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FIGHTING INSURGENCY: THE PSYCHOLOGICAL IMPLICATIONS ON NIGERIAN MILITARY PERSONNEL

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ABSTRACT: *Military deployment against insurgency comes with numerous psychological challenges that affect soldiers' quality of life and performance. Posttraumatic stress disorder and depression are conditions commonly associated with combat against insurgency. Divergent views emerge on the rationale behind Boko Haram Islamic insurgency in Nigeria. It is perceived as an attempt to Islamize Nigeria, as well as an attempt by Northern Nigeria to dominate other ethnic regions in the country. The research therefore examines the psychological implications of fighting insurgency on Nigerian soldiers. The psychological effects of fighting insurgency on Nigerian soldiers are enormous. Recommendations are proffered for rehabilitation, reorientation and other psychological treatment/assistance be given to soldiers who engaged in fighting insurgence after the assignment.*

KEYWORDS: Insurgency, Psychological Implications, Nigeria, Military, Personnel

INTRODUCTION

Insurgency is a condition of revolt against a government that is less than an organized revolution and that is not recognized as belligerency (Ukpong, 2016). It is the rising up against what is believed to be a constituted or legitimate authority. The term "insurgency" is used in describing a group's unlawfulness, capacity to pose a threat to a state, and seen by lawful authority as not being authorized, so that executing it is illegitimate (Shafer, 1988). When used as in the consideration above, those causing the uprising are seen as rebels, whereas the latter will see the authority itself as being illegitimate (Ukpong, 2016). Insurgency is an act of rebellion against a legitimate authority.

However, such an authority would have acquired the recognition by an international body such as the United Nations, while those taking part in the rebellion are not recognized as belligerents. It can be deduced from the foregoing that if there is a rebellion against the authority (recognized by the United Nations) and those taking part in the rebellion are not recognized as belligerents, the rebellion is an insurgency. The United States Department of Defense (DOD, 2007) defines insurgency as an organized movement aimed at the overthrow of a constituted government through the use of subversion and armed conflict. The threats of insurgency have intensified and assumed global dimension in recent times. However, not all rebellions are insurgencies. A rebellion may not be viewed as an insurgency if a state of belligerency exists between one or more sovereign states and rebel forces, even if the revolt takes the form of armed rebellion.

Having established the character of the Nigerian state which impinges on its ability to manage armed conflicts, an insurgency can be seen as an armed uprising against it. It is an organized rebellion aimed at overthrowing the constituted government of Nigeria through the use of subversion and armed conflict. There is therefore, an evidence of insurgency in Nigeria, with the presence of armed groups in various parts of the country who rise up in rebellion against the government. The ultimate goal of an insurgency is to challenge the existing government for control of all or a portion of its territory, or force political concessions in sharing political power. An insurgency can be fought via counter-insurgency warfare, and may also be opposed by measures to protect the population, and by political and economic actions of various kinds aimed at undermining the insurgents'

claims against the incumbent regime (Peter, 1964).

Since the inception of the deadliest insurgence – the Boko Haram in Nigeria, the Nigerian military have been engaging them via counter-insurgency warfare. This has undoubtedly caused some psychological implications for the Nigerian military. Therefore, this study shall focus on the psychological implications of fighting the Boko Haram insurgency on the Nigerian military.

LITERATURE REVIEW

Theoretical Framework

In social sciences, specifically behavioral sciences, there is no universal/general theory that captures human actions and reactions. To this, we engaged two theories, **stress response theory** and the **theory of shattered assumptions**, to unpack this study.

Stress response theory by Horowitz (1976, 1986) shows the relationship between traumatic event and human sanity. The key idea of this theory is that a traumatic event affects cognition of an individual and, depending on how such individual handles all the various thoughts within him, will determine if the individual would be diagnosed as having PSTD or not. According to Horowitz, failure to process the trauma information leads to persistent post-traumatic reactions as the information remains in active memory and continues to intrude into consciousness in the form of intrusions, flashbacks, and nightmares. For instance, in the case of Chibok girls kidnapped by the Boko Haram sect, as at the time of the kidnap, these children would have diverse thought running through their minds and if not guided they might be at psychiatric risks. This explains why Machel (1996) recommends speedy measures to promote the psychological recovery of violated children as regards violence.

With WHO (in press) emphasizing the economic and social burden caused by PTSD and how this could be significantly reduced if PTSD symptoms are identified earlier and appropriate cognitive and behavioural intervention provided. Any traumatic event influences an individual's total wellbeing (school children and their parents) as their inability to match thought and memories of trauma would result in nightmares and if not timely managed, can lead to a psychiatric case.

Drawing from the stress response theory, individual's reaction to traumatic events involve the following: Cognition (intrusion thoughts; impaired memory; denial; flashbacks and confusion), emotional (shock and numbness; fear and anxiety;), helplessness (anger at anybody (perpetrators, themselves and the authorities), depression and anhedonia (loss of pleasure in what was initially pleasurable), and social withdrawal (isolation, irritability and denial). Though, Horowitz, Wilner, and Alvarez (1979) developed Impact of Event Scale (IES) to measure two out of the three distinct symptoms of PTSD, namely, intrusion and avoidance, this scale is limited in that McGorry et al. (1991) discovered an insignificant relationship between the subscales assessing intrusion and avoidance symptoms. Also, Horowitz's theory does not offer explanation regarding how elements of support networks, resilient factor, individual differences and meaning interpretations affect emotion processing (Dalgleish, 2004).

Theory of shattered assumptions by Janoff-Bulman (1992) explains the role of worldview in psychological efforts by the individual to retain and improve perceptions of control and stability following a traumatic occurrence. The persons develop fundamental yet, silent assumptions about the world and themselves. According to this theory, the basic assumptions of any individual regarded to be most relevant in influencing response to trauma are in three folds, namely: the world is kind or benevolent, the world is meaningful, and the self is worthy. The worldview aim is to offer the individual with meaning, self-esteem and the misconception of invulnerability. During a traumatic event, the worldview of an individual changes, the world is no more perceived as benevolent or kind nor do they perceive themselves as competent and secured. The implication of this consequence of defenceless, confusion, awareness of insecurity, results in anxiety and physiological reactivity that characterize PTSD. Significantly, two things are happening at the same time, when the worldview assumption of the individual is shattered, the worldview is destabilized and the awareness of

the individual's mortality becomes intense (Janoff-Bulman, 1992).

Although the theory of shattered assumptions seems convincing, the theory is not without its limitations. Drescher and Foy (1995) noted that the theory did not give explanation to the representativeness of this model, evaluation of the model focused solely on using World Assumptions Scale [WAS] (Janoff-Bulman, 1992) known to be used for psychometric issues (Kaler et al., 2008). Hence reported findings are results from self-administered retrospective writing and lacks future studies to support the arguments (Drescher & Foy, 1995). Also, the model does not describe how shattered worldview affects PTSD, particularly, individual suffering from comorbid disorders (Drescher & Foy,1995). In view of these theoretical underpinnings, this study argues that, Boko Haram insurgency in the North-eastern Nigeria must be curbed, as violence disregards the constitutional principle of universal human rights and has the potential of impacting psychological consequences on people.

Empirical Review

Boko Haram, a Nigerian jihadist sect, publicly commenced its operation in 2002 and has become a significant security threat to the Nigerian state and its neighboring countries through its indiscriminate attacks on civilians, security agencies, destruction of public and private properties, and kidnappings (Amusan & Oyewole, 2015). In 2014, thousands of people were killed through bomb blasts, gun shots, and other violent attacks from the group while over 250 high school female students at Chibok Girls High School in Borno State were kidnapped (Aliyu, Moorthy, & Idris, 2015; Onapajo & Usman, 2015). Despite the security measures deployed by the Nigerian state and its surrounding countries to respond to Boko Haram insurgencies, the sect remains capable of initiating significant attacks. These series of attacks on the Nigerian military and the military confrontation of the sect can have many psychological effects on the military.

'Shell-shock', which is now known as Post Traumatic Stress Disorder (PTSD), was first identified during the First World War and since this time the mental health of service personnel has been an issue of concern, particularly during times of armed conflict. The deployment of British troops to Afghanistan and Iraq as part of the 'war on terror', has put the Armed Forces under strain and resulted in a growing clamour to address the mental health consequences of operational overstretch among British service personnel (Green et al 2008). Interest in PTSD has grown in recent years. However, it is a relatively rare disorder. What is much more common among soldiers is depression, anxiety, and drug and alcohol abuse, domestic violence and self-harm.

Concern about the mental health of service personnel has been a regular feature in the media since the onset of the action in Iraq and Afghanistan with regular newspaper articles describing the horrors to which combat troops are exposed, the impact it may have on their mental health, as well as the short and long term consequences of this both for their future military careers and for their psychological and social return to civilian life (Green et al 2008). Between 1984 and 2005, 638 suicides occurred among the UK regular Armed Forces: 624 males, 14 females. The overall age-specific suicide rate for the Army was statistically significantly higher than for the other two services, at 14 per 100,000 compared to 9 for the Navy and 10 for the RAF. Army males aged 20-24 years and those aged under 20 years had the highest rates at 18 and 16 per 100,000 respectively. Army males had a statistically significant increased risk of suicide of about 50 per cent compared with the general UK population (Defence Analytical Services Agency ONS 2006). It is clear that there is a high level of mental health need among service and ex-service personnel. It is not at all clear whether this need is adequately met.

Mental Health of Current and Ex-Service Personnel

War inevitably produces 'psychiatric casualties' (Wessely 2005). Combat is stressful and sufficiently traumatic to lead to the development of somatic symptoms which may become chronic, disabling and refractory to treatment (Clauw 2006). A systematic review of studies published between 1990 and 2001 of military personnel deployed to the Gulf

concluded that there is increased prevalence of mental health problems of Gulf War veterans compared to the prevalence in a comparison group of active service personnel not deployed to the Gulf (Stimpson, Thomas, Weightman, Dunstan & Lewis, 2003).

There is a strong and positive association between the total killed and wounded in conflict and the number of psychiatric casualties (Jones and Wessely 2001). A US study reports that the proportion of study subjects with major depression, anxiety or PTSD is significantly higher after duty in Iraq than before deployment, particularly so for PTSD (Hoge, Castro, Messer, McGurk, Cotting et al 2004). They also have higher rates of use of mental health services (Hoge, Auchterlonie & Milliken 2006). However, preliminary findings from a British study of soldiers deployed to Iraq suggests that there is an improvement in mental health after returning from deployment (Hacker-Hughes, Cameron, Eldridge, Wessely & Greenberg 2005). This conclusion may though be premature as the post-deployment measures were collected only one month after return from deployment and many mental health problems may take longer than this to emerge (Jhingan 2006).

With operations in both Iraq and Afghanistan, British armed forces are over-stretched in that a significant number of personnel, particularly in the Army, are exceeding the length of time on deployment as set out in the harmony guidelines (National Audit Office (2006). Rona et al., (2007) study of British service personnel deployed for 13 months or longer over a 3-year period (which is in breach of 'harmony guidelines') show that this has an adverse impact on psychological health. Compared with troops deployed for shorter periods they are more likely to fulfill the criteria for PTSD, have higher rates of 'caseness' as measured by the General Health Questionnaire and there is a significant association between duration of deployment and severe alcohol problems.

Each service has set harmony guidelines on the amount of time that personnel should spend away, which aims to ensure that service personnel and their families have a sustainable balance between time away and time at home. The impact on mental health of security and peacekeeping duties have been less researched than combat deployments but studies suggest that soldiers on security duties report high levels of psychological morbidity (Lawrenson & Ogden 2003). Peacekeeping duties may carry long term psychiatric consequences (Gabriel & Neal 2002, Hotopf et al 2003). Furthermore, a US study shows that military personnel engaged in routine peacetime assignments report suffering from more job stress than civilian workers which provides convincing evidence that work stress in the military is not solely related to the stress of war (Planz & Sonnek 2002).

The evidence suggests that there is a high prevalence of mental health problems among service personnel with particular risks for younger personnel. Between 1984 and 2005 army males under age 20 had a statistically significant increased risk of suicide of about 50 per cent compared with the general UK population (Defence Analytical Services Agency 2006). Lord Drayson, Minister of State, Ministry of Defence reported that between January 2003 and September 2006, 2,123 British military personnel (Regular and Reservists) deployed to Operation TELIC2 were assessed by, and received treatment from, the Defence Medical Services for mental health conditions thought to be related to their deployment. This represents around 2% of personnel deployed to Operation TELIC over the same period. Of this number, 328 service personnel fulfilled the diagnostic criteria for PTSD and 904 were diagnosed with an adjustment disorder (Hansard 28 March 2007 cWA269).

The strong media interest and "the epidemic of stories about PTSD" (Wessely 2005) obscures the fact that other mental health problems notably depression and alcohol misuse are more common among service personnel (Rona, Jones, French, Hooper & Wessely, 2004). A study of British aero-medical evacuees from Iraq reported that "in over 85% of cases evacuation was for low mood attributed to separation from friends or family, or difficulties adjusting to the environment" (Turner et al 2005 p476). A recent study found that excessive alcohol consumption was more common in the

UK armed forces than the general population (Fear et al 2007).

Compelling evidence suggests that mental health problems are the leading category of discharge diagnoses among men and the second leading category among women. In one US study (Hoge et al 2002) 47% of those hospitalized for the first time for a mental disorder left military service within 6 months, compared to an attrition rate of 12% for those with other health needs. A prospective study that followed-up military trainees referred for mental health evaluation during training found that two-thirds failed to complete their tour of duty (Cigrang, Carbone & Lara 2003). 2 Operation (or Op) TELIC is the codename under which all British operations of the 2003 Invasion of Iraq and after are being conducted.

Young Service Personnel

The UK recruits young people under the age of 18 to all three branches of the military, many of whom come from disadvantaged backgrounds. The adverse publicity over the culture of bullying and suicides at the military training establishment Deepcut and the 'beasting' episode involving a group of Marines ('Marine 'bullying' video condemned', BBC 2005) reveal what some vulnerable young military personnel may be experiencing. Furthermore, the UK is the only European country to reserve the right to deploy under-18 year olds in war fighting situations, which is against the spirit of Article 38 of the UN Convention on the Rights of the Child that recommends that signatories refrain from sending children into battle (see Harvey 2002 for a detailed analysis of the legislation relating to child soldiers in the UK). A Defence Select Committee report on the duty of care expressed concern that the "MOD is not accepting appropriate responsibility for under 18 year olds in its care" (recommendation 18) and that they should "examine the potential impact of raising the recruitment age for all three Services to 18" (recommendation 14) (House of Commons 2005).

Young military personnel may already have several predisposing elements for developing mental health problems as the demographic profile indicates that the majority of military recruits are from poorer socio-economic groups, from which a higher proportion of young people are at greater risk of developing mental health problems (Walker, 2005). The evidence suggests that young service personnel may be developmentally and emotionally immature and thus more at risk of developing mental health difficulties under the strain of intense post-recruitment training or actual combat deployment (Walker 2003).

The World Health Organization (WHO) recognizes that young soldiers exposed to conflict situations can more easily develop PTSD leading to persisting patterns of problematic behaviour and functioning long after the end of military service (WHO 1996).

Responses to the Mental Health Needs of Soldiers

A range of assistance is available to military personnel, while in the services, at the point of departure and after leaving. Whilst in the services, there is support aimed at reducing the incidence of mental health problems including: primary prevention to prepare and train those likely to be exposed to traumatizing events; secondary prevention using a variety of psychological techniques; and tertiary interventions to treat those with severe and enduring mental health problems.

Screening for mental health morbidity and vulnerability has been used in a number of contexts prior to recruitment, as well as pre- and post- deployment. The evidence suggests that it has limited value (Wessely 2005). Hoge et al (2006) population-based study of all soldiers completing a routine post-deployment health assessment finds that the post-deployment health assessment has limited utility in predicting the level of mental health need in soldiers. Single-session psychological debriefings are no longer recommended as there is evidence that they do not reduce psychological distress (Wessely and Deahl 2003) and screening for psychological illness has little support among servicemen (Rona et al 2004). There is evidence that support from informal social networks composed of family and peers is protective. A retrospective questionnaire cohort study of returning UK peacekeepers identifies support from informal networks as key (Greenberg et al 2003). Having such support and being able to talk about peace-keeping

experiences is associated with less psychological distress.

A peer mentoring care and support system is a prevention strategy that has had some success in the British Royal Marines (Keller et al 2005). The intervention aims to educate junior non-medical personnel to provide support to their peers following critical events and facilitate referral to an appropriate treatment agency. Another preventative measure that is recommended in a Defence Select Committee report is the provision of 'decompression' following return from front-line duty so that there is time to assimilate and recover from combat experiences within a military environment in the company of those who have shared those experiences (House of Commons 2008).

A US study of an intervention to assist soldiers with emerging mental health problems demonstrates effectiveness of supportive mentoring and close monitoring particularly with young junior-grade soldiers without serious psychiatric diagnosis (Hassinger 2003). Severe health problems may require hospitalization. A case matched comparison of the efficiency of a military psychiatric hospital and a military training and rehabilitation unit (MRTU) at restoring soldiers to full active duty reports that conventional in-patient treatment is less effective (Neal, Kiernan, Hill, McManus, and Turner 2003). Since the closure of the military psychiatric hospital at Catterick in 2003, the MoD has had a contract with the Priory Group of hospitals to treat service personnel requiring psychiatric hospitalization.

Within the Armed Forces, the main focus of health care is to keep soldiers fit for duty and those that are unable to perform their duties are, following detailed occupational and social reports, referred to a formal medical board which makes a final decision about whether or not they should be discharged (Turner & Neal 2003). The armed forces resettlement package is intended to help with the transition from military to civilian life. It consists of a cash payment for civilian training and advice on jobs, training, housing and finances.

People discharged for medical reasons are entitled to the full resettlement package, irrespective of their length of service. 'Leaving the Services' (National Audit Office 2007), a report ordered by the House of Commons, recommends that all personnel who are medically discharged are assessed to identify any additional resettlement support they may need. The focus of the resettlement package is more upon practical than emotional support. This is also the case with most of the 200+ organizations for ex-service personnel. However, the public concern over the likely mental health consequences of 'overstretch' due to simultaneous action in Iraq and Afghanistan, has led to mental health support having greater priority. Combat Stress, an organization that provides support to ex-servicemen with combat-related psychological injuries has received increased funding, and in response to research that showed that reservists are more likely to display mental health problems than regular troops the MoD has introduced the Reserves Mental Health Programme to improve the overall healthcare for demobilized Reservists (Hansard 28 March 2007 cWA269).

Upon leaving the Armed Forces, responsibility for medical care passes to the NHS. There is a feeling that routine NHS treatment for ex-soldiers may not be appropriate for their specific needs and compares unfavorably with the US which has extensive military and veteran health services. However, a Defence Select Committee report endorses the treatment of secondary care in NHS Trusts as it enables the Defence Medical Services to work with the NHS to provide treatment in a "semi-military environment" (House of Commons 2008). In addition, a number of new initiatives are being implemented to improve the treatment of veterans suffering with mental health problems. For example, the UK health departments and Combat Stress have been working together to develop and implement a new community-based model for mental health services for veterans (Hansard 28 March 2007 c WA269).

Barriers to Care

According to Greenberg, Langston and Gould (2007), the military environment may exacerbate mental health problems by creating barriers to care including stigma. Stigma generally denotes the possession of a trait that marks one out as different from others and is

negatively regarded and is often a precursor to discrimination or unfair treatment. As well as stigma from others, those requiring help will also stigmatize themselves as they are aware of the attitudes of their peers and share the cultural values that equate emotional stress with weakness (Greene-Shortridge, Britt & Castro 2007). This process of self-stigmatization is strongly associated with low self-esteem (Walker 2003a).

Stigma is identified as the major barrier to providing mental health support to service personnel even more so than within the civilian population (Greene-Shortridge et al 2007). Studies in the US report that seeking treatment for mental health problems is seen as a barrier to subsequent career progression (Stone 1998; Westphal 2004). Psychiatric disorder is judged by 85% of British soldiers to be detrimental to careers (Cawkill, 2002 cited in Greenberg et al 2007) and a US study showed that 40% would not trust a returning stress casualty (Schneider & Luscomb, 1984 cited in Greenberg et al, 2007).

There is clear evidence that stigma discourages service personnel from seeking treatment. It is estimated that up to 50% of military personnel who experience traumatic events and develop a subsequent mental health problem do not seek medical help (Gabriel & Neal 2002). Among US service personnel returning from Bosnia, admitting a psychological problem is perceived as much more stigmatizing as admitting a medical problem and people who are referred with a psychological problem are much less likely to follow through (Britt 2000). A study of British armed forces reports less than 30% of those who screen 'positive' for a mental health problem accept a follow-up invitation to attend a medical centre (Rona et al 2004). The macho culture of military life and emphasis on group loyalty and individual heroism militate against admitting vulnerability. Concern about stigma is disproportionately higher among those most in need of help from mental health services. Those scoring positive for a mental disorder are twice as likely as those who do not to report being stigmatized by others (Hoge et al 2004).

Consequences of Failure to Meet Mental Health Needs

A longitudinal cohort study of 8195 service personnel who left the British Army showed that whilst most resettle into civilian life relatively successfully, those with mental health problems fare less well, and are at far higher risk of social exclusion (Iversen et al 2005a). A further study following-up 496 of the cohort who were 'vulnerable' in terms of their mental health or lack of employment finds very high rates of depression, anxiety disorders, PTSD and alcohol dependence (Iversen et al 2005b). It also reports that only approximately half of those with a psychiatric diagnosis are seeking help largely attributed to the stigma and embarrassment of doing so compounded by having a universal health care system, without bespoke care for ex-service personnel.

Furthermore, there is clear evidence of higher rates of homelessness, alcohol abuse, domestic violence, relationship breakdown and criminality among former military personnel with untreated mental health problems (Dandeker, Wessley, Iversen & Ross, 2003). An in-depth study of homeless ex-service personnel reports high prevalence of alcohol dependency, mental health problems and relationship breakdown (Lemos & Durkacz, 2005). This research confirms the existence of a link between armed service and homelessness, but does not necessarily attribute this to a failure of the armed forces in their duty of care during or after service. Instead, the research suggests that the link is partly explained by the types of people more likely to join the armed forces, as many come to the army with 'psychological baggage' from their childhood (Lemos & Durkacz,, 2005).

Army life has some features that result in ex-service personnel having difficulty and being unprepared for civilian life. A report by Dandeker et al (2003) lists among these:

1. The 'dependency culture' in the armed forces leading to limited self-reliance;
2. Heavy alcohol use;
3. A feeling that their medical problems are not fully understood by civilian NHS services

These may both endanger the mental health of ex-service-personnel and make it harder to provide an appropriate response to those with mental health problems. This highlights the vulnerability and the high level of need of ex-service personnel with mental health problems. The number of combat veterans from Afghanistan will increase as the campaign lengthens in duration. There is little evidence of any active long-term planning to manage the inevitable increase in numbers who will suffer mental health problems and require skilled, expert nursing help and support in the community and during in-patient admissions to cope with the aftermath.

Findings (Deductions)

The war against insurgency has been declared by the Nigerian government against the insurgency especially the deadly Book Baram. Since then the Nigerian army has carried out several operations including ‘’operation lafia dole’’ to flush the insurgence. Although these operations have undoubtedly yielded some positive results items of giving the insurgence group a technical knockout but the psychological implications it has on the military cannot be undermined as deduced below:

1. Nigerian military personnel’s exposure to insurgency combat operations could have disposed soldiers to PTSD, alcohol/drugs abuse, and other mental health challenges.
2. While attentions were being given to the physical injuries incurred by the Nigerian military personnel, little or no attention may be paid to their psychological state and treatment.
3. This may account while some of the military personnel redeployed from the North-East always come down to the South to exhibit unprofessional conducts.

Recommendations

The findings of this study have necessitated the following recommendations:

1. There is need for a proper psychological evaluation of all the military fighting the insurgence to access the level of psychological damages it has caused to them.
2. There is need for rehabilitation, reorientation and psychological treatment/assistance to all personnel sent to fight insurgence before redeploying them to other part of the country for a different assignment.

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