

Journal of Peace, Security & Development

ISSN: 2360-9435

Volume 1, No. 3, 2014



Journal of Peace, Security and Development

————— Volume 1, No. 3, 2014 —————



Centre for Peace & Strategic Studies
University of Ilorin, Ilorin, Nigeria

Published by:
Centre for Peace and Strategic Studies,
University of Ilorin, Ilorin, Nigeria

© Centre for Peace and Strategic Studies, 2014

ISSN: 2360-9435

All rights reserved:

No part of this publication may be reproduced or transmitted in any form
or by any means electronic or mechanical including photocopy, recording,
or any information storage and retrieval system,
without the prior permission of Centre for Peace and Strategic Studies,
University of Ilorin, the copyright owner.

Printed by:
UNILORIN PRESS

Electoral V
Dr. A. A. A.

Civil-Milit
Paul Adu

2010 Elect
Anwarul

Democracy
Obasanjo's
Gordon, B

Conflict-O
Nigeria's F
Glenville

The Crisis
Developm
West-Afric
Raji Shitt
83

Political a
Azer: Oth

Climate C
Datan Al

Oil and W
Abusede C

Interrogat
Ajilabi, A

Newspap
Nigerians
Azer, Ad

Effective
The Place
Abdubwa

CONTENTS

Electoral Violence in Nigeria: Typology and Causal Analysis <i>Dr. A. A. Karim</i>	1
Civil- Military Relations and Internal Security Challenges in Nigeria <i>Paul Audu Akagwu</i>	17
2010 Electoral Act, Party Funding and Prospect of Alternating Power in Nigeria <i>Animashaun Mojeed Adekunle</i>	35
Democracy, Development and Nigeria's Foreign Policy Objectives during Obasanjo's Administration <i>Garuba, Rasheed Obasekore</i>	52
Conflict-Orphaned Children and Post-Traumatic Stress Disorder (PTSD) in Nigeria's Fourth-Republic <i>Gbemisola Animasawun PhD & Moradeke Adeleye</i>	64
The Crisis of Development in Africa And Africa's Sub-Regional Development Institutions: A Case Study of the Economic Community of West African States (ECOWAS) <i>Raji Shittu, PhD</i> 83	
Political alignment and realignment in the 2014 Ekiti governorship election <i>Azeez Olaniyan, PhD</i>	117
Climate Change and Human Security in Nigeria <i>Dotun Akanni</i>	131
Oil and Violent Conflict in Africa <i>Abosede Omowumi Babatunde, PhD.</i>	144
Interrogating the 1968/69 Class Conflict in South-western Nigeria <i>Afolabi, Abiodun S. PhD</i>	165
Newspapers' Coverage of Boko Haram Attacks and its Influence on Nigerians' Perception of Security Situation in the Country <i>Azeez, Adesina Lukuman (PhD) & Onifade, Ifeoluwa Funmilola</i>	180
Effective Information Dissemination for National Development: The Place of The Library <i>Abdulwahab Olanrewaju Issa, PhD.</i>	

CONFLICT-ORPHANED CHILDREN AND POST-TRAUMATIC STRESS DISORDER (PTSD) IN NIGERIA'S FOURTH-REPUBLIC

Animasawun, Gbemisola PhD

Centre for Peace & Strategic Studies
University of Ilorin
aganimasawun@gmail.com

&

Adeleye, Moradeke

Center for Peace & Strategic Studies
University of Ilorin
moradekeadeleye@yahoo.com

Abstract

As children orphaned are displaced by violent conflicts and living outside their homes, this research probes for the presence and extent of Post-Traumatic Stress Disorder (PTSD) in each of these (18) children against the background of their traumatic experiences of losing their parents to sectarian violence and witnessing their slaughtering in some in two instances. Also, the PTSD test revealed that 66.7% of them have adopted avoidance of any reminder of the experience as a coping mechanism, while 55.6% of them still suffer from functional impairment. While the children can be described as resilient despite what they experienced, this article presents the symptoms of PTSD, being orphaned and displaced as constituting the brunt of ethno-religious conflicts that the children are forced to bear which would not have been the case had the conflicts been nipped in the bud or constructively managed.

Key Words: Conflict-Orphaned, Displaced, Children, Nigeria & Post-Traumatic Stress Disorder (PTSD)

Introduction

One of the regular categories of victims thrown up in conflicts is children who kill, get killed, become orphans and become refugees or internally displaced. Children in such places are endangered and equally constitute sources of danger because they shape and are shaped by the peculiarities of such societies. While a plethora of literature have portrayed and examined their roles as victims especially in the context of child-soldiers, policy responses in the aftermath of such conflicts are skewed towards the rehabilitation, reintegration and

reconstruction processes which largely favour the combatants. This article based on both primary and secondary data presents the experiences of children whose parents were murdered in the course of religious conflicts in northern parts of Nigeria. The focal concerns that girded the study were the assessment of the presence and extent of Post-Traumatic Stress Disorder (PTSD); how they have coped and their experiences living outside their homes.

Much as staying in one's home for children may not guarantee the best that life has got to offer cognizant of global inequalities, being forced out of the home comes with a huge sense of loss and trauma.

Therefore, when circumstances such as natural disasters, wars and armed-conflicts create fatalities and casualties, the inner hurt borne by children often festers as they grow because in most instances this is often taken for granted at the post-conflict level by both policy makers and academics. A ready explanation for this is the common assumption that they will be taken in as it is in most situations by humanitarian organizations and foster parents. This often forecloses further attention to the psychological needs of the children based on the assumption that their physical needs are being met.

Intra-state conflicts in Nigeria, sub-Saharan Africa's most populated country since its fourth-republic, inaugurated on the 29th of May, 1999, continue to produce victims across demographic groups including children. This brings to mind the argument of Ato Quayson quoted in Obadare and Adebani (2010: 8); that 'the postcolony is a space for violence and death'. With the rising incidences of violent conflicts in Nigeria since 1999, there has been an unprecedented increase in the rate of internal displacement and forced migration with children who are lucky to survive becoming vulnerable and left to live with the trauma of such incidences with little or no support offered by the state except the support provided by faith-based organizations and other humanitarian agencies.

While a plethora of studies and policy responses have been articulated for children orphaned by HIV/AIDS, not

much can be seen as academic or policy responses to the plight of children orphaned by intra-state violent conflicts that have become defining of post-Cold War Africa including Nigeria. Despite the wide range of instances and scenarios documented in the context of the experiences of stateless children (Bhabha, et al 2011), the work contains no mention of the plight of children out of their homes by conflicts in Africa despite the rising wave of intra-state conflicts on the continent. Sequel to the eruption of inter-religious violence between the proponents of the full implementation of Sharia law, and those opposed to it in the city of Kaduna on February 4, 2001 (Adebani 2004), in which over two thousand lives were lost and property worth billions destroyed, this research presents the live experiences of some children who have been living outside the home since then as displaced and as conflict-orphaned children.

Nigerian Children, Displaced Conflict-Orphans and Post-Traumatic Stress Disorder

From a macro perspective, the orphans of conflict are the 'world's 25 million internally displaced persons, strewn throughout about fifty countries...these individuals have been driven from their homes by conflict...' (Steinberg N.D:1). This huge number results from the increasing rate of internal displacements as a result of intra-state conflicts that have been on the increase, especially in post-Cold War Africa since 1989 and in Nigeria since the inception of

the fourth-republic on the 29th of May, 1999. Irrespective of the scale and scope, armed conflict is one of the major causes of displacement of populations. While studies have been done on the abduction of women for sexual slavery during conflicts, not much has been done to engage the plight of children born of such conflicts and children who also become orphans as a result of violent conflicts.

Despite the global reduction in the spate of civil wars, this has not been matched by a reduction in the incidences of intra-state conflicts. Rather, there has been an unprecedented rise in 'one-sided violence' based on the increasing rate of deaths of unarmed civilians during armed conflicts, strikes by terrorists, excesses of state militaries and other forms of insurgencies (Sundberg N.D). Kristine and Hultman (2007 quoted in Sundberg N.D) define one-sided violence as 'the use of armed force by the government of a state or by a formally organized group against civilians which results in at least 25 deaths.'

Attention has been focused on children who become orphans after losing parents to HIV/AIDS more than children who become orphans after deaths of their parents from many incidences of one-sided violence. One of the consequences of such is the creation of orphans sequel to the killing of many civilians especially during conflicts.

While the precise number of deaths and losses suffered during conflicts are imprecise in Nigeria, most instances of conflicts constantly create orphans and attendant displacement or

conflict-induced migration which has led to continuous north-south migrations since 1999 in Nigeria. One of the inescapable realities facing such children is the fact that they get removed from their homes as a result of expulsion or conflict-induced migration. Unlike adults who are able to make a choice to stay or take to flight in the face of or aftermath of conflict, conflict-orphaned children do not have such luxuries.

Close to being stateless, being dislocated as a conflict-orphaned child comes with peculiar physical, emotional and psychological strains that are often not given the desired attention even when such children get accommodated. One of the factors that matters here is the circumstances surrounding the loss of parents. While loss of parents to natural disasters and non-conflict related issues might not really demand a relocation of such children, loss of parents to violent conflicts especially in neighborhoods where reprisals usually call for the relocation of such children not only out of their communities, but also out of their homes in most instances due to fear of being attacked in reprisal or continuation of such conflicts.

Unlike child-labourers, conflict-orphaned children carry a particular type of hurt and images within them, based on the peculiarities of the circumstances that produce them. Such images and hurt do not change even when they are displaced. This is why it deserves a conscious effort to identify and deal with such which constitutes post-traumatic stress disorder in most cases.

The vulnerability and pliability of a child who loses either parent during armed conflict cannot be over-emphasized. Dallaire (2011:128) identifies and expatiates on this as a pull and push effect on children towards being recruited as child-soldiers. This is because once orphaned, such children seek protection from the available group of adults who seem capable of protecting them as means of survival which makes them pliable by armed groups in a lot of instances. Dallaire (2011) reveals that armed groups often prey on the child's sense of fear or revenge while offering to replace the desperately needed family. As a critical mass of the dislocated, most orphaned children are left with very limited options for forging ahead in life. Consequently, such children in the words of Betancourt and Khan (2008:128) develop: "a sense of belonging to something when nothing else is functioning." Also, such children may find themselves in new forms of dependencies such as 'submission to a leader, compulsive conformity and addiction' Guiberbau (2013: 65), any of which could have been avoided if they had not been dislocated from their homes.

In Nigeria, children have also been constant victims of violent conflicts in varying degrees but their travails are hardly reported. Adeola Ogunlade (2013: 14-15) presents the account of some children who became orphans as a result of the sectarian violence in parts of northern Nigeria in the fourth-republic. Blessing Justing was a 7 year old girl in the year 2000 when his father was killed

during the Sharia'ah crises in Kaduna state. According to her:

On February 21, 2000, we were all at home when it was announced that there would be a peaceful protests against the Sharia law that was being imposed. . . on February 22, my father left the house early in the morning . . . after he left, our house was attacked by the rioters . . we waited for our father till later that evening, but he was nowhere to be found. Later at night, my uncle who witnessed the killing came to relay the news of my father's death to us.

For 13-year old Silas Victoria who was living in Gombe state with her parents until 2009 when they were killed during sectarian violence:

. . . it was like a joke in 2011 when Christians were told to leave within three days. it was on the fifth of January . . . around 7pm . . . they shot my father, brother, and elder brother on his two laps and his spinal cord. . . ironically, we had good relationship with our Muslim neighbours . . . they wept when they heard that we were leaving. I will love to go back to Gombe I only implore the religious fanatics to change...

Rachel David who was rescued from Maiduguri reported that:

One day, they passed by our house

and saw my younger brother but they did not do anything. They came back to ask where he was . . . they started shooting into the air. They took my father and asked whether to shoot him in the back or in the stomach. . . they shot him in the ear. His teeth and brains popped out and he died.

Also, since the Nigeria's war against radical Islamism became full blown in 2009, children have continued to suffer different kinds of trauma. According to Bello Furo, the Executive Chairman of Adamawa State Universal Education Board (ADSUBEB) one of the worst hit areas by the insurgency, over 20,000 children have been forced out of school 'most of these children you meet today, some of their parents were slaughtered before their eyes. . . These young children have been forced to leave their places, to flee their homes and become IDPs' (Edafioka 2015). Similarly over 200 school girls preparing to write their final high school exams were kidnapped from their hostels in the Government Secondary School (GSS) of Chibok community in Borno state on the night of April 14/15, 2014. Since then, the children, who are mainly girls, have remained in the custody of the Boko Haram Islamist group. While children continue to suffer as a result of these conflicts, responses to their psychological well-being have not been consistent.

As children now living outside the home, they become susceptible to so many dangers physically, socially and

psychologically. One of these is Post-Traumatic Stress Disorder (PTSD), an emotional illness that is classified as an anxiety disorder and occurs as a result of life-threatening, terribly frightening or highly unsafe experiences. It is an anxiety disorder that some people get after seeing or living through a dangerous event and it has also been referred to as combat fatigue, gross stress reaction, post-Vietnam syndrome, battle fatigue and shell shock (Hamblen & Barnett, 2009) which became formally diagnosable since in the 1980s.

Events that could cause PTSD in children include car and plane crashes, natural disasters such as floods and earthquake, acts of war and terrorism, violent crimes such as home invasion, kidnapping or murder, physical, emotional or sexual abuse (either of the child or of another family member in front of the child), neglect, house fires, exposure to violence at school or in the community, suicide or murder of a family member. Children who witnessed killings, especially involving people close to them such as parents and siblings, who see houses destroyed, who experience the fear of attack, who become orphaned or separated from their families and loved ones or who have to cope with displacement and seeking refuge away from their communities are likely to be affected by PTSD. It usually develops when the child perceives the experience as life threatening or extremely dangerous.

According to Djeddah and Shah (1996), apart from factors such as the duration of the circumstance triggering the trauma, other contributory factors to

psychological problems in children affected by armed conflict include ethnic cleansing or genocide; the loss or death of the father, mother or other members of the family. Other consequences of violent conflicts leading to PTSD include loneliness and lack of vital protection and care, torture, sexual abuse or exploitation, imprisonment and detention under inhuman conditions, concentration camps; participation in military and paramilitary actions, including being used to kill members of one's own family or other people, the witnessing of atrocities, kidnapping of families, uprooting; cultural oppression; interruption of education; and uncertainty of the future.

Children with adverse stress reactions and behavioural symptoms for longer than 1 month's time may be at increased risk of developing PTSD or violent and delinquent behaviours later in life (Beauchesne, et al 2002): In such cases, it is appropriate and necessary for children to receive counseling from a mental health specialist. Children may exhibit symptoms of PTSD differently from adults and this is discernible through different indications like: "time skew," when the memory is recalled, trauma-related events are mis-sequenced; "omen formation," which is the belief that the trauma could be anticipated through warning signs; post-traumatic play, a representation of the trauma; or post-traumatic reenactment, where aspects of the trauma are behaviorally recreated (Hamblen & Barnett, 2009).

Symptoms of PTSD

According to the National Institute for Mental Health (2008:1-2) symptoms of PTSD can be grouped into 3 categories thus:

1. Re-experiencing symptoms

- Mentally re-living the trauma over and over again.
- Bad dreams and severe nightmares either about the traumatic event or other frightening things.
- Frightening thoughts
- Flashbacks of the event, feeling like one is actually going through the experience again. (S)he may hallucinate scenes, sounds or smells from the experience.
- Words, objects or situation that are reminders of the event can also trigger re experiencing
- The child may need to 'hash out' the event verbally or in play.

2. Avoidance symptoms

- Staying away from events, places or objects that are reminders of the experience
- Feeling emotionally numb to feelings and surroundings,
- Feeling strong guilt, depression or worry
- Loss of interest in activities that were enjoyable in the past
- Blocking out' or difficulty in remembering details of the event.
- Feelings of detachment and alienation.

Things that remind a person of the traumatic event can trigger avoidance symptoms. These symptoms may cause a person to change his or her personal routine. For example, after a bad car accident, a person who usually drives may avoid driving or riding in a car.

3. **Hyperarousal symptoms**

- Being easily startled or frightened
- Feeling tense or "on edge"
- Having difficulty sleeping or staying asleep
- Having angry outbursts of unprovoked or excessive anger
- Difficulty concentrating on schoolwork or other routine tasks.

Hyperarousal symptoms are usually constant, instead of being triggered by things that are reminders of the traumatic event. They can make the person feel stressed and angry. These symptoms may make it hard to do daily tasks, such as sleeping, eating, or concentrating.

Although ethnic, political, and religious conflicts are frequent in Africa, few studies have documented the nature of PTSD in African countries. Different studies (Kinzie et al (1986), Sack et al (1994), Mousa et al (1999), Hasanovic et al (2006) Espié et al (2009) have been undertaken to reflect the prevalence of PTSD after a conflict in children such as studies of PTSD among child survivors of the Rwandan genocide show that about two thirds of these children have PTSD

(Negebauer et al 2009: 1033-1045).

Studies have also shown that the severity of the post traumatic stress symptoms is also related to the level of exposure to the trauma (Cooley-Quille and Boyd 2001) and number of exposures (Allwood et al 2002). Children exposed to multiple traumas (e.g., shelling, combat) and those who were bereaved, victimized by or had witnessed violent acts, showed more PTSD symptoms than those who had not witnessed such acts. Also, children who had experienced separation from their parents and are displaced exhibited more depressive symptoms than those who remained with their parents. Examination of the relationship between exposure to violence and mental health outcome in adolescents in the USA showed that a quarter of the adolescents who participated in the study met the criteria for PTSD (Sinnerbrink et al 1997). The association between severity of exposure in terms of number and proximity of experienced events and the presence of PTSD in children and adolescents has been supported in different cultures (Papageorgiou et al 2000).

Diagnosing PTSD

A diagnosis of PTSD as listed in the *Diagnostic and Statistical Manual of Mental Health Disorders* (fourth edition) (APA, 2000) requires that several criteria be met. These criteria include events that relate to the nature of the trauma and the responses it evokes. The person must have been exposed to a traumatic event in which the following were present:

1. The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others such as the death of a parent(s) in situations of armed conflict.
2. The person's response involved intense fear, helplessness, or horror. In children, this may be expressed instead by disorganized or agitated behaviour.
3. Finally, the disturbance must cause "clinically significant distress or impairment in social, occupational, or other important areas of functioning" (APA, 2000:467)

The 3 types of generally recognised stressors for PTSD are:

1. Threatened death or serious injury to one's person such as being the victim of violence.
2. Learning about the death, near death or serious injury of a family or close friend.
3. Witnessing the death, near death or serious injury of another person.

For most children, these symptoms gradually decrease over time and disappear. However, some children will go on to develop PTSD, and a certain percentage of these individuals will develop a chronic form that persists

throughout their lifetimes. Childhood psychic trauma is a crucial etiologic factor in the development of a number of serious psychiatric disorders in childhood and adulthood (Pynoos & Nader, 1993; Terr, 1991). PTSD is also a possible risk factor for the development of other co-morbid conditions including depression and anxiety, which can wreck havoc on a person's life (Seedat, Kammerer, Lockhat, & Stein, 2000). The number of children who will experience PTSD will depend on how traumatic the event was for them and the support and intervention they received afterward.

Coping Mechanisms and Supports for Orphans with PTSD

Children orphaned as a result of conflict, exhibit many behavioural attitudes to enable them come to terms with the trauma experienced as a result of the death of their parents during conflict. *Article 39 of the UNICEF convention on the protection of the Rights of the Child states that, "Children who have been neglected, abused or exploited should receive special help to physically and psychologically recover and reintegrate into society". This is best achieved by ensuring, from the outset of all assistance programmes, that the psychosocial concerns intrinsic to child growth and development are addressed.*

Children who have been continually exposed to violence almost always experience a significant change in their beliefs and attitudes, including a fundamental loss of trust in others. This is especially true of children who have been

attacked or abused by people previously considered neighbours or friends, as happened in Rwanda and the former Yugoslavia. At a seminar convened on behalf of the study, a Bosnian boy told of this devastation: "We spent our childhood together. I saw him and hoped that he would save my life. He was ready to kill me" (Machel 1996: 53). Experiences like this etch permanently in the memory of survivors and subsequently contributing to PTSD in such individuals. However, the available support for these category of children is more in the aftermath of full-blown wars than in cases of low-intensity or intra-state conflicts like many that have been on the increase since 1999 in Nigeria.

Study Design and Data

The data for this study was generated based on interactions with members and children of the Stephen Centre International (SCI) Abeokuta in south-western Nigeria. The following tables present the demographic characteristics of the respondents in terms of gender, age and educational background.

Table 1 Distribution of Respondents by Sex

Gender	Frequency	Percentage
Male	12	66.7%
Female	6	33.3%
Total	18	100%

Source: Field Survey 2014

Table 2 Distribution of Respondents by Age

Age bracket	Frequency	Percentage
Below 18	3	16.7
18-20	12	66.7
20 and above	3	16.7
Total	18	100%

Source: Field Survey 2014

Table 3 Distribution of Respondents by Educational Qualifications

Qualification	Frequency	Percentage
SSCE (High School) Students	14	78
Undergraduates	4	22.2
Total	18	100

Source: Field Survey 2014

The tables above depict that the majority of the respondents are males (67%), within the ages of 18 and 20 (67%) and had SSCE as the highest educational qualification (78%). The variance in the number of males and females would not affect the findings of this study.

Section B: Re-experiencing symptoms

This part of the study presents variables which are related to assessing if the children have re-experiencing symptoms. The codes below depict the number of times the children experience these symptoms.

*0=not at all

*1=once a week or less/once in a week

*2= 2 to 4 times a week/half the time

*3=5 or more times a week /almost always

*4= everyday

Table 4 Distribution of respondents based on intrusive memories

Responses	Frequency	Percentage
*0	4	22.2%
*1	11	61.1%
*2	0	0%
*3	2	11.10%
*4	1	5.6%
Total	18	100%

Source: Field Survey 2014

The table above shows that 22.22% percent agreed that they do not have intrusive memories of the trauma, 61.1% agreed that memories of the trauma come to their memories once a week or less/once in a week, 11.10% agreed that the memories come to their mind from 5 or more times a week. 5.6 % however agreed that the memory comes to mind every day.

Table 5 Frequency of Nightmares since the incidence occurred

Responses	Frequency	Percentage
*0	15	83.33%
*1	3	16.67%
*2	0	%
*3	0	%
*4	0	%
Total	18	100%

Source: Field Survey 2014

Table above 83.33% agreed they do not have nightmares, 16.67% agreed that they once a week or less have nightmares. This shows that oftentimes such incidence are in the sub-conscious mind and it only comes to the memory when certain events bring the memories to conscious mind

Table 6 Distribution of responses on whether they are hunted by fear of re-experiencing the same event

Responses	Frequency	Percentage
*0	13	72.22%
*1	4	22.22%
*2	1	5.56%
*3	0	%
*4	0	%
Total	18	100

Source: Field Survey 2014

Table above reveals that 72.22% agreed that they do not at all act like the traumatic event would happen again, 22.22% agreed that they feel and act like the event would happen again once a week or less, while 5.56 agreed that it only happens to them 2 to 4 times a week. The table above suggests that individual minds would be pleased with positive memories to be repeated, negative memories are thus forcefully turned down by the human mind except certain event triggers such negative memories to reoccur.

Table 7 Distribution of respondents on whether they have had freezing episodes

Responses	Frequency	Percentage
*0	6	33.33%
*1	6	33.33%
*2	1	5.56%
*3	1	5.56%
*4	4	22.22%
Total	18	100

Source: Field Survey 2014

The table above presents that 33.33% do not at all have episodes which they seem to freeze, 33.33% equally agrees that this happens to them once a week or less. However 5.56% agreed that it happens to them 2 to 4 times a week, 5.56% also agreed that it happens to them 5 or more times a week.

Table 8 Distribution of respondents by whether they get upset when exposed to reminders of the event

Responses	Frequency	Percentage
*0	5	27.78%
*1	6	33.33%
*2	3	16.67%
*3	2	11.11%
*4	2	11.11%
Total	18	100%

Source: Field Survey 2014

It can clearly be deduced from the table above that 27.78% are of the opinion that they do not at all get upset when exposed to reminders of the event, 33.33% are of the opinion that they get upset when exposed to reminders of the events, 16.67% agreed that they get upset 2 to 4 times a week when exposed to reminders of events, however 11.11% are of the opinion that they have it close to 5 or more times a week, 11.11% also agreed that they have this upset when exposed to reminders.

Table 9 Distribution of respondents on whether they get physically distressed when exposed to reminders

Responses	Frequency	Percentage
*0	11	61.11%
*1	4	22.22%
*2	1	5.56%
*3	0	0%
*4	2	11.11%
Total	18	100%

Source: Field Survey 2014

The table above suggests that 61.11% do not at all get physically distressed when exposed to reminders of traumas, 22.22% agreed it happens once a week or less, 5.56% agreed that they get physically distressed when exposed to such reminders, 11.11% agreed that they get physically distressed when they are exposed to reminders of such traumas

experienced before.

Section C: Avoidance and Numbing symptoms

This part of the study deals with the presentation of specific variables which are related to assessing if the children have avoidance and numbing symptoms.

Table 10 Distribution of respondents on whether they try to avoid conversation that might remind them of the trauma

Responses	Frequency	Percentage
*0	9	50%
*1	6	33.33%
*2	1	5.56%
*3	0	0%
*4	2	11.11%
Total	18	100%

Source: Field Survey 2014

The above table suggests that 50% are of the opinion that they do not at all try to avoid conversation that might remind them of the trauma, 33.33% agreed that once a week or less, they do avoid the conversations that might remind them of the trauma, 5.56% agreed that they often say 2 to 4 times a week avoid conversations that might remind them of the trauma, while 11.11% agreed that they often avoid this conversations every day. This means that often times, traumatized people tend to avoid conversations that could bring negative memories of the past. This thus gives the understanding that an individual would only want conversations that can bring positive memories of the past rather than the traumas.

Table 11 Distribution of respondents on whether they try to avoid things or places that remind them of the trauma

Responses	Frequency	Percentage
*0	5	27.78%
*1	3	16.67%
*2	2	11.11%
*3	4	22.22%
*4	4	22.22%
Total	18	100%

Source: Field Survey 2014

The table above shows the distribution of respondents on whether they try to avoid things or places that remind them of the trauma. 27.78% were of the opinion that they do not necessarily avoid places that remind them of the trauma. 16.67% agreed that this frequently happens to them, 11.11% agreed that it often happens to them, while 22.22% agreed that it happens to them almost always, while 22.22% agreed that it happens to them every day. Things or events that can recall memories of the past can affect an individual therefore; an avoidance technique is always employed by the victims so as to shy away from such memories that would affect them.

Table 12 Distribution of respondents on whether they have difficulties remembering the whole incidence

Responses	Frequency	Percentage
*0	12	66.67%
*1	2	11.11%
*2	0	0%
*3	1	5.56%
*4	3	16.66%
Total	18	100%

Source: Field Survey 2014

The above table shows that 66.67% were of the opinion that they do not have difficulties in remembering the whole events, 11.11% are of the opinion that they once in a while have difficulties

at remembering the whole incidence, 5.56% are of the opinion that they have difficulties almost always in remembering the whole incidence, 16.66% are equally of the opinion that they find it very difficult to remember the whole incidence.

Table 13 Distribution of respondents on whether they have lost interest in things they do since the trauma

Responses	Frequency	Percentage
*0	13	72.22%
*1	2	11.11%
*2	1	5.56%
*3	1	5.56%
*4	1	5.55%
Total	18	100%

Source: Field Survey 2014

The above table shows that 72.22% have not lost interest in the things they do since the trauma, 11.11% are of the opinion that this only happens once in a while, 5.56% are of the opinion that it thus happens half the time. Also 5.56% are of the opinion that it thus happens almost always, and finally 5.56% are of the opinion that it happens every day.

Table 14 Distribution of respondents on whether they show a restricted range of emotions on their face compared to before

Responses	Frequency	Percentage
*0	8	44.44%
*1	5	27.78%
*2	1	5.56%
*3	1	5.56%
*4	3	16.66%
Total	18	100%

Source: Field Survey 2014

The above table shows that 44.44% are of the opinion that they do not show restricted range of emotions on their faces compared to before, 27.78% are of the opinion that this happens once a while, 5.56% are of the opinion that it happens half

of the day, also 5.56% equally agreed that this happens almost always and 16.66% agreed that it happens every day.

Table 15 Distribution of respondents on whether they have lost hope for the future

Responses	Frequency	Percentage
*0	18	100%
*1	0	%
*2	0	%
*3	0	%
*4	0	%
*5	0	%
Total	18	100%

Source: Field Survey 2014

The totality of the respondent agreed that they have not lost hope for the future. This means that many of the respondents agree that they have to move on and face the future challenges that might come their way. They keep the past behind and face the future.

Table 16 Distribution of respondents on whether they have become more distant and detached from family members since the trauma started

Responses	Frequency	Percentage
*0	12	66.67%
*1	1	5.56%
*2	1	5.56%
*3	2	11.11%
*4	2	11.11%
Total	18	100%

Source: Field Survey 2014

66.67% from the table above agreed that they have not become more distant from family members since the trauma started, 5.56% are of the opinion that once in a while they have found themselves been discharged from families, 5.56% equally agreed that they have half the time distant and detached themselves from families, 11.11% are of the opinion that they almost always

distant themselves from families, and finally 11.11% agreed that they everyday detached from the family. The above table shows the importance and significant roles others play, especially the family as an institution, in shaping the personality figure of an individual.

Section D: Arousal symptoms

This part of the study deals with the presentation of specific variables which are related to assessing if the children have increased arousal symptoms.

Table 17 Distribution of respondents on whether they have had a hard time falling asleep or staying asleep since the trauma

Responses	Frequency	Percentage
*0	9	50%
*1	9	50%
*2	0	%
*3	0	%
*4	0	%
Total	18	100%

Source: Field Survey 2014

50% of responses from the table above are of the opinion that they do not find it difficult to sleep since the trauma started, also 50% of the respondents equally agreed that they equally find it difficult to sleep since the trauma started. Thus, a logical deduction can be drawn from the table above that the events, still being recent and fresh in the memories of most of the respondents agreed that they are not being able to sleep.

Table 18 Distribution of respondents on whether they become more irritable or had outburst of anger, or development extreme temper since the trauma

Responses	Frequency	Percentage
*0	11	61.11%
*1	2	11.11%
*2	3	16.7%
*3	2	11.11%
*4	0	0%
Total	18	100%

Source: Field Survey 2014

The table above shows that 61.11% are of the opinion that they do not feel irritable, angry, and do not develop extreme temper since the trauma started, 11.11% are of the opinion that once in a while get or feel irritable, angry, and develop extreme temper, 16.7% are of the opinion that they do have the time to be irritable, angry, and to develop extreme temper, and 11.11% are of the opinion that they almost always get irritable, angry, and develop extreme temper since the trauma started.

Table 19 Occurrence of difficulties in concentration Distribution since the trauma...

Responses	Frequency	Percentage
*0	10	55.56%
*1	5	27.78%
*2	0	0%
*3	3	16.66%
*4	0	%
Total	18	100

Source: Field Survey 2014

The table above shows that 55.56% agreed that they are not affected by the trauma, especially when it comes to concentrating, 27.7% are of the opinion that it happens once in a while, and 16.66% are of the opinion that this happens almost always. Hence, it can be deduced that it is only when the memories

of the trauma come that, as individual tends to lose concentration. However, when in a stable state of mind devoid of past experience, they tend to have good concentration.

Table 20 Distribution of respondents on whether they have been more on the alert for bad things to happen

Responses	Frequency	Percentage
*0	9	50%
*1	4	22.22%
*2	2	11.11%
*3	0	0%
*4	3	16.67%
Total	18	100%

Source: Field Survey 2014

The table above shows that 50% do not perceive themselves as being alerted for bad things to occur, 22.22% are equally of the opinion that it happens once a while, 11.11% are also of the opinion that it does half of the time, and finally 16.67% are of the opinion that it happens almost always.

Table 21 Distribution of respondents on whether they startle more easily than before the trauma

Responses	Frequency	Percentage
*0	6	33.33%
*1	3	16.67%
*2	2	11.11%
*3	1	5.56%
*4	6	33.33%
Total	18	100%

Source: Field Survey 2014

The table above shows that 33.33% are of the opinion that they not all get startle more easily than before the trauma started, 16.67% are equally of the opinion that this happens once a while, and 11.11% also agreed that half of the time it does happen, and 5.56% agreed that it does almost always and finally, 33.33% agreed that it happens everyday.

Section E: Functional Impairment

This part of the study deals with the presentation of specific variables which are related to assessing if the trauma has in any way affected their functional impairment.

Table 22 Distribution of respondents on how symptoms affect inter-personal relations with their caregivers

Responses	Frequency	Percentage
*0	10	55.56%
*1	2	11.11%
*2	4	22.22%
*3	2	11.11%
*4	0	0%
Total	18	100

Source: Field Survey 2014

55.56% are of the opinion that the symptoms affect the way on how to get along with their caregivers, interfere in the relationships, 11.11% are of the opinion that it once in a while affects them, 22.22% are of the opinion that half of the time, it thus affects their relationship, while 11.11% are of the opinion that it almost always affects their relationships.

Table 23 Distribution of respondents on how they get along with brothers or sisters in the home

Responses	Frequency	Percentage
*0	13	72.22%
*1	4	22.22%
*2	1	5.56%
*3	0	%
*4	0	%
Total	18	100%

Source: Field Survey 2014

The table above shows how the symptom affects their relationships with brothers and sisters in the home. 72.22% are of the opinion that the symptoms do

not at all affect their relationship with brothers and sisters at home, 22.22% are also of the opinion that it once in a while affects their relationship with brothers and sisters, and 5.56% agreed that half the time affects their relationships with brothers and sisters at home. It can be deduced that at times other siblings also suffer from the trauma and due to this, all of them would rather come together and search for a place and condition themselves for emotional peace.

Table 24 Distribution of respondents on how/if symptoms get in their way with teachers in class room

Responses	Frequency	Percentage
*0	12	66.67%
*1	4	22.22%
*2	0	0%
*3	2	11.11%
*4	0	0%
*5	0	0%
Total	18	100%

Source: Field Survey 2014

The table above shows that 66.67% are of the opinion that the symptoms do not affect their way with teachers, 22.22% suggests that they once a week allow such symptoms to get on their ways with teachers, 11.11% agrees that these symptoms often interfere in relating with their teachers.

Table 25 Distribution of respondents on how they get along with friends

Responses	Frequency	Percentage
*0	13	72.22%
*1	3	16.67%
*2	0	0%
*3	2	11.11%
*4	0	0%
Total	18	100%

Source: Field Survey 2014

The table above shows that 72.22% agrees that the symptoms do not affect them

getting along with friends, 16.67% agrees that this happens once a week or less, 1.11% are of the opinion that these various symptoms affect their relationship with friends and how they get on with them.

Table 26 Distribution of respondents on whether the symptoms hinder public outings

Responses	Frequency	Percentage
*0	12	66.67%
*1	2	11.11%
*2	1	5.56%
*3	1	5.56%
*4	1	5.56%
No response	1	5.56%
Total	18	100%

Source: Field Survey 2014

The table above shows that 66.67% are of the opinion that the symptoms do not make it harder for them to go out in public, 11.11% are of the opinion that once a week or less, 5.56% agreed that these symptoms affects their going out in public 2 to 4 times a week, also 5.56% also agreed that this happens 5 or more times a week.

Table 27 Distribution of respondents on whether these behaviours cause them to feel upset

Responses	Frequency	Percentage
*0	4	22.22%
*1	8	44.44%
*2	2	11.11%
*3	1	5.56%
*4	2	11.11%
No response	1	5.56%
Total	18	100%

Source: Field Survey 2014.

The table shows that 22.22% agreed that these behaviours do not make them or cause them to feel upset, 44.44% are of the opinion that they make them feel upset once a week, 11.11% agreed

that they make them feel upset say 2 to 4 times a week, while 5.56% agreed that that this happens 5 or more times a week, 11.11% thus agreed that it happens daily.

Data Analysis based on PTSD Checklist

The PTSD checklist method of analysis of data was used. This is a more reliable source of analysis to assess PTSD in the children. The codes used are:

CA: Clinical Attention means that they may not have enough symptoms for the diagnosis but would still benefit from treatment.

PD: Probable Diagnosis means that they probably have enough symptoms to meet the full PTSD diagnosis.

The total of the scores were computed for each section and the cut off marks for each section are stated in the table below.

Table 28 Scoring cut off for PTSD

Symptoms	Clinical Attention	Probable Diagnosis
Re-experiencing	4	8
Avoidance and Numbing	2	4
Arousal	4	8
Total	10	20
Functional Impairment	2	4

Source: Field Survey 2014

Table 29 Distribution of Respondents showing if they have a full diagnosis to determine if they have PTSD

Symptoms	Clinical Attention		Probable Diagnosis	
	Frequency	Percentage	Frequency	Percentage
Re-experiencing	13	72.2%	5	27.8%
Avoidance and Numbing	6	33.3%	12	66.7%
Arousal	13	72.2%	5	27.8%
Total	14	77.8%	4	22.2%
Functional Impairment	8	44.4%	10	55.6%

Source: Field Survey 2014

Analysis

The table shows that 72.2% of the respondents do not have enough re-experiencing symptoms to benefit from full diagnosis but may require medical attention, while 27.7% of the respondents have enough re-experiencing symptoms to benefit from the diagnosis. Also, 33.3% of the respondents do not have enough avoidance and numbing symptoms to benefit from full diagnosis but may require medical attention, however, 66.7% of the respondents have enough avoidance symptoms to benefit from the diagnosis. An estimated 72.2% of the respondents do not have enough arousal symptoms to benefit from full diagnosis but may require medical attention, whereas 27.8% of the respondents have enough arousal symptoms to benefit from the diagnosis. In relation to 77.8% of the respondents, they do not have enough symptoms to benefit from full diagnosis but may require medical attention while 22.2% of the respondents have enough symptoms to benefit from the diagnosis. For 44.4% of the respondents, they do not suffer from any functional impairment to benefit from full diagnosis, but they may require medical attention, while 55.6% of the respondents have enough functional impairments to benefit from the diagnosis.

Conclusion

Given the rising spate of social disequilibrium arising from the tide of religious, political and ethnic crises

including Islamist insurgency, the rate of children affected by conflicts experiencing anxiety disorders, depression, PTSD, anger and general existential fears; requiring psychological diagnosis and support such as the respondents of this study is on the increase. That 55.6% of the members of SIC deserve further diagnosis due to functional impairment speak to the horrendous impact of being displaced from one's home for a vulnerable group like children. It can also be argued that the 44.4% demonstrates a remarkable level of resilience in a way that contributes to the debate on whether frequency or severity determines resilience in children (Henry 2014). This is because despite the shared experience of being orphaned by conflict and living displaced to the same place, they still demonstrated different PTSD needs which would not have arisen if there had not been conflicts that orphaned and displaced them.

References

- Adebanwi, W. (2004) "Democracy and Violence: The Challenge of Communal Clashes". In: Agbaje A.B.A, Diamond. L and, Onwudiwe. E (eds.) *Nigeria's Struggle For Democracy and Good Governance; A Festschrift For Oyeleye Oyediran*. Ibadan .Ibadan University Press. 327-348
- Allwood, M. A., Bell-Dolan, D. & Husain, S. A. (2002) 'Children's trauma and adjustment reactions to violent and non-violent war experiences, *Journal of the American Academy*

- of *Child and Adolescent Psychiatry*, 41, 450-457.
- American Psychiatry Association (2000). *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Text Revision. Washington DC: American Psychiatry Association.
- Beauchensne, et al (2002)
- Bhabha, J. (2011). *Children Without a State: A Global Human Rights Challenge*. London: The MIT Press: Cambridge Massachusetts
- Betancourt, T.S and Khan, K.T. "The Mental Health of Children affected by Armed Conflict: Protective Processes and Pathways to Resilience", *International Review of Psychiatry* 20(3): 317-328
- Cooley-Quille, M., Boyd, R., Frantz, E., & Walsh, J. (2001). "Emotional and Behavioral Impact of Exposure to Community Violence in Inner-city Adolescents", *Journal of Clinical Child Psychology*, 30, 199-206.
- Dallaire, R. (2011). *They Fight Like Soldiers, They Die Like Children*. London: Arrow Books.
- Djeddah, C. & Shah, P.M. (1996) *The Impact of Armed Conflict on Children: A Threat to Public Health*. Geneva: WHO, Family and Reproductive Health.
- Dryden-Edwards, R. (n.d.) Post Traumatic Stress Disorder. Retrieved May 24th 2013 from www.medicinenet.com
- Edafioka, L. (2015). "800 Children Affected by Boko Haram Insurgency under Psycho-Social Therapy in Adamawa", Accessed on 13/2/2015 at <http://www.today.ng/news/800-children-affected-by-boko-haram-insurgency-undergo-psycho-socio-therapy-in-adamawa>
- Espié, E., Gaboulaud, V., Baube, T., Casas, G., Mouchenik, J., Yun, O., Grais, R.F and Moro, M.R. (2009). "Trauma-Related Psychological Disorders Among Palestinian Children and Adults in Gaza and West Bank, 2005-2008", *International Journal of Mental Health System* 3(21)
- Guibernau, M. (2013). *Belonging Solidarity and Division in Modern Societies*. Cambridge: Polity Press
- Hamblen, J. & Barnett, E. (2009) *PTSD in Children and Adolescents*. National Center for PTSD. Retrieved May 24th, 2013 from [http://www.ptsd.va.gov/professional/pages/Hasanović, M., Sinanović, O., Selimbašić, Z., Pajević, I., Avdibegović, E. \(2006\) "Psychological Disturbances of War-traumatized Children from Different Foster and Family Settings in Bosnia and Herzegovina", *Croat Medical Journal* 47\(1\):85-94.](http://www.ptsd.va.gov/professional/pages/Hasanović, M., Sinanović, O., Selimbašić, Z., Pajević, I., Avdibegović, E. (2006) 'Psychological Disturbances of War-traumatized Children from Different Foster and Family Settings in Bosnia and Herzegovina', Croat Medical Journal 47(1):85-94.)
- Kinzie, J.D., Sack, W.H., Angeli, R.H., Manson, S. M & Ben, R. (1986). "The Psychiatric Effects of Massive Trauma on Cambodian Children". *Journal of the American Academy of Child Psychiatry*, 25(3), 370-376.
- Kristine, E. and Hultman, L. (2007). "One-Sided Violence Against Civilians

- in War: Insights from New Fatality Data" *Journal of Peace Research* 44:2, 233-246
- Mousa T.A.A. and Vostanis P. (1999). "Post-Traumatic Stress Reactions in Children of War", *Journal of Child Psychology Psychiatry* 40(3):385-91
- National Institute of Mental Health (2008) NIH Publication Number 08 6388
- Neugebauer, R., Fisher, P.W., Turner, J.B., Yamabe, S., Sarsfield, J.A., Stehling-Ariza, T. (2009) "Post Traumatic Stress Reactions among Rwandan Children and Adolescents in the Early Aftermath of Genocide" *Int Journal Of Epidemiology* 38(4)1033-1045
- Obadare, E and Adebawu, W. (2010). "Introduction: Excess and Abjection in the Study of the African State". In: Wale Adebawu and Ebenezer Obadare (eds), *Encountering the Nigerian State* New York: Palgrave Macmillan. 1-28.
- Ogunlade, A. (2013). "How our Parents were Gruesomely Murdered by Religious Fanatics – Inmates of Ogun Orphanage", Accessed at <http://thenationonline.net/new/how-our-parents-were-gruesomely-murdered-by-religious-fanatics-inmates-of-ogun-orphanage/> on 15/12/2014
- Pynoos, R., & Nader, K. (1993). Issues in the Treatment of Posttraumatic Stress In Children and Adolescents. In J. P. Wilson & B. Rapheal (Eds.), *International Handbook Of Traumatic Stress Syndromes* (pp. 535-549). New York: Plenum
- Quayson, A. (2003). *Calibrations: Reading for the Social*. Minneapolis: University of Minnesota Press.
- Sack, W.H., Mcsharry, S., Clarke, G.N., Kinney, R., Seeley, J., & Lewinsohn, P. (1994). "The Khmer Adolescent Project: I. Epidemiologic Findings in Two Generations of Cambodian Refugees," *Journal of Nervous and Mental Disease*, 182(7), 387-395
- Seedat, S., Kaminer, D., Lockhat, R., & Stein, D.J. (2000). "An Overview of Posttraumatic Stress Disorder in Children and Adolescents", *Primary Care Psychiatry*, 6, 43-48
- Sinnerbrink, L., Silvone, D., Field, A., Steel, Z., & Manicavasagar, V. (1997) "Compounding of Pre- Migration Trauma and Post-Migration Stress in Asylum Seekers", *The Journal of Psychology*, 131 (5), 463-470
- Steinberg, D. (N.D) "Orphans of Conflict: Caring for the Internally Displaced", United States Institute for Peace Special Report Accessed at <http://www.usip.org/sites/default/files/sr148.pdf> ON 12/2/2015
- Sundberg, R. (N.D). Revisiting One Sided Violence: A Global and Regional Analysis using Uppsala Conflict Data Program (UCDP) Paper Number 3 accessed at www.ucdp.uu.se on 12/2/2014