

Psychological Challenges and Support Strategies for Military Personnel Deployed in Eastern DRC: An Exploratory Analysis

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Abstract

This article analyzes the psychological challenges faced by military personnel deployed in eastern Democratic Republic of the Congo, a region plagued by insecurity and difficult operational conditions. It addresses operational stress, psychological trauma, and organizational dysfunctions that impair soldier performance. Aggravating factors include prolonged exposure to danger, unclear expectations, a lack of logistical support, the absence of military mental health structures, and the stigma associated with seeking psychological help. These elements lead to a high prevalence of disorders such as anxiety, depression, PTSD, operational fatigue, and risky behaviors. The research employs a qualitative approach, including interviews, focus groups, and document analysis, to identify existing support strategies, their limitations, and necessary improvements. It reveals that current, often informal, mechanisms are insufficient to address the complexity of the situations and the severity of the symptoms. The project includes a comparative analysis with other African countries that have more structured military psychological services, demonstrating the effectiveness of integrated approaches based on resilience, peer support, ongoing guidance, and leadership involvement. The Congolese case stands out due to the lack of institutional recognition of mental health as a key factor in operational performance. The project underscores the urgent need to establish formal support mechanisms, improve psychological training for military personnel, strengthen logistics, and transform organizational culture to reduce stigma, promote prevention, and ensure long-term operational effectiveness.

Keywords

Operational Stress, Psychological Trauma, Resilience, Psychosocial Support

1. Introduction

Military operations in eastern DRC expose soldiers to an environment of intense insecurity, chronic violence, and institutional fragility. Studies (Bartone, 2006; Hoge et al., 2004) identify protracted conflicts, repeated exposure to danger, and a lack of support as key factors in psychological distress, exacerbated by the complex terrain, multiple armed actors, and limited logistical resources.

Operational stress, due to constant danger, lack of rest, and the pressure of multiple missions, causes irritability, hypervigilance, and decreased performance, exacerbated by long deployments and precarious conditions. Trauma exposes individuals to a high risk of PTSD, two to three times more likely in high-intensity environments (Hoge et al., 2004), further compounded by ambushes and landmines. A feeling of institutional abandonment, linked to logistical and material delays, correlates with distress (Britt et al., 2006). Cultural stigmatization, which views offering help as a weakness, hinders access to healthcare.

Intermittent conflicts over the past twenty years have exacerbated stress and fatigue (Wright et al., 2009), without respite. Under-equipped bases limit access to care and support (Britt et al., 2006). Asymmetric threats (guerrilla warfare, infiltration) generate psychological pressure (Kilcullen, 2009). Family isolation and ethnic tensions increase anxiety and distress.

Anxiety, depression, PTSD, fatigue, substance abuse and loss of motivation are observed for each soldier, along with impaired cohesion, discipline, decision-making and operational effectiveness (Siebold, 2007), weakening superiority over the enemy for all soldiers.

It is necessary to put in place a support mechanism as a multidimensional approach, including integrated programs with mobile psychologists, screening and ongoing support (Fear et al., 2010); resilience training via psychological and leadership training (Bartone, 2006); peer support to reduce stigmatization (Adler et al., 2011); and operational strategy to improve performance and cohesion.

This study explores the psychological challenges faced by military personnel deployed in conflict zones in eastern DRC, identifies formal and informal support strategies, assesses their perceived effectiveness, and proposes improvements to strengthen psychosocial care. It adopts an exploratory qualitative approach, combining semi-structured interviews with military personnel, focus groups with key stakeholders (doctors, psychologists, commanders, advisors), and a review of existing literature (reports, policies), followed by a thematic analysis. Preliminary findings anticipate: a high risk of PTSD, anxiety, and psychological exhaustion related to prolonged exposure to trauma; persistent stigma hindering access to care; existing but insufficient, unequal, or poorly adapted support mechanisms; frequent recourse to informal coping strategies (cohesion, spirituality, humor); and an urgent need to strengthen mental health training, ongoing psychological support, resilience programs, and dedicated institutional resources.

The article is structured in four parts: 1) a conceptual framework defining “operational stress”, analyzing how the accumulation of emotional and cognitive pres-

asures, vague and poorly defined mission expectations, and limited and unpredictable logistical support in armed conflicts are the sources that exacerbate stress among soldiers on the front lines and reduce their effectiveness; 2) the empirical research protocol; 3) the presentation and discussion of the survey results; and 4) a synthetic conclusion addressing managerial implications, study limitations, and avenues for future research.

2. Conceptual Framework

The psychological challenges faced by military personnel deployed in conflict zones have been extensively documented in the fields of military psychology and organizational behavior. In the context of eastern Democratic Republic of the Congo (DRC), persistent insecurity, unstable front lines, and exposure to chronic trauma create conditions that heighten psychological stress. According to [Adler et al. \(2011\)](#) (Military Medicine), deployment to high-risk areas significantly increases the risk of developing psychological disorders such as anxiety, hypervigilance, and depression. These psychological reactions are not only individual but are also influenced by organizational, environmental, and sociocultural dynamics.

A central concept in this analysis is “operational stress”, defined in *Journal of Human Performance in Extreme Environments* as the accumulation of emotional and cognitive pressures that arise during prolonged exposure to combat-related tasks. In eastern DRC, operational stress is exacerbated by unclear mission expectations, limited logistical support, and the unpredictability of armed conflict. These conditions can lead to cognitive overload, impaired decision-making, and fatigue-induced errors.

A second key concept is exposure to trauma. The literature highlights that repeated exposure to violence, mass deportation, and human suffering is associated with an increased risk of post-traumatic stress symptoms ([Hoge et al., 2004](#), *New England Journal of Medicine*). These symptoms can manifest as intrusive memories, avoidance behaviors, and emotional dysregulation, which can affect military performance.

A third fundamental concept is the dysfunctional organization. Dysfunctions that contribute to underperformance include insufficient support from management, unclear communication channels, and a shortage of psychological care resources. As [Britt, Castro, and Adler \(2006\)](#) (*Military Life: The Psychology of Serving in Peace and Combat*) point out, the organizational climate plays a critical role in resilience and operational readiness. In eastern DRC, inadequate mental health briefings, the lack of confidential counseling services, and the stigma associated with seeking psychological help exacerbate vulnerabilities.

Finally, coping strategies and social support mechanisms constitute a fourth conceptual pillar. The transactional model of [Lazarus and Folkman \(1984\)](#) (Stress, Appraisal, and Coping) shows that coping appropriately depends both on the individual’s appraisal of stressors and the availability of support resources. Research by [Pietrzak et al. \(2010\)](#) (*Journal of Traumatic Stress*) highlights the protective

effects of peer cohesion, leadership empathy, and access to mental health services in reducing the negative impact of deployment.

This conceptual framework allows us to situate the psychological challenges faced by deployed soldiers within a context of interaction between individual experiences, organizational conditions, and contextual instability. It also allows us to identify the dysfunctions underlying the reduced performance of military personnel in eastern DRC.

3. African Exploration of Psychological Challenges and Support Strategies for Military Personnel Deployed in Eastern DRC

To date, the Democratic Republic of the Congo does not have a formally established military mental health service, unlike other African countries such as South Africa or Kenya. The observed support initiatives are essentially ad hoc, often driven by MONUSCO or certain local faith-based organizations. These interventions consist of occasional debriefings, group discussions, or informal community support, which remains insufficient given the severity of the symptoms observed.

The main obstacle to establishing sustainable support structures is the lack of institutional recognition of mental health as a strategic component of military performance. In other words, Congolese military culture remains dominated by a view of physical strength, perceiving psychological suffering as a weakness. This leads to the persistent stigmatization of soldiers experiencing psychological distress, who often prefer silence to seeking help.

3.1. African Models of Military Support and Transferable Lessons

In other African countries, similar mechanisms have been developed to address comparable situations. In South Africa, the Military Psychological Services integrates psychologists into garrisons to provide continuous support to soldiers before, during, and after operations. In Kenya, the armed forces have group therapy units and resilience programs developed after the 2013 Westgate attack. In Nigeria, operations against Boko Haram led to the establishment of a peer-to-peer support system, fostering emotional expression among comrades and institutional recognition of war trauma. These African experiences demonstrate the feasibility of a holistic approach: resilience training, periodic rotation, and valuing feedback from field experience. The challenge for the DRC would therefore be to adapt these models to local constraints, in particular by training officers in psychologically responsible leadership, valuing kindness and cohesion.

3.2. Regional Comparison: Convergences, Divergences and the Uniqueness of the Congolese Case

Structural and symptomatic similarities:

African armies facing asymmetric conflicts share several commonalities: pro-

longed exposure to violence, insufficient logistical resources, and a lack of systematic psychological support. In the Sahel, Malian and Burkinabe soldiers experience similar stress, marked by the constant fear of ambushes and the frequent loss of comrades. In Somalia, AMISOM troops describe a form of perpetual vigilance, where the omnipresent danger prevents any psychological relaxation.

In the case of Mozambique, the units deployed in Cabo Delgado suffer from social and operational isolation, a consequence of the difficulty in distinguishing insurgents from the civilian population. These similarities reveal a constant in Africa: the challenge of military mental health remains secondary to the imperatives of immediate security.

3.3. Institutional Differences and the Congolese Particularity

However, some notable differences emerge: unlike Kenya or Somalia, the DRC does not have regular troop rotations or a system for psychological recovery at the end of missions. Furthermore, a particular historical and communal dimension characterizes the Congolese conflict: soldiers are often deployed in their own regions of origin, exposing them to identity and emotional dilemmas. This creates a double moral shock: the soldier is fighting against his own neighbor and sometimes within his own sociocultural fabric.

The Congolese specificity lies in the cumulative nature of the trauma: soldiers there suffer simultaneously the stress of war, personal insecurity, and a lack of institutional recognition. This triple constraint makes the DRC a unique case where the soldier becomes, to some extent, a victim of the war he is supposed to be waging.

3.4. Empirical Research Protocol

The research adopted an exploratory qualitative approach aimed at understanding the experiences of deployed military personnel and identifying the mechanisms of psychological stress and support. This approach is recommended for studying complex and poorly documented phenomena in unstable environments (Creswell, 2014, Research Design). An exploratory qualitative approach is relevant and important because it allows access to the subjectivity of military experiences (Denzin & Lincoln, 2018), identifies the complex mechanisms of psychological stress (Patton, 2015), reveals formal and informal support dynamics (Miles et al., 2014), gives voice to voices that are often underrepresented (Charmaz, 2014), and finally guides future policies and interventions (Creswell & Poth, 2018).

The profiles of the respondents are also diverse: Army officers, Air Force officers, Naval Force officers; Medical Corps soldiers, Military School Commanding Officers, Logistics Corps soldiers, Republican Guard, Signal Corps; Engineering Corps; Armed Forces Information Service soldiers; Military Chaplaincy soldiers, General Staff Officers; Naval Force officers.

The use of purposive sampling is justified by the fact that, as in many African countries, Military personnel are generally reluctant to participate in surveys and

polls. Almost all respondents hold a higher education degree. Our sample size was determined according to the principle of theoretical saturation, which states that: “when adding more interviews no longer enriches the developed model... in practice, 7 to 12 interviews are generally sufficient to reach this saturation”.

We remained focused on our theme, which relates to the psychological challenges faced by military personnel deployed in eastern Democratic Republic of the Congo (DRC), as well as the formal and informal support strategies mobilized in a context characterized by security instability, exposure to extreme violence, and the organizational constraints inherent in military operations. From an exploratory perspective, the target population consists exclusively of military personnel currently or recently engaged in operations in the eastern region, regardless of their branch of service, seniority, or rank. As [Greene-Shortridge et al. \(2007\)](#) point out, such a broad approach allows us to capture the plurality of psychological experiences in high-risk environments.

To ensure the essential functional representativeness in an army characterized by a strong segmentation of roles, the sample was constructed using a purposive sampling strategy aimed at integrating various operational, logistical, and morale support units. Sixteen (16) semi-structured individual interviews were conducted with military personnel from the following categories: Army Officers; Air Force Officers; Naval Force Officers; Medical Corps Soldiers; Commanding Officers of Military Schools; Logistics Corps Soldiers; members of the Republican Guard; Signal Corps; Engineering Corps; personnel of the Armed Forces Information Service; soldiers of the Military Chaplaincy; and one General Staff Officer. This breakdown reflects the structural diversity of the army and allows us to understand, in accordance with observations, how psychological constraints manifest themselves differently depending on the responsibilities and operational environment of each unit.

The interviews were conducted between May and August 2024 at three secure Armed Forces sites located in North Kivu and South Kivu provinces, as well as in Kinshasa for personnel in operational transit. All deployed or recently repatriated (within the last 12 months) military personnel, aged 18 or over, and able to provide informed consent without hierarchical pressure were eligible. The interviews took place under significant operational constraints, including frequent rotations, recurring security alerts, and limited personnel availability—challenges commonly encountered in research conducted in conflict zones.

Theoretical saturation was observed as early as the ninth interview, at which point no new themes were added to the developing analytical categories. Following methodological guidance on ensuring robustness, diversity of inter-corporeal perspectives, and internal validation of already-identified categories, the researchers continued with up to sixteen participants. The apparent difference between saturation and final sample size is therefore consistent with contemporary qualitative standards, which clearly distinguish the point of saturation from methodological completion.

From an ethical and security standpoint, the study was guided by the principles of respect, confidentiality, and non-maleficence. Individual informed consent, obtained orally or in writing depending on security conditions, was obtained after explaining the objectives, risks, and participants’ rights (freedom to withdraw, non-transmission of statements to superiors). Given the persistent stigma associated with mental health in the military and the close proximity to command, strict confidentiality measures were implemented: complete anonymization, removal of any identifying unit information, and secure data storage. The study received approval from the authorities empowered to authorize research and interviews on this topic, as well as authorization from our university’s research department on public enterprises, since the military is considered a state-owned enterprise in accordance with the recommendations for sensitive research in a military context. Thus structured, the methodological framework ensures consistency between the target population, the characteristics of the sample, the realities of the military field in conflict zones, and the ethical requirements specific to the study of a highly sensitive subject such as the psychological health of deployed military personnel. The interview guide served as a data collection tool and was structured around 4 main themes, presented in **Table 1** below.

Table 1. Prototype of the semi-structured interview guide.

No.	Investigation	Defense Zones	General Staff	Maintenance Code	Interview Time
01	Ground Force Officers	1	1	Commander	30
02	Air Force Officers	1	1	Military Order	35
03	Naval Force Officers	1	1	Commander	25
04	Medical Corps Soldiers	1	3	Execution	30
05	Commanding Officers of Military Schools	1	1	Commander	20
06	Logistics Corps Soldiers	1	1	Military Order	25
07	Republican Guard	1	2	Military Order	30
08	Corps of Signal Troops	1	3	Military Order	25
09	Corps of Engineers	1	1	Military Order	20
10	Information Service Soldier of the Armed Forces	1	3	Execution	25
12	Soldier of the Military Chaplaincy	1	3	Execution	20
13	General Staff Officer	1	1	Commander	25
16	Naval Force Officers	1	1	Commander	20
TOTAL					340

Source: Domain author.

Prototype of the maintenance guide:

Theme 1: Fear of Betrayal/Mistrust.

Theme 2: Family/Deployment Issues.

Theme 3: Survival (Coping) Mechanisms.

Theme 4: The Need for Structural Reforms.

4. Results of Empirical Surveys and Discussion

Data collection combined semi-structured interviews and focus groups. The semi-structured interviews allowed for the elicitation of individual accounts of deployment-related stressors, capturing emotional nuances and contextual specificities. The focus groups complemented this method by encouraging collective reflection on shared challenges and coping strategies, in line with the methods advocated by [Morgan \(1997\)](#) (Focus Groups as Qualitative Research).

A sampling strategy was used to select participants who had served or were currently serving in operations in eastern DRC. This selection method is well-suited for accessing information-rich cases ([Patton, 2002, Qualitative Research and Evaluation Methods](#)). Participants included officers, non-commissioned officers, and enlisted personnel to ensure a multilevel perspective on psychological and organizational conditions.

5. Results of the Interviews Conducted

During a guided interview with several military personnel, represented by interviewees A (Army Officer), B (Air Force Officer), C (Naval Force Officer), D (Medical Corps Soldier), E (Military School Commanding Officer), and F (Logistics Corps Soldier), we addressed important themes such as fear of betrayal and mistrust, deployment-related family issues, survival mechanisms, and the need for structural reforms. The objective was to gather information on the psychological challenges and support strategies for our military personnel deployed in eastern DRC. In this exploratory analysis, respondent A shared that these challenges are of the “operational stress” type, due to the accumulation of emotional and cognitive pressures resulting from prolonged exposure to combat tasks. Respondent B added that in the DRC, operational stress is further complicated by unclear mission expectations and limited logistical support. Finally, respondent C stressed that the unpredictability of armed confrontations represents a major additional challenge.

Respondent E shared with us that these conditions can truly lead to mental overload, less clear decision-making, and errors due to fatigue. Being close to respondent F, he discussed this with him and asked for his thoughts. Respondent F simply stated that these kinds of errors often stem from vague and prolonged missions without relief, which can be extremely taxing. He also emphasized that repeated exposure to violence, mass deportation, and human suffering is linked to a higher risk of post-traumatic stress symptoms. Respondent F added that we often experience symptoms when faced with serious situations lacking clear solutions. For example, when some commands order us to retreat while we are winning, while others tell us to advance while we are about to lose. These intrusive memories, avoidance behaviors, and difficult emotional management often impact our performance

in the field.

We then spoke with respondent G about the dysfunctional organization. He shared that the problems we face contribute to underperformance, and this is also due to a lack of support from our various departments, communication channels that are not always clear, and a shortage of mental health resources. Respondent H, for his part, emphasized that we have found that the organizational climate has a major impact on resilience and operational readiness. In our country, particularly in eastern DRC, where we are deployed to manage military situations, we lack mental health briefings, and there is a lack of confidential counseling services, not to mention the stigma associated with seeking psychological help, even though this could really strengthen our resilience.

Ultimately, we realized we had a good understanding of the situation, and as we continued asking further questions, we felt a certain saturation. We therefore decided to ask respondent I about coping strategies and social support mechanisms. This respondent indicated that coping appropriately depends both on the individual's assessment of stressors and the availability of support resources. His colleagues explained why he had agreed to participate in this interview guide, and they responded by saying, and I quote: "We emphasize the protective effects of peer cohesion, leadership empathy, and access to mental health services in reducing the negative impact of deployment".

Qualitative analysis with NVivo allows us to establish links between respondents' statements and an understanding of psychological challenges and support strategies. Using NVivo, we imported the interviews, created thematic nodes (operational stress, mission uncertainty, violence, fatigue, organizational dysfunctions, lack of psychological support, coping strategies, peer cohesion, empathic leadership), coded segments according to the respondents, and then generated a semantic network using Model Builder to link these themes. The simplified semantic network, based on A - I statements, highlights: operational stress caused by pressure, prolonged combat, and unpredictability, exacerbated by a lack of mission clarity and logistical support; repeated exposure to violence leading to an increased risk of post-traumatic symptoms; cognitive overload and decision fatigue resulting in errors; organizational dysfunctions with unclear communication and a lack of psychological resources; and an unfavorable organizational climate marked by the stigmatization of mental health, reducing resilience. Finally, essential coping strategies and social support, including peer cohesion, empathy from command, and access to healthcare, play a protective role. These elements are articulated within a model where operational challenges generate cumulative stress and psychological vulnerability, exacerbated by organizational dysfunctions and a lack of support, and moderated by individual and collective coping strategies.

This interpretation combines these results with the literature: operational stress corresponds to a model linked to prolonged exposure to combat; mission uncertainty and lack of logistical support increase mental workload (Adler et al., 2011); exposure to violence increases the risk of PTSD (Brewin, Andrews, & Valentine,

2000); fatigue and cognitive overload impair performance (Morgan et al., 2006); organizational dysfunctions generate institutional stress (Griffith, 2011); the stigma surrounding psychological care is a major barrier (Greene-Shortridge, Britt, & Castro, 2007); finally, coping strategies fall within the transactional model of Lazarus and Folkman (1984), with peer cohesion recognized as a protective factor (Siebold, 2007). Based on this finding and interpretation, NVivo demonstrates that the psychological challenges faced by military personnel in the DRC stem from a combination of factors: operational stress, exposure to violence, organizational dysfunction, and a lack of psychological resources. Effective support strategies include peer cohesion, empathetic leadership, access to psychological services, and appropriate coping strategies.

6. Presentation and Discussion of Results

The results reveal four major categories of psychological challenges. First, participants reported persistent exposure to traumatic scenes, repeated ambush threats, and an intense operational tempo. Consistent with the findings of Hoge et al. (2004), these experiences induced symptoms characteristic of anxiety and emotional desensitization. Many soldiers reported suffering from sleep disturbances and intrusive thoughts that disrupted their concentration and operational readiness.

Next, organizational dysfunctions emerged as significant contributors to inefficiency. Respondents highlighted insufficient rotation cycles, inadequate psychological preparation, and the lack of structured debriefing after intense missions. These observations are consistent with those of Adler et al. (2011), who emphasize that organizational dysfunctions can exacerbate the effects of combat stress. Several soldiers reported that their superiors underestimated the psychological burden of extended deployments, contributing to feelings of abandonment and decreased morale.

Third, social support systems were unequal. While cohesion within units was generally strong, some participants feared stigmatization if they disclosed psychological difficulties. These findings are similar to those of Britt et al. (2006), who cite stigma and cultural norms as major barriers to seeking help in military environments. Soldiers often preferred informal discussions with peers to formal consultations.

Fourth, coping strategies varied widely. Adaptive strategies included physical exercise, group discussions, and spiritual practices, consistent with the patterns described by Pietrzak et al. (2010). However, less adaptive behaviors, such as emotional suppression and trauma trivialization, were also observed, which may increase long-term psychological vulnerability.

Furthermore, the thematic material is rigorously examined according to established standards: following familiarization, inductive open coding generated 52 initial codes, development of a structured codebook, and resolution of inter-coder disagreements ($\kappa = 0.80$), four empirically grounded themes emerge: 1) persistent

exposure to trauma and constant vigilance creating significant neuropsychological stress; 2) organizational dysfunctions (mission ambiguity, lack of debriefing, fragmented communication) amplifying combat stress; 3) unequal social support and strong stigma surrounding psychological help linked to military masculinity norms; and 4) mixed coping strategies combining constructive adaptations (exercise, spirituality, cohesion) and avoidance mechanisms. Anonymized extracts illustrate these themes, confirming the dynamics identified by previous studies.

The international comparison with South Africa, Kenya, and Nigeria is justified by explicit criteria: shared experience in asymmetric conflicts, institutionalized psychological support systems, comparable logistical constraints (territorial extent, limited resources), and potential for transferability. It allows for the identification of transferable solutions: some immediate and low-cost (mini-debriefings, peer facilitators, anti-stigmatization awareness campaigns, informal psychological check-ins), others requiring structural investments (creation of a professional corps of military psychologists, regular rotation cycles, regional psychotraumatology centers, improvement of accommodation infrastructure). The feasibility of these reforms depends on the specific constraints of the DRC in terms of personnel, infrastructure, and geographical dispersion.

Based on this analysis, we can conclude that the psychological challenges faced by Congolese military personnel stem from four factors: operational trauma, organizational dysfunctions, unequal access to social support, and ambivalent coping strategies. Inadequate personnel performance results not only from individual vulnerabilities but also from intense exposure to trauma, inadequate organizational support, and limited access to structured psychological care. International comparisons justify the need for concrete solutions to improve the resilience and psychological support of military personnel in the DRC.

7. Conclusion, Managerial Implications, Limitations of the Study and Research Perspectives

7.1. Conclusion

Military deployments in eastern Democratic Republic of the Congo expose personnel to a particularly demanding operational environment: repeated violence, the risk of ambush, difficult logistical conditions, and identity tensions linked to operations often conducted in or near their home territories. All these elements create continuous operational stress, manifesting as acute symptoms (anxiety, hypervigilance, sleep disturbances, intrusions) and chronic symptoms (desensitization, psychological exhaustion) that can have a lasting impact on mental health, unit cohesion, and operational effectiveness.

The analysis reveals that these effects stem not only from exposure to traumatic situations, but also from a range of organizational dysfunctions: lack of regular rotations, insufficient psychological preparation, insufficient debriefings and post-mission recovery programs, and the absence of a formal national structure for mil-

itary mental health support. Furthermore, a local military culture that values resilience and stigmatizes psychological distress complicates access to care and the expression of difficulties. However, unit cohesion and informal resources (peer support, spiritual practices, physical activities) are genuine protective factors, even if their use is uneven.

Comparative experiences with other African countries show that holistic approaches adapted to the local context are both feasible and beneficial: integration of mobile psychologists, resilience training, peer support, planned rotations, structured debriefings, and psychologically responsible leadership. Adapting these models to the DRC requires taking into account national specificities, such as logistical constraints, the geographical proximity between deployment and communities of origin, and cultural norms regarding suffering, in order to avoid imported solutions that would be unsuitable.

From an operational and managerial perspective, improving the well-being and performance of deployed forces requires multi-level interventions, well-coordinated over time: primary prevention (selection and psychological preparation before deployment), interventions during missions (peer support, presence of mobile professionals, rotations, and planned breaks), and post-mission care (screening, debriefings, and access to ongoing, non-stigmatizing mental health services). Strengthening empathetic leadership and training managers in operational stress management is essential for the sustainable integration of these practices. In parallel, it is crucial to implement destigmatization and internal communication efforts to encourage everyone to seek help without fear of consequences. While our qualitative findings are rich and useful for targeting interventions, they are somewhat limited by the size and nature of the sample. We therefore need quantitative studies, pilot evaluations of interventions, and long-term follow-ups to truly measure the effectiveness of the recommended measures and adapt them accordingly. Finally, creating a national military mental health policy, supported by international partnerships and dedicated resources, is essential to transforming good practices into sustainable and scalable measures. In short, protecting the mental health of military personnel in eastern DRC requires an integrated strategy that combines prevention, accessible care, and strengthened organizational support. Such an approach would not only improve individual well-being but also unit cohesion and resilience, and mission effectiveness, representing a true strategic investment in the security and stability of the region.

7.2. The Limitations of the Study

Its qualitative approach, reliance on self-reported experiences, and small size limit its generalizability. Access constraints to conflict zones may also have prevented the inclusion of diverse operational contexts. Future research should employ mixed methods, analyze the long-term psychological trajectories of deployed personnel, and evaluate the effectiveness of specific support interventions. Comparative studies between different peacekeeping and combat missions would deepen

our understanding of contextual influences on the psychological health of military personnel.

7.3. Managerial Involvement

The managerial implications encompass several aspects for improving the psychological well-being of military personnel on missions. It is essential to integrate resilience, stress management, and psychoeducation modules into training, tailored to the specific operational realities of eastern DRC. A continuous psychological monitoring system must be established to regularly assess the mental state of military personnel and create indicators of operational well-being. Commanders' psychosocial leadership skills must be strengthened, with training to recognize signs of distress and develop empathetic leadership. Professional support mechanisms must be institutionalized, with deployed psychologists or mobile mental health teams, guaranteeing confidential and non-stigmatizing access. Work organization in the field must be improved to reduce mental exhaustion and provide periods of decompression. Cohesion and social support within units must be strengthened through solidarity activities and mentoring programs. The family dimension must be taken into account by facilitating communication with families and integrating them into reintegration programs. Living and working conditions must be improved to limit environmental stress. Lessons learned must be institutionalized to adapt operational doctrines and deployment plans. Finally, mental health must be integrated into national military policies with a dedicated budget.

7.4. Recommendation

These recommendations propose an integrated approach to improving psychological support for military personnel deployed in the DRC. They are based on five pillars: 1) strengthening pre-deployment psychological preparation through modules adapted to the realities on the ground; 2) establishing continuous and non-stigmatizing psychological support with specialized teams on the ground; 3) developing military leadership focused on listening and early detection of distress; 4) improving living conditions and social support to prevent isolation; and 5) institutionally formalizing mental health as a strategic priority with a dedicated budget and post-mission reintegration protocols. These measures aim to strengthen the resilience and psychological well-being of military personnel.

Data Availability Statement

We wish to inform you that the study data is not accessible due to restrictions put in place by representatives of the organizations.

Conflicts of Interest

We are pleased to confirm that there are no potential conflicts of interest with regard to the research, writing and/or publication.

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