INTERNATIONAL JOURNAL OF RESEARCH IN EDUCATION AND PSYCHOLOGY (IJREP)
An International Peer Reviewed Journal
http://ijrep.com/

Vol.1 Issue 1
2015

RESEARCH ARTICLE

ISSN:2455-426X

NEED FOR POST -TRAUMATIC STRESS DISORDER (PTSD) COUNSELING POLICY IN NIGERIA

Dr.Sylvester Okenyi

(Dept of Educational Foundations,ESUT, Enugu.)

Abstract

This article centered principally on the absolute necessity for establishing a counseling policy for PTSD in Nigeria. The study adopted a theoretical approach supported with secondary data sourced from text books, journals and internet materials. The findings revealed that though there is an abundance of evidence to show that sections of Nigeria have been variously exposed to situations that cause PTSD, there are no nationally recognized centres nor policy for interventions available for victims of PTSD. In view of the fact that the current situation in Nigeria is such that both the environmental and the risk factors that predispose people to exhibiting symptoms of PTSD are ongoing in Nigeria, the study concluded with the fact that time is due for a national policy on PTSD in Nigeria and highlighted issues to be taken into consideration in formulation of the policy

.

Key words: *Counseling, Policy, Trauma, Stress, Disorder, Cognitive*

.

1.0 INTRODUCTION

During his recent visit to Nasarawa state in Nigeria, the ex-military leader of Nigeria, General Yakubu Gowon who presided over the Nigeria-Biafra war re-iterated the theme of his end of the war speech "No victor No vanquished". He maintained that as far as he was concerned the Nigeria – Biafra war had ended. The speech was directed at the current leaders of Movement for the Actualization of the Sovereign State of Biafra (MASSOB)- a body that has been engaged in a running battle with the Federal government of Nigeria to recognize the existence of the defunct Biafran state, and who had confronted him at the burial ceremony of late General Odumegwu Ojukwu. Ex –President Gowon regretted the fact that when he visited Nnewi during the burial of Odumegwu Ojukwu, the late leader of the defunct Biafra, he was not able to visit the Biafran war veterans who are still living in a Rehabilitation Centre for Biafra War Veterans at Oji River Handicapped Centre, 45 years after the civil war. The ex-president did not say what his government and other governments after him had done to help these victims of the war.

In other climes one of the "first aid" psychological treatments given to soldiers who survived the war is the provision of services for evaluation and management of certain psychological problems that afflict soldiers and civilians alike after a prolonged exposure to trauma as a result of war and similar events (Waite T. (1993)). Very common and almost inevitable among such post war psychological problems is Post traumatic Stress Disorder (PTSD).

2.0 WHAT IS PTSD?

The Oxford Concise Medical Dictionary (10th edition) defined PTSD as a form of anxiety disorder caused by a major personal stress of a serious or frightening event. Williams (2007) in the Dictionary of Psychology adds that the PTSD may involve actual or threatened serious injury to self or others.

It is a psychological condition, formerly known as 'shell shock' and 'combat stress' which develops after experiencing, or witnessing, a stressful, frightening or traumatic event. Sufferers of PTSD have ongoing, debilitating feelings of fear, distress, anxiety and hopelessness (Williams 2007). Many people with PTSD also have difficulty sleeping and concentrating, and are more easily startled than before. These symptoms are the body's normal reaction to an abnormal situation - like a kind of survival mechanism. In response to a traumatic or life-threatening event, the mind works to ensure a person is always on the alert for danger. This is to prevent the body suffering further harm and distress (Slater & Lancaster (1995.).

From the foregoing therefore, it is inferable that victims of war, of genocide, rape and others who witnessed the brutality and barbarianism of various cadres of trauma would likely manifest symptoms of PTSD.

2.1 GENERAL SYMPTOMS OF PTSD

According to Alexander (2005), the most characteristic symptoms of PTSD are re-experiencing symptoms. PTSD sufferers involuntarily re-experience aspects of the traumatic event in a very vivid and distressing way. These include flashbacks where the person acts or feels as if the event was recurring, nightmares and repetitive and distressing intrusive images or other sensory impressions from the event. Reminders of the traumatic event arouse intense distress and/or physiological reactions. In children, re-experiencing symptoms may take the form of re-enacting the experience, repetitive play or frightening dreams without recognizable content. Avoidance of reminders of the trauma is another core symptom of PTSD. These include people, situations or circumstances resembling or associated with the event (Solomon, Neria, Ohry, Waysman and Ginzburg, 1994).

Many Igbo survivors of the Biafran war could not stand the sight of soldiers in uniform many years after the war.

People with PTSD often try to push memories of the event out of their minds and avoid thinking or talking about it in detail, particularly about its worst moments. On the other hand, many ruminate excessively about questions that prevent them from coming to terms with the event (for example, about why the event happened to them, about how it could have been prevented, or about how they could take revenge) (Hagengimana , Mburu , Kang'ethe, Ndetei& Wulsin 1998).

PTSD sufferers also experience symptoms of hyper-arousal including hyper-vigilance for threat, exaggerated startle responses, irritability and difficulty concentrating, and sleep problems. Others with PTSD also describe symptoms of emotional numbness. These include lack of ability to experience feelings, feeling detached from other people, giving up previously significant activities, and amnesia for significant parts of the event (Slater, & Lancaster (1995.) .

Symptoms of PTSD often develop immediately after the traumatic event but in some (less than 15% of all sufferers) the onset of symptoms may be delayed (Alexander2005). PTSD sufferers may not present for treatment for months or years after the onset of symptoms despite the considerable distress experienced. This type of attitude is compounded by the culture of silence and stigmatization prevalent in many Nigerian communities whereby people who visit psychiatric centres or ordinary counseling consultations are given negative labels. Assessment of PTSD under such culture of silence and stigmatization also present significant challenges as many people avoid talking about their problems even when symptoms of PTSD are very apparent in them.

2.2 SURVIVORS OF BIAFRAN WAR AND PTSD

As explained above, Posttraumatic stress disorder (PTSD) is a psychiatricdisorder that can occur following the experience or witnessing of life threatening events such as military combat, natural disaster, terrorist incidents, serious accidents, or violent personal assaults like

rape and war. The Igbos in the south-eastern part of Nigerian state suffered various forms of the aforementioned and so are prone to developing symptoms of PTSD. Before, during and after the Biafran war in the current Nigeria, millions and millions of the Igbo people were rounded up in several regions, states, cities, towns, and villages in northern and western Nigeria and "slaughtered". During the 1966 Biafran war in particular Igbo young girls were first gang raped by scores of men and then carried to Leper colonies to be raped by leper patients before being killed; the Biafran nursing mothers had their breasts cut off; while their men when caught were buried alive. (Nnedum , 2004, p.97).

Ever since then, the Igbo people are often exposed to traumatic events that flood their life with pain and sorrow. During the recent electoral crisis in 2011 the same Igbo people were slaughtered in different parts of Nigeria for no other reason than that they were pursuing their legitimate business. The recurrent traumatic events like the Boko Haram massacres, recent political and ethnic conflicts in the Northern and Western Nigeria, in which the Igbo earned victim-hood, only reinforce their lived experiences of the Biafran annihilation, a pogrom that can only be compared to that of the Rwandan genocide.

Most of the Biafran war survivors had lost their husbands, wives, children, properties and relatives following the flood of these recurrent internal crises and conflict. Nnedum (2004) asserted that "every day, stigmatized and marginalized people, specifically, the "Igbos" routinely suffer from deep-rooted hate crimes emanating from other ethno-linguistic groups in Nigeria. It appears, in recent times, that the incidence of habitual armed violence is more devastating than the Biafran war genocide"

Physical trauma is easily fixed, healed, but not psychological trauma. Psychological trauma often lasts the rest of an individual's life time, affecting just about everything he or she does. Trauma phenomenon is seen in soldiers who were exposed to battle front killing. It used to be called battle fatigue or shell shock(Ford1999).

The author has a very direct experience of the manifestations of the PTSD phenomenon in the victims of Rwandan genocide.

2.3 PTSD EXPERIENCE OF VICTIMS OF RWANDAN GENOCIDE

It was reported that Rwanda's 1994 civil war officially ended in July of that year, but as massacres and episodes of genocide continued to erupt sporadically within and around Rwanda's borders, the many faces of posttraumatic stress disorder (PTSD) continued to surface in dramatic ways (Hagengimana , Mburu , Kang'ethe , Ndetei & Wulsin L(1998). Each April through July after the war and during the anniversary of the genocide, the University of Rwanda Trauma Clinic in Butare continued to witness a parade of people with severe PTSD. For instance, in May 1997, a young Rwandan girl came to the clinic reporting nausea and the feeling of insects crawling on her face. She complained of the strong smell of faeces and grew increasingly agitated and fearful, describing vivid images of people trying to kill her at that moment. For months she had vomited at the sight of avocados, and for three years she had been unable to tolerate the sight of rice.

During the clinical evaluation, she related that her parents and siblings had been murdered in the genocide of 1994 and that she had been severely wounded. The perpetrators, thinking she was dead, had thrown her into an open public toilet, where she lay for one week among feces and maggots-white maggots resembling bloated grains of rice-feeding on the avocados that fell on her from a tree above the toilet. The girl's case was evaluated as a severe case of post-traumatic stress disorder (PTSD).

In another instance, in April 1997, more than 30 teenagers from Nyanza Secondary School attended a reburial ceremony of the remains of their relatives who died in 1994. They developed acute emotional reactions such as agitation, seeing vivid images of genocide and weeping for over two days after the ceremony ended. The children fled the scene; the government ordered the school to close. Closer investigation by the school faculty and a consulting psychiatrist suggested mass hysteria as the most likely explanation (Hagengimana , Mburu , Kang'ethe, Ndetei& Wulsin (1998).

It is necessary to state here the context that necessitated the report in detail of the post-genocide experience in Rwanda. Many Biafran soldiers who suffered "shell-shock" came out of the war manifesting various forms of abnormal behaviours: hallucinations, talking to themselves, being insensitive to their immediate environment, wandering aimlessly and often pointing at invisible persons threatening to kill them etc. Most often, months and months after the war, at a full market sessions in the villages currently occupied by Biafran war survivors, men and women would scamper to "take cover" from imagined Nigerian war planes spreading death and carnage as was the case during the war. These apparently could be seen in their proper perspectives: symptoms of PTSD as will be discussed further in details below.

The incidents above tend to suggest also that PTSD as a psychological disorder, once it afflicts a victim remains with him all his life, occasioning permanent impairment of the victim's life. This is why researchers and psychologists(Nnedum, (2004), Nnedum, & Ezeokana, Chine &, Omonijo 2007)are asking questions as to what the government of Nigeria is doing to prevent /manage the prevalence of PTSD among Nigerian citizens who continue to experience almost on daily basis devastating traumatic incidents.

3.0 **REASONS WHY PTSD IS ON INCREASE IN NIGERIA**

Many reasons abound why there is likely increase in the rate of prevalence of PTSD in Nigeria. Amaraegbu (2015) outlined the following reasons:

3.1 Ignorance and lack of statistics

Ignorance and lack of statistics lead to under reporting or total negligence of available data on the issues of PTSD. Ignorance of the symptoms, devastations and dangers, ignorance of the onset and exacerbation; ignorance or negligence of obtaining professional therapy and doing so timely. For instance, many husbands cannot appreciate the depth of emotional and mental torture a pregnant wife undergoes after abortion or miscarriage. Particularly if the loss of foetus is not a result of deliberate action. The woman experiences a similar degree of

mourning and grief equal to the type that is manifested during the demise of a grown up person. Though the degree of PTSD may vary from one woman to the other, generally, the impact is very significant on the psychological health of the victim.

3.2 Cultural expectations and norms

Cultural expectations and norms contribute to the escalation of post-traumatic stress disorders in Nigeria today. For example, in most Nigerian societies, victims of rape are stigmatised, and by this expression of such a negative cultural norm, such people are further exposed to PTSD. Instead of assisting them, our society criminalises and criticises them. They are erroneously judged as being wayward and deserving the evil fate which had befallen them. Such adding of insult to an already putrefying sore only worsens the traumatic situation they find themselves.

3.3 General Decline in Virtuous living

The situation in our globe today seems to portray a situation where virtue is increasing in numerical strength while vice is increasing in geometric dimension. It is a prevailing culture of violence, vengeance and vendetta. Humanity is losing in an alarming rate her appreciation of all that is noble, virtuous and gracious. A contemporary case at hand is the attitude of many politicians and those in governance in Nigeria. Those who lost elections at any level are comparable to pregnant women who lost precious foetus at the various stages of cyesis. This awareness or knowledge may be remote to multitudes. No wonder many opponents engage in callous and crucifying attitudes against their competitors. When one considers the huge investments in terms of time and talent, material and mental, social and spiritual resources channeled towards achieving success at the polls, one can then begin to at least to sympathise with the losers.

3.4 Adverse Cultural and Religious Practices

Dangerously too, the misunderstanding and misapplication of religion in Nigerian today has led to the escalation of all forms of post- traumatic stress disorders. From genital mutilation of females to regarding them as evil and sex objects, to social exclusion, persecution and destruction of lives of infidels, religious bigotry is one of the major causes of PTSD in Nigeria today. For one person who is undergoing religious persecution or victimization, there are at least three others connected to them who bear a similar degree of the consequences.

3.5 Dearth of professional personnel and adequate equipment to handle PTSD

The dearth of professional personnel and adequate equipment to handle PTSD is yet another reason why this group of psychological disorders is increasing in leaps and bounds. For instance in Nigeria, the health centres that can provide professional attention for PTSD are psychiatric and university teaching hospitals, a few general hospitals, some university clinics or health centres and a few private clinics. Until this situation improves, the tendency for increase in the rate of incidences of PTSD cannot be ruled out.

4.0 RISK FACTORS OF PTSD

Research (WHO 1992) shows that approximately one in three people who go through trauma will develop PTSD. It is not known why some people develop the condition and others do not. Theories however, suggest various risk factors that can enhance the probability of someone developing PTSD after a traumatic event. We present in brief form some of these theories as shown in (WHO; 1992)

4.1 **A history of psychological illness**

Individuals who have suffered from anxiety and depression in the past are considered to be more vulnerable to developing PTSD than others. A family history of these types of illnesses will also increase the risk as a genetic element could be present.

4.2 **Hormonal imbalance**

Studies have shown that PTSD may be related to abnormal levels of stress hormones. These hormones are produced when the mind becomes aware of potential danger. They work by triggering a reaction in the body, which stimulates the 'flight or fight' reaction. Some people with PTSD have been found to produce excessive amounts of this hormone. As a result their 'flight or fight' reaction is over stimulated - even when there is no danger. This could help to explain some of the symptoms of post-traumatic stress disorder, such as hyper-arousal (Terr &Chowchilla (1983).

4.3 **Differences in the brain**

Brain scans have shown differences in the brains of some people with post-traumatic stress disorder (WHO; 1992). Parts of the brain involved in emotional processing and memory in particular, are smaller in size. As a result, the brain cannot effectively process memories linked to the trauma, so the anxiety they generate persists. This is why post-traumatic stress disorder treatment tends to involve processing painful memories. This process helps to make flashbacks and nightmares related to trauma disappear.

4.4 **Other factors**

The following factors are also contained in (Cantor & Price 2007):

PTSD tends to be more common in certain groups of people. This is due to a combination of social, environmental and psychological factors. Firefighters have a very high risk of developing post-traumatic stress disorder. It is estimated that one in five experience symptoms at some point in their career. Studies (Ford, 1999) also show that female rape victims (one in two) and teenage survivors of car crashes (one in three) are more vulnerable.

4.4(i) **Complex PTSD**

This type of post-traumatic stress is not as common as PTSD, and differs slightly in terms of causes and symptoms. Complex PTSD results from prolonged or sustained exposure to emotional trauma or abuse (Gardner 2004)..For example, a child who witnesses a friend's

death in an accident may develop symptoms of post-traumatic stress disorder. However, a child who experiences abuse for several years is more likely to develop symptoms of complex PTSD.

Individuals with complex PTSD typically exhibit the following symptoms (this list is not exhaustive): avoidance, denial, depression, hyper vigilance, panic attacks, self-loathing .low self-esteem, and learned helplessness, fear of abandonment, selective memory and selective amnesia (Gardner 2004).

5.0 Problem with PTSD treatment

Due to the complex nature of PTSD the condition often goes unrecognized. As a result, many sufferers miss out on treatment. Those who feel uncomfortable talking about trauma and painful feelings may not want to admit they are struggling. They may fear being thought of as weak and emotionally unstable. Nnedum, & Ezeokana, (2007) report that this attitude is very prevalent in Nigerian rural communities. The result is that the victims' loved ones, colleagues and friends may be left in the dark about what is really going on.

5.1 Forms of PTSD treatment

For prolonged cases of PTSD, treatment can be provided via a range of interventions. These aim to address both the psychological and physical symptoms of post-traumatic stress disorder. This is to help individuals cope better with the effects of their trauma. Although treatment is highly effective, there is no intervention that will completely erase all memories of a traumatic incident.

5.2 Counseling for PTSD

Counseling for PTSD aims to address issues that deeply affect people emotionally and physically. Talking therapies can also help to address mental health conditions that are entwined with PTSD. These include depression, phobias and anxiety.

WHO (1992) list the following counseling approaches:

5.3 **Cognitive behavourial therapy (CBT)**

CBT for PTSD is where a therapist helps a client to understand their current thought patterns. This is so they can identify those that are harmful and unhelpful. Through this process sufferers can come to terms with their trauma and gain a sense of control over their fear. By focusing on realistic thoughts, they can avoid falling back into negative thinking patterns whenever they encounter a trigger.

5.4 **Eye movement desensitisation and reprocessing (EMDR)**

This approach aims to reduce symptoms of PTSD via a series of side-to-side eye movements. EMDR addresses the brain differences in sufferers, helping them to process memories and flashbacks of a trauma more effectively.

5.5 **Counseling for complex PTSD**

There is limited research into the treatment of complex PTSD, but the methods and processes involved tend to be similar to the ones used in counseling for PTSD (Waite 1993). Self-discovery and exploration of the trauma is a key part of treatment. This helps sufferers to come to terms with what has happened, accept that it was undeserved and find ways to overcome it. Recovery involves focusing on the problems that can be resolved to help sufferers to regain a sense of control.

5.6 Medication

Medication for sufferers of PTSD can only be recommended bya health professional if he feels they may benefit from extra support. The role of a school counselor is to refer the victim to such a professional.

Medication for PTSD such as anti-depressants can be beneficial for those who are at risk of ongoing trauma. A primary example is domestic violence (Gardner. 2004). If medication for post-traumatic stress proves effective, treatment will usually continue for a minimum of 12 months. It will then be gradually withdrawn over a period of four weeks or longer. The ultimate aim of treatment - particularly counseling for PTSD - is to help sufferers come to terms with their trauma and process their emotions more effectively. This is to promote a healthier and more positive way of thinking.

6.0 Establishment of Referral System

Based on the existing referral chain of the Nigerian health care system, after identification of PTSD in individuals who may require specialist intervention, the referral is from the primary health care level to the secondary level (where the specialists exist) or directly to the specialist neuropsychiatric centres (Amaraegbu, 2015). A directory of where and when the specialist services exist would be developed and circulated to the volunteers and all the clinics with trained staff centers, along with the establishment of collaborations specialist hospitals to facilitate a harmonious working relationship.

6.1 MONITORING AND EVALUATION

According to National Mental Health Consultant of the NPHCDA Monitoring and Evaluation is performed by the national implementation team using process indicators such as numbers of cases identified and provided interventions. This is an ongoing process, with local recruitment of the mental health professionals in the tertiary healthcare facilities of the given setting playing a local supervisory and supporting role to guide, encourage and accept referrals of cases that may be beyond the competence of school counselors.

7.0 CONCLUSION/RECOMMENDATION

The imperative need for urgent psychosocial interventions for PTSD in Nigeria currently witnessing untold destruction and dislocation of lives and properties is clear. The counseling aspect of these interventions should start from secondary and tertiary education counseling

centres. Provision of adequate referral personnel with the requisite expertise and the means, through the appropriate health agency of the Federal Ministry of Health to provide cost-effective trainings to the Public Health consultants, staff and members of civil societies that will empower them to screen, correctly identify and provide much needed psychosocial interventions that are culturally appropriate and acceptable to the communities cannot be over-emphasized. Most importantly, a national PTSD policy that takes into consideration the ideas articulated above should be put in place.

Rererences

Alexander DA(2005) *Hostage taking: effects, coping and adjustment*. In: Brown J, Campbell E, editors. Cambridge Handbook of Forensic Psychology. Cambridge: Cambridge University Press.

Amaraegbu, P (2015) Reasons For Escalating Rate Of Post-Traumatic Stress Disorders (PTSD) in The Guardian, Nigeria, August 16, 2015

Cantor C, & Price J. (2007) Traumatic entrapment, appeasement and complex post-traumatic stress disorder: evolutionary perspectives of hostage reactions, domestic abuse and the Stockholm syndrome. Aust NZ J Psychiat. 2007;41:377–84.[PubMed]

Ford, J. D. (1999). Disorders of Extreme Stress Following War-Zone Military Trauma: Associated Features of Posttraumatic Stress Disorder or Comorbid but Distinct Syndromes Journal of Consulting and Clinical Psychology. 67, (1), pp. 3-12.

Gardner LC (2004). The Case That Never Dies: The Lindbergh Kidnapping. New Brunswick, NJ: Rutgers University Press

Hagengimana A, Mburu J, Kang'ethe R, Ndetei D, Wulsin L (1998), PTSD in Survivors of Rwanda's 1994 War. American Psychiatric Association Annual Meeting. New Research #621

Nnedum, O. A. U. (2004). Etiology and Consequences of Internal Population Displacement in Nigeria: A Psychological Analysis in O. N. Oranye and N. A. Nnonyelu (eds). Understanding Social Sciences, Oktek (Nig) LTD, Enugu, Nigeria, pp. 88-95.

Nnedum, O. A. U. and Ezeokana, J. O. (2007). The Validation of Los Angels Symptom Checklist (LASC) in Nigeria. Nigerian Psychologist: An International Journal. 2, (1), pp.6-12.

Slater S, Lancaster P.(1995) Beyond Fear: My Will to Survive. Oxford: ISIS Publishing.

Solomon, Z; Neria, Y; Ohry, A; Waysman, M and Ginzburg, A. (1994). PTSD Among Israeli Former Prisoners of War and Soldiers With Combat Stress Reaction: A Longitudinal Study. Am J Psychiatry, 151(4), pp. 554-559.

Terr LC.& Chowchilla D(1983) Revisited: the effects of psychic trauma four years after a school bus kidnapping. Am J Psychiatry. 1983;140:1543–50.[PubMed]

Waite T. (1993). Taken on Trust. London: Hodder & Stoughton.

Williams R(2007). The psychological consequences for children of mass violence, terrorism and disasters. Int Rev Psychiatr.;19:263–77.[PubMed]

World Health Organization. The ICD-10 Classification of Mental and Behavioural Disorders. Geneva: WHO; 1992.