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The Wounds of Religious Violence and Terrorism in Nigeria: Posttraumatic Stress Disorder

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Abstract:
A quasi experimental study designed to establish the wounds of Religious violence and Terrorism in Nigeria: PTSD. 102 Nigerian military personnel participated in the study using accidental sampling technique, 85(83.33%) are males and 17(16.67%) females. 58(56.9%) are younger soldiers ages 19-37, 42(41.2%) are older soldiers ages 38-58, 77(75.49%) are married, 24(23.53%) singles and 1(0.98%) widower. Three hypotheses were tested; data was collected using Posttraumatic Stress Disorder Keane Scale (PKS). Result revealed that, there was a significant difference in PTSD scores, t=2.365, df=100, p=0.020(p<.05); with mean scores of 19.31 and 22.67 for soldiers that participated in peace keeping missions in Adamawa, Borno, Plateau and Yobe than those that did not participate respectively. There was no significant difference in scores on PTSD scale among soldiers who participated in more than one mission than those who participated once, t=0.809, df=49, p=0.422(p>.05); with PTSD mean scores of 18.63 and 20.08 for soldiers that had one mission and those that had more than one mission respectively. Older soldiers (38-58years) did not have a significant higher scores on PTSD than younger soldiers (19-37years) irrespective of missions attended, t=0.208, df=97, p=0.836 (p<.05); with PTSD mean scores of 20.28 and 21.20 for younger and older soldiers respectively.

Keywords: *Posttraumatic stress Disorder, Wound, Religious, Violence, Terrorism, Military/Soldiers, Nigeria*

1. Background of Study

When individuals are exposed to traumatic events such as rape, disaster, or acts of violence, they often experience a variety of negative psychological effects (Kessler, 2000). A well-recognized aftermath to traumatic events is Posttraumatic Stress Disorder (PTSD) (Kesler, Sonnega, Bromet, Hughes, and Nelson, 1995). PTSD is an anxiety disorder in which the individual experiences several distressing symptoms for more than a month following a traumatic event such as a reexperiencing of the traumatic event, an avoidance of reminders of the trauma, a numbing of general responsiveness, and increased arousal (Halgin and Whitbourne, 2000).

Some people develop an acute stress disorder soon after a traumatic event. In this condition the individual develops intense fear, helplessness, or horror. Dissociative symptoms may appear, such as feeling numb, unreal, or detached, and amnesia about the event may develop. Despite the extreme nature of the symptoms of acute stress disorder, most people are able to return to relatively normal functioning within days or weeks. Others, however, do not. They go on to develop posttraumatic stress disorder (PTSD), a diagnosis that is appropriate when the symptoms persist for more than a month. In the aftermath of an acute stress disorder, the symptoms of PTSD may start to take hold and take on a chronic and unremitting course. Reminders of the trauma, either in the person's own thoughts or in the environment, evoke intense levels of psychological or physiological distress. Even the anniversary of the event may stir up intense psychological and physical disturbance. These symptoms are so painful that people who suffer from PTSD intentionally go to great lengths to avoid anything that may remind them of the trauma (Halgin and Whitbourne, 2000).

The symptoms of PTSD seem to fall into two related clusters. The first, called "intrusions and avoidance" includes intrusive thoughts, recurrent dreams, flashbacks, hyperactivity to cues of the trauma, and the avoidance of thoughts or reminders. The second cluster, "hyper arousal and numbing," includes symptoms that involve detachment, a loss of interest in everyday activities, sleep disturbance, irritability, and a sense of a foreshortened future. Thus, intrusive thoughts give rise to the avoidance of disturbing reminders, and hyper arousal leads to a numbing response (Taylor, Kuch, Koch, Crockett and Passey, 1998).

One year after the 1982 Lebanon War, the authors assessed the prevalence, type, and severity of PTSD in a large representative sample of Israeli soldiers who had been treated for combat stress reactions. Comparisons were made with a group of soldiers who had

fought in the same battles but had not been treated for this reaction. A dramatically higher percentage of soldiers with combat stress reaction (59%) than soldiers without combat stress reaction (16%) developed PTSD. Age was significantly associated with PTSD (Solomon, Weisenberg, Schwarzwald, and Mikulincer, 1987).

Natural disasters such as road traffic accidents, floods, fires, volcanoes, mud slides, earthquakes and tsunamis have all been implicated as stressors causing PTSD (Kaplan and Saddocks, 1994; Gelder and Mayou, 1996). Regarding its etiology, the presence of a stressor is necessary for the development of PTSD. Manmade events e. g assault, bombings, armed robbery, ethno-religious violence etc may predispose to it (Burke 2011; Ramsy, Gorst-Unsworth, and Turner, 1993).

Religious violence is a term that covers phenomena where religion, in its diversity, is either the subject or object of violent behavior (Wellman, James; Tokuno, and Kyoko 2004). Religious violence is, specifically, violence that is motivated by or in reaction to religious precepts, texts, or doctrines. Religion and violence are often woven together in history's tapestries (Cohn 1993).Conventional definitions of violence center on the use of physical force to cause injury to persons and, sometimes, damage to property. These definitions pose neat objective standards, and they underscore the point that the exercise of force is not always violent. However, they do not hold up very well, either in objective terms, or when cultural issues are considered (Hall, 2001). Juergensmeyer (2000) argues that religious violence sometimes involves symbolic and per formative pursuit of a war that cannot be won, in which defeat nevertheless is unthinkable.

Terrorism is from the word 'terror' which conjures the image of fear and trepidation. It is an act intended to instill fear and submission in the targeted victim(s). It is usually unprovoked, random and unpredictable while its commonest form is bombing. It could also take the form of hijacking of commercial aircraft, kidnapping, assassination, gun attack, arson and frontal assaults on important state institutions. The essential purpose being the desire to draw attention to and/or gain sympathy for a cause, the perpetrators are usually religious fundamentalists, extremists of the right and left, governments and underground organizations. In Nigeria the dastardly terrorist activities of "Boko Haram" have manifested profoundly in the various bomb/gun attacks on police stations, army barracks, prisons, churches as well as some other public institutions, and prominent personalities (Ajayi, 2012).

Following World War, I and II, there were numerous reports of psychological impairment described with such terms as "shell shock," "traumatic neurosis," "combat stress," and "combat fatigue." Concentration camp survivors were also reported to suffer long- term psychological effects, including the "survivor syndrome" of chronic depression, anxiety, and difficulties in interpersonal relationships (Chodoff, 1963; Eaton, Sigal and Weinfeld, 1982).

McCarroll, Ursano, and Fullerton (1993) in their study of soldiers involved in Operation Desert Storm in 1991, reported that individuals who had the job of handling human remains were more likely to develop intrusive and avoidant symptoms of PTSD. Experienced workers were less likely to suffer these symptoms, but even among experienced workers there was a positive relationship between the number of body remains that they handled and the degree of their symptoms. Even 1 year later, those who handled human remains still suffered psychological disturbances (McCarroll, Ursano, and Fullerton 1995)

Makput and Rabbebe, (2011) reported, 70 (28%) out of the 250 respondents in their study developed PTSD. Of the 130 males who participated in the study, 30(23.1%) developed PTSD, compared to 40 (31.8%) of the 126 females. Thus of the 70 total number of participants who developed PTSD, 30 (42.9%) were males and 40 (57.1%) were females. Therefore, in terms of PTSD prevalence by gender, more females developed PTSD giving a M:F ration of 1:1.4

In the 1980s, when the diagnosis of PTSD was added to the DSM, the media drew attention to the psychological aftereffects of combat experienced by Vietnam War veterans (Halgin and Whitbourne, 2000).

War is perhaps one of the most challenging situations that a human being can experience. The physical, emotional, cognitive and psychological demands of a combat environment place enormous stress on even the best-prepared military personnel. High level of stress that is naturally experienced in combat typically results in a significant percentage of soldiers at risk for developing PTSD upon the return home. Indeed, the Iraq/Afghanistan combat theatres, with their ubiquitous battlefronts, ambiguous enemy identification, and repeated extended deployments has produced large numbers of returning American Service Members reporting symptoms that are congruent with the diagnosis of PTSD and other mental disorders. In the first systematic study of mental health problems due to these conflicts, "…The percentage of study subjects whose responses met the screening criteria for major depression, generalized anxiety, or PTSD was significantly higher after duty in Iraq (15.6 to 17.1 percent) than after duty in Afghanistan (11.2 percent) or before deployment to Iraq (9.3 percent)" (Hoge, Castro, Messer, , McGurk, Cotting, and Koffman (2004).

2. Theoretical Review

2.1. Biological Perspective

Although by definition PTSD has its origins in life experiences, researchers have increasingly been turning up evidence linking its symptoms to biological abnormalities. In recent years, some researchers formulated the theory that, once a traumatic experience has occurred, parts of the individual's nervous system become primed or hypersensitive to possible danger in the future. Subcortical pathways in the central nervous system, as well as structures in the sympathetic nervous system, are permanently on "alert" for signs of impending harm (Heim, Owens, Plotsky, and Nemeroff, 1997; Rauch, Van der Kolk, Fisler, Alpert, Orr, Savage, Fischman, Jenike, and Pitman, 1996). Genetic predisposition may also play a role in the development of PTSD. In one study of more than 4,000 twin pairs who fought in Vietnam, genetic factors seemed to play an important role in their susceptibility to the development of re-experiencing, avoidance, and arousal symptoms (True, Rice, Eisen, Heath, Golberg, Lyons, and Nowak, 1993).

2.2. Psychological Perspective

According to classical behavioral approaches, it is assumed that the person with PTSD has acquired a conditioned fear to the stimuli that were present at the time of the trauma. Because of a learned association, the individual experiences anxiety when these or similar stimuli are present, even in the absence of the traumatizing experience (Halgin and Whitbourne, 2000). Cognitive – behavioral theorists (Foa, Steketee, and Robaum, 1989) have incorporated the concept of how people's beliefs about a traumatic event influence how they cope with it. Thought that are likely to have a detrimental effect, and can ultimately lead to PTSD, include excessive self – blame for events that are beyond personal control, as well as guilt over the outcome of these events (Kubany, 1994; Ramsay, Gorst-Unsworth, and Turner, 1993).

3. Aim of Study

This study focuses on two manmade events (Religious violence and Terrorism) that are stressors causing PTSD. Therefore, the study is aimed at seeing if Religious violence and Terrorism are predicting factors for the development of PTSD among Nigerian Military troops that participated in peace keeping missions related to religious violence and terrorism in Adamawa, Borno, Plateau and Yobe states of Nigeria.

4. Hypothesis

1. There is the likelihood that soldiers who participate in peace keeping mission in Adamawa, Borno, Plateau and Yobe will likely have higher Post-traumatic Stress Disorder (PTSD) score than those who did not.
2. There will be no significant difference in scores on PTSD scale among soldiers who participated in more than one mission than those who participated once.
3. There is the likelihood that older soldiers (38-58 years) will have higher scores on PTSD than younger soldiers (19-37 years) irrespective of missions attended.

5. Method

- Research Design: Quasi experimental design

5.1. Instrument for Data Collection

The Posttraumatic Stress Disorder Keane Scale (PKS) is used in data collection. PKS is a 46 items instrument developed by Keane, Malloy and Fairbank (1984). The purpose is to measure Posttraumatic Stress Disorder (PTSD), Panic anxiety, Social anxiety, and Environmental anxiety. The 46 – item inventory is one of the six additional MMPI-2 supplementary Scales. There are however, two independent scales derived from MMPI-2 to measure posttraumatic stress disorder (PTSD), the scales are PKS authored by Keane et al (1984) and PSS authored by Schlenger and Kulka (1989). The PKS is particularly valuable in distinguishing war veterans with PTSD from those of them with either psychiatric disorder but no PTSD or no disorder at all.

5.2. Psychometric Properties

- Norms: Keane et al (1984) provided the original psychometric properties for American samples. Psychometric properties for Nigerian samples were developed by Ayonuwe (2003).The norms reported here are the mean scores of samples drawn from mixed populations, M 14.38 (n=50), F 12.44 (n=50).
- Reliability: The reliability coefficients reported by Keane et al (1984) are cronbach Alpha Men .50 and Women .87, Test-retest Men .86 and Women .89
- Validity: Keane et al (1984) obtained a concurrent validity coefficient of .80 by correlating the PKS version in MMPI-1 with that in MMPI-2. By correlating PKS with SCL- 90 Somatization scale Derogatis, Lipman and Covi, (1977) and PSC Omoluabi (1987), Ayonuwe (2003) obtained concurrent validity coefficients of .87 and .84 respectively.

6. Procedure

- Sampling Technique: Accidental sampling technique was used in selecting participants.

6.1. Participants

The Nigerian Army constituted the population of this study. 200 soldiers were selected using the accidental sampling technique within the 3 Amour Division Jos. However, only 138 questionnaires were returned out of which only 102 were valid. During coding the questionnaires were grouped into two groups(those that have participated in peace keeping missions in Adamawa, Borno, Plateau and or Yobe states respectively and those that have not) of equal number. Each group has 51 participants.

- Choice of Statistics: t- test is used in analyzing data
- Data Analysis: All statistical analysis is performed using version 20 of the statistical package for social sciences (SPSS).

7. Result

85 (83.33%) of the participants are males and 17 (16.67%) are females, 74 (72.55%) are Christians, 28 (27.45%) are Muslims. 77 (75.49%) of the participants are married, 24 (23.53) are singles while only 1 (0.98%) is a widower. Participants are serving in 8 different units, 3 Div headquarters has 10 (9.81%) participants, 3 Div provost group 2 (1.96%), 3 Div supply and transport 8 (7.84), 330 signal unit 12 (11.76%), 3 Div Hospital 18 (17.65%), 82 Battalion 23 (22.55%), 3 Div Garrison 17 (16.67) and 303 artilleries 12

(11.76%).51 participants were exposed to peace keeping mission either in Adamawa, Borno, Plateau and or Yobe while 51 participants were not exposed. Out of the 51 participants that are exposed to peace keeping operations, 27 (26.5%) only participated once (in one state) while 24 (23.5%) participated more than once (in more than one state).
The Soldiers status ranged between private and 2 Lieutenant. 16 (15.69%) are privates, 24 (23.53) are Lance corporal, Corporal and Sergeants has 20 (19.61%) each, 10 (9.80%) are Staff Sergeant, 6 (5.88%) are warrant officers and only 1 (0.98%) is a Master warrant officer, and 5 (4.90%) are 2 Lieutenants.

Soldiers	N	Mean	Standard Deviation	T	Df	Mean difference	p-value
Participated in peace keeping	51	19.31	6.38				
				2.365	100	3.353	0.020
Did not participate in peace keeping	51	22.67	7.86				

Table 1: Peace keeping missions attended or not

Results of the first hypothesis is accepted, t-test statistic revealed that there was a significant difference in PTSD scores, t = 2.365, df = 100, p = 0.020 (p <.05); with post-traumatic stress disorder mean scores of 19.31 and 22.67 for soldiers that participated in peace keeping missions in either Adamawa, Borno, Plateau states and or Yobe states than those that did not participate respectively

Number of Missions	N	Mean	Standard Deviation	T	df	Mean difference	p-value
One mission	27	18.63	6.31				
				0.809	49	1.454	0.422
More than one mission	24	20.08	6.51				

Table 2: Number of missions attended

Results of the second hypothesis showed that there was no significant difference in scores on PTSD scale among soldiers who participated in more than one mission than those who participated once, t = 0.809, df = 49, p = 0.422 (p>.05); with PTSD mean scores of 18.63 and 20.08 for soldiers that had one mission and those that went for more than one mission respectively.

Age group	N	Mean	Standard Deviation	T	Df	Mean difference	p-value
Younger soldiers	58	20.88	7.75				
				0.208	97	0.316	0.836
Older soldiers	41	21.20	7.02				

Table 3: Age group

Result of the third hypothesis indicated that older soldiers (38-58 years) did not have a significant higher score on PTSD than younger soldiers (19-37 years) irrespective of missions attended, t = 0.208, df = 97, p = 0.836 (p<.05); with PTSD mean scores of 20.88 and 21.20 for younger soldiers and older soldiers respectively.

8. Discussion

Result of this study revealed that there was significant difference in PTSD scores among soldiers who participated in peace keeping mission in Adamawa, Borno, Plateau, and Yobedue to religious violence and or terrorism than those who did not. Result is in line with earlier studies, Obinna, Chukwukelue, Ugochukwu and Ojo (2011) reported that, there were significant differences in the group's experience of posttraumatic stress disorder (PTSD). The disabled combatants Biafran war survivors had significantly high experience of PTSD than the combatant and non-combatant Biafran war veterans. The combatant war veterans that had experienced intense ethnic, political or religious conflict following the Biafran war had significantly high PTSD than those that had not.
Stretch, Marlowe, Wright, Bliese, Knudson, and Hoover, (1996) reported that, approximately 8 percent of those returning from Operation Desert Storm developed PTSD symptoms. Survivors of terrorist attacks had higher rates of PTSD than motor vehicle accident survivors (37.8% versus 18.7%). The type of traumatic event, however, did not add to the prediction of PTSD from the emergency room heart rate, peritraumatic dissociation symptoms, and early PTSD symptoms. The longitudinal course of early PTSD symptoms was not affected by the greater frequency of terrorist attacks (Shalev and Freedman, 2005).
There is no significant difference in PTSD scores among soldiers who participated in more than one mission than those who participated once as expected. Finally, older soldiers did not have a significant higher score on PTSD than younger soldiers irrespective of number of missions attended. This result is in line with earlier study, Davidson and Foa (1991) reported that, not everyone exposed to traumatic experiences, combat- related or otherwise, suffer from PTSD. What are the factors that increase the likelihood that a particular individual will become one of the victims of trauma- related symptoms? One has to do with the nature of the traumatic experience itself. A general principle that emerges from a variety of studies on trauma victims is that there is direct relationship between the severity of the trauma and the individual's risk of developing PTSD later. This principle applies to war – related combat experiences (Spiro, Schnurr and Aldwin, 1994; Sutker, Uddo, Braity and Allain, 1993) and the experience of living in a country ravaged by war and political or religious violence (Macksound and Aber, 1996; Weine, Becker, McGlashan, Laub, Lazrove, Vojvoda, and Hyman, 1995). Underlying these experiences is the individual's perceived threat to life.

9. Conclusion

What happens to civilian population in states that experience Religious violence and or Terrorismin the country? Since military troops that participated in peace keeping missions in four states of the country that experience religious violence and terrorism come down with PTSD after their participation in the mission. This implies that psychologist and other mental health professionals in the country should get ready to manage PTSD cases among both military and civilian populations which will likely be on the increase in the next few years due to the wounds (aftermath effects) of religious violence and or terrorism in most parts of the country. This calls for the setting up of trauma healing centers by both Federal/State governments and private individuals across the country for people traumatized to be cared.

10. Limitations

The sample size used in the study is limited, compared to the general size of military personnel in 3 Armor military Barracks Rukuba where participants are drawn from.

Sample is drawn only from the Nigerian army, other security agencies that are members of the joint security task force on peace keeping missions in the states engulf by religious violence and terrorism are not included in the study.

11. Suggestions/ Recommendations

For further study on PTSD in relation to religious violence and or terrorism sample should be drawn from both the Military, Police, other security agents that also participate in peace keeping missions and civilian population. This will help in indicating the prevalence of PTSD in the country.

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