, and military deployed to Iraq and Afghanistan, who showed an increase in PTSD symptoms as a result of their postings.<sup>2,5,8,14</sup> This finding highlights that working in a conflict zone is associated with psychological ill-health even in personnel who are not directly involved in active combat.<sup>10</sup> Similar findings have also been found for military personnel.<sup>5,8,11,23-28</sup> In this study, fearing death, being shot at, coming under indirect fire, seeing people wounded or killed, and sustaining an injury that needed treatment was associated with more PTSD symptoms, lending support to the importance of the trauma itself and factors linked to it, as predictors for PTSD.<sup>29-31</sup> This finding may have relevance for diplomatic staff working in countries, other than I/A, where civil disturbance is common.

Although diplomats posted to Iraq and Afghanistan reported increased PTSD symptoms, this was not associated with frank illness and there was no difference between the two groups on well-being measures. The prevalence of common mental health disorders within the sample was 22% (as measured by the GHQ), PTSD was 2.1% and chronic fatigue was 28%; surveys of the United Kingdom general population morbidity report similar prevalence rates<sup>32,33</sup> with the exception of chronic fatigue, which was significantly higher in the FCO sample (psychiatric morbidity is 26%<sup>32</sup>; PTSD is 3%<sup>34</sup> and level of fatigue (as measured by CFS) is 18.3%.<sup>33</sup> High levels of fatigue may be explained by the long hours diplomats reported working.

## DIFFERENCES BETWEEN THE GROUPS

There may be several explanations for not finding many significant differences between the two groups. Diplomats must undergo a rigorous assessment before postings to Iraq and Afghanistan and have hostile environments training before going away. Foreign and Commonwealth Office employees tend to have better living conditions than the military and there is a high level of security on these postings. The FCO also uses an intensive PTSD psychoeducational trauma risk management strategy (TRiM), based on a peer-group model of psychological risk assessment.<sup>35</sup> Trauma risk management strategy is an organizational-level intervention, which aims to mentally prepare diplomats for the experiences they encounter while on postings to Iraq and Afghanistan and good managerial and organizational factors have been found to protect against mental health problems.<sup>36</sup> Also, in contrast to the military, diplomats have scheduled periods of leave every 6 to 8 weeks, leaving the country for a 2-week break. Another plausible explanation is that diplomats join the FCO for the challenge and excitement of working in different countries and to feel that they are doing something for the greater good. They elect to go on postings to Iraq and Afghanistan and are, therefore, in control of making the choice to request a placement there. These postings may fit with the civil service ideal of making a difference, diplomats' ideas about their role and purpose in the FCO and the meaning of being a diplomat.

No association was found between length of posting and well-being scores, suggesting that longer deployments do not have an adverse impact on diplomats' mental health. Although previous

research has found an association between length of posting and adverse mental health outcomes,<sup>8</sup> it is difficult to draw any firm conclusions from the current study. The sample size in this study may not have been large enough to detect differences for those going away for longer periods of time as few participants in the study were on postings that lasted for more than 12 months. There is also limited research on this area suggesting that more studies are needed before more definite conclusions can be drawn. Another possible explanation may be that, unlike the military, there is no mismatch between expectations about the duration of the deployment and reality. Furthermore, as discussed previously the rigorous assessment, preparation for postings, psychoeducation, decompression breaks, and high levels of security while on postings to Iraq and Afghanistan may also explain why longer postings do not have an adverse effect. Unlike the military, diplomats choose to extend their postings, perhaps enabling them to feel more in control of their experience. Research shows that beliefs about personal control are important to quality of life, and perceptions of personal control are associated with higher levels of mental functioning, more positive affect and less negative affect.<sup>37</sup>

### IMPLICATIONS

The findings from this study have implications for companies who routinely send staff to conflict zones. The study findings appear to highlight the importance of selective assessment, organization preparedness for dealing with exposure to traumatic situations (TRiM), and training (hostile environments training). Thorough assessment and training may ensure that suitable applicants are chosen to go to conflict zones and helps to mentally prepare staff for the experiences they may encounter while living in a conflict zone. Psychoeducation and the use of TRiM may enable staff to recognize signs of posttraumatic stress in themselves and others, hopefully leading to earlier identification of mental health problems. The findings also point to the benefits of a rotational system for sending staff to conflict zones. Further research could focus on companies that use different schedules of work/leave to investigate the issue.

Also of interest to companies that deploy personnel to conflict zones are the reasons cited for choosing a posting to a conflict zone and appraisals following the posting. The findings suggest that diplomats were motivated to go on their postings for different reasons; those who had been to Iraq or Afghanistan were motivated by seeking adventure, while those on overseas postings took positions to advance their career. Although both groups recalled their postings with a feeling of accomplishment, diplomats who had been posted to Iraq or Afghanistan were more likely to recall their posting with pride while those posted overseas were more likely to recall their posting with fondness. Diplomats who had been to Iraq or Afghanistan were also more likely to report that their posting had been personally rewarding, again suggesting that diplomats are motivated by different reasons when they choose to go to Iraq or Afghanistan. Finally, diplomats were less likely to revoluteer for postings to Iraq and Afghanistan when compared with those in the overseas group. Perhaps in going once to Iraq or Afghanistan, diplomats felt that they had done enough; there might be a limit to how long diplomats feel comfortable being in more hazardous environments or putting their lives at risk. It is also possible that they choose not to go back because of disruption to their personal life or because of external pressures on diplomats such as family. This study is also a reminder that, on the whole, only a minority appear to develop serious psychological illnesses such as depression and PTSD and provides support for emerging psychological models that emphasize strength and resilience.

### CONCLUSIONS

This study provides further insight into normal psychological processing of stressful and traumatic experience. On the whole, diplomatic staff deal well with adversity and only a minority develop

serious psychological illnesses such as depression and PTSD. Working in Afghanistan or Iraq was associated with having significantly more symptoms of PTSD and increased exposure to trauma; however, worse mental health outcomes were not specific to diplomats posted to Iraq or Afghanistan only and exposure to trauma was not sufficient to explain the development of PTSD. These findings add to the debate concerning the relative importance of the traumatic experience versus other vulnerability factors in the development of PTSD and mental illness.

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