Research on Humanities and Social Sciences
ISSN 2222-1719 (Paper) ISSN 2222-2863 (Online)
Vol.3, No.5, 2013

Posttraumatic Stress Syndromes among Victims of the Ife/Modakeke Crisis

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Abstract
The main purpose of this study was to estimate the incidence of posttraumatic stress disorder (PTSD) among the victims of the March 2000 Ile-Ife/Modakeke crisis. It also examines most of the risk factors (such as degree of exposure, age and gender) that predispose the victims to PTSD. An initial sample of 456 male and female respondents from both communities field in a simple questionnaire that assessed the degree of exposure to trauma and self-reported PTSD symptoms. The results indicate that a substantial proportion (19%) of the initial sample reported symptoms of such magnitude as could be diagnosed as PTSD. Age and the degree of exposure to trauma were fund to be risks factors for PSTD in the population. The implications of these results for therapy, the provision of relief to traumatized populations and future research are highlighted and discussed.
Keywords: Posttraumatic stress syndromes, victims, Ife/Modakeke crisis

1. Introduction

In recent years Nigeria has witnessed a series of disasters such as oil spills and flooding; catastrophes like air-crashes, bomb blasts and horrific road accidents; and civil strives including religious and communal conflicts. People who saw their parents, peers and friends shot, burnt or beheaded; were themselves shot at or physically attacked and/or injured; saw their houses and properties burnt or were exposed to the grotesque (for example to mutilated and/ or decaying corpses) as happened during the Ile-Ife/Modakeke crisis of March, 2000 will bear some negative effects of such events. The Ile-Ife/Modakeke crisis has a long history (Asiyanbola, 2010) whose main cause has been traced to differences over land ownership and the payment of royalties for such land (Agbe, 2001; Toriola, 2001). The first Ife/Modakeke crisis according to Albert (1999) occurred between 1835 and 1849. The latest in this long line of communal conflicts occurred in 2000. Asiyanbola (2010) noted that between 1835 and 2000, seven major wars were recorded between the Ifes and the Modakekes (1835-1849, 1882-1909, 1946-1949, 1981, 1983, 1997-1998, and 2000). During this conflict, several people were killed, maimed and/or driven from their homes, houses and other properties destroyed or burnt (Durosaro & Ajiboye, 2011, Oladoyin, 2001). This crisis was of such proportion that the state government had to impose a dusk to dawn curfew in the town after one week of mayhem. The physical, human and environmental scars of the conflict are still very visible more than twelve years after.

Among effects of such conflicts are psychological disturbances of various types and severity. A recent review of 50 studies on disasters and psychological problems concluded that a small but significant relation exists between the two (Neria, Nandi & Galea, 2007, Rubonis & Bickman, 1991). Lonigan, Carey & Finch (1994) suggest that severely stressful experiences can produce a psychological reaction that is much stronger than simple anxiety. Post-traumatic stress disorder (PTSD) is the most prolonged and the most serious of all reactions to severe stress (Loey, Schoot, & Faber, 2012, Neria, Nandi & Galea, 2007, Hales & Zatzick, 1997).

Stress is inevitable and in some cases a desirable fact of everyday life. Some stressors, however, are so catastrophic and horrifying that they can cause serious psychological harm to those who experience them. Both the survivors and witnesses to traumatic stressors are expected to be greatly distressed as part of their normal response. For some victims, the trauma continues long after the event itself has ended. The horrifying experience leads to general increases in anxiety and arousal, avoidance of emotionally charged situations and the frequent reliving of the traumatic event. When the symptoms persist for more than a month, this condition is reffered to as post-traumatic stress disorder (PSTD). The APA (2000) describes PTSD as characterized by three broad clusters of symptoms:

1. re-experiencing the trauma;
2. numbered responsiveness and avoidance of stimuli associated with the trauma;
3. persistent symptoms of increased autonomic and emotional arousal.

An important distinction is made between PTSD and Acute Stress Disorder (ASD) or Acute Stress Reaction (ASR). ASD is applicable soon after a traumatic event, that is, less than a month after the experience of severe stress. PTSD can be relatively short-lived, lasting a month or two with flash backs in some victims up to a year or more (Powers, Crude, Daniels, Stevens, 1994). However, the diagnostic criteria for PTSD closely resemble those of ASD with the primary differential diagnostic criteria being the time course. For a diagnosis of ASD the symptoms must occur within four weeks of the traumatic event and be resolved within the four week period. The diagnosis of PTSD

applies to a similar constellation of symptoms if they persist longer than one month or if on-set of symptoms begin later than one month after the traumatic event.

Delayed stress reactions usually follow an intensively stressful and often prolonged experience in which:
(a) individual experienced, witnessed or were confronted with an event that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or those others, and
(b) Individual response involved intense feelings of fear, horror or helplessness.

Thus, the most frequent predictor of PTSD is the degree of exposure to the disaster (Deblinger, McLeer, Atkins, Ralphe & Foa, 1989, Rubonis & Bickman, 1991). Although the prevalence of PTSD varies greatly depending on the types and degree of exposure to a disaster, researchers suggest that 10-30% of highly exposed individuals develop the disorder (Blanchard, Hickling, Tailor & Loos, Oei, Lim and Hennessy, 1990; Powers, Cruse, Daniels, & Stevens, 1994). The greatest risk is in persons exposed to life treat, who experienced the grotesque, and/or who were injured (Breslau, Davis, andreski & Peterson, 1991). However, it appears that the small number of PTSD cases in the general population has made it difficult for researchers to find differences in the prevalence of PTSD among subjects of different ages and sexes (Helzer, Robins & Mcenvoy, 1987). Nonetheless, age has been implicated as one of the factor that increase the risk of PTSD in those exposed to traumatic events. Children and adolescents emerge as being at greater risk for traumatic stress-related sequelae (Pynos, 1992). Often community leaders, aid workers and teachers notice how wonderfully quiet children who have experience trauma are and are often thankful or the apparent low level of distress. However, the inhibition of the normal activity of children is an indicator of their degree of distress. Often times the parents' distress increases that of their children (Pynoos, 1992). Breslau, Davis, Andreski, & Peterson (1991) reports that trauma is more likely to be experienced by men, by those with less education, and by people who has history of emotional problems. The present study is an attempt to estimate the incidence of PTSD among the victims of the Ile-Ife/Modakeke communal crises. It also examined the variation in incidence rates due to age and gender.

2. Method

2.1 Design

The ex-post-facto, quasi-experimental approach was employed in this study since the independent variables – gender and age already existed and the event referred to took place several years before the study. Equal members of subjects were selected to represent these two factors thereby ensuring a 2(males vs females) x 2 (adolescents vs adults) factorial design.

The participants were drawn from both the Ile-Ife and Modakeke communities that were involved in the communal conflict. Each community had equal representation, which is 100 respondents that was drawn from both communities. There was also equal representation on the basis of gender and age groups. The age range of the participants was 13-44 years with mean age of 28.05 years and a standard deviation of 21.45 years. Respondents were divided into two age groups on the basis of their reported age. The aged 13-20 years was classified as adolescents while those aged 21 years and above formed the adult group.

2.2 Measure

A single simple paper and pencil questionnaire was used to measure the dependent variable. However, to ensure that subjects actually experienced the trauma associated with the conflict, the first set of nine questions tagged the "Initial Trauma Experienced" (ITE) was used as a screening instrument. Items in this section of the questionnaire to which respondents were to answer "Yes or No" included questions on threat of life and property or loved ones during the crisis.

Section B of the questionnaire measures self-reported symptoms of PTSD. Items in this section were sourced from the APA (1994) and ICD-10 diagnostic criteria for PTSD and the literature on the disorder (Breslau et al, 1994; Hales & Zatzick, 1997; Omer, 1992; Rubonis & Bickman, 1991). Examples of items include constipation, nightmares and disturbing dreams, nausea, anxiety, sexual functioning and so on. Although there were 23 items in this section of the questionnaire, all carried a 5 point Likert-type scale ranging from very frequently (4) to not at all (0). Respondent are to rate the extent or the frequency they have felt these symptoms within the past two months. the responses were scored from the most negative (that is, very frequently) to the most positive (that is, not at all) alternatives. Some on all 23 items were summed to get a total PTSD score. Thus, the higher the score the more disturbed the respondent.

2.3 Procedures

People in wards of the town that were severely affected by the crisis were targeted. To ensure that participant actually experienced the conflict, the snowball sapling technique was employed with an identified prospective participant giving the names and present addresses of people who went through the experiences with them to the investigator. As a further check on the experience of the trauma, the ITE was administered. The ITE was used to screen out those who did not experience much of the trauma. This was achieved through the rejection of the questionnaires of those scoring below the cut-off point on the ITE. The cut-off point on the ITE was set at 15.26 because the mean score of the respondents was found to be 11.53 with a standard deviation of 3.73 thus, the cut-off point was one standard deviation above the mean. Therefore, although 456 questionnaire were initially distributed, this number was reduced drastically due to this criterion. The number of subjects finally included in the analysis was further reduced to 200 due to the need to have equal representations on all the stratifying variables (community, age, gender). The latter reduction was achieved through the use of SPSS random selection programme.

The questionnaire was administered on the respondents individually either in their homes, shops or schools. Most of those approached refused to fill in the questionnaire with some saying they did not want to be reminded of what happened during the conflict.

2.4 Results

Due to the screening criteria employed, those who experienced severe trauma reported more severe PTSD symptoms than those who were adjusted not to have been so traumatized (t[448]=25.93, P<.001). These results are presented in Table 1 below.

TABLE 1: t-Test Comparison of the Mean PTSD Scores of the ITE Groups

Group	N	X	SD	Df	t	P
Traumatized	153	27.460	7.460	448	25.953	.0001
Not Traumatized	297	10.830	7.730			

Also, using the number of symptoms reported as an index of PTSD, significantly higher proportion (86%) of those classified as traumatized had symptoms of such magnitude that could be diagnosed as PTSD than the less traumatized (34%; X2 = 56.926, P<.0001). Overall, appropriately 19% of the initial sample of 456 could be said to be reporting a clinically significant number PTSD symptoms. This figure was significantly higher than would be expected by chance (X2 = 40.182, P<.001).

The two way analysis of variance (2-way ANOVA) was used to assess possible age and sex differences in the elf-report of PTSD symptoms. The result of the analysis is presented in table 2. The analysis revealed only the main effect of age (F[1,196 = 23.486, P<.0001). This indicates that adolescents reported more PTSD symptoms following the Ile-Ife/Modakeke crisis than adults (see Table 3. The gender effect was not statistically significant.

TABLE 2: Summary of the ANOVA on PTSD symptoms by age and gender

Source	SS	Df	MS	F	P
Age	1343.693	1	1343.693	23.486	.0001
Sex	10.397	1	10.397	0.182	.670
Age & Sex	159.490	1	159.490	2.788	0.97
Error	11213.735	196	57.213		
Total	12727.314	199			

It is worth of note, however, that the interaction of age and sex approach but failed to reach conventional levels of statistical significance (F[1,196] = 2.788, P<097). Table 3 shows the means and standard deviations of the age and gender groups on PTSD.

TABLE 3: MEANS AND STANDARD DEVIATIONS OF AGE AND GENDER GROUPS.

Age Group	Gender				TOTAL	
	Male		Female			
	X	SD	X	SD	X	SD
Adolescents	31.880	6.480	30.200	7.420	31.040	6.950
Adults	24.600	7.090	20.850	8.140	22.525	7.780
TOTAL	28.240	6.785	25.525	7.780		

It is apparent from the Table that adolescents of both sexes are experiencing more severe symptoms of PTSD than the adults (t [48] = 6.002, P <<.001 and t[48] = 5.359, P<<.001 for males and females respectively). The mean differences appear to indicate that the level of disturbance was determined by the person's age and sex. This means that adolescent males were the most disturbed followed by adolescent females.

2.5 Discussion

The first point worthy of note is the large number of prospective participants who refused to take part in this study. This made the final sample all volunteers and to a large extent self-selected. The extent to which this influenced the results of the study is difficult to determine. It could be that this group of people were still experiencing symptoms of such magnitude that they would not want to be reminded of what they went through during the crisis under investigation. Time has not healed their wounds. Thus, the reliving and flashbacks they have to live with is like an open sore and any reminder of or references to that era causes a lot of pain still. Apart from the obvious loss of data, their refusal to participate in the study raises the question of who people would want to discuss their traumatic experiences with. Observations in the field during this study, shows that though people prefer to discuss such issues with professionals (doctors, psychologists, pastors, imams and so on) they are freer in groups. Since the interview and questionnaire administration was one on one, most refused to answer the questions. However, when one or two other persons they know went through the trauma as themselves were present they more readily opened up. Data on such persons were lost due to the fact that the questionnaire administration phase or this study was planned to be one respondent at a time. Perhaps, it would have been better to employ the focus group discuss for the data collection. This may be explored in future research on PTSD in a Nigerian setting.

The results indicate that a substantial proportion of the respondents self-reported PTSD symptoms of such magnitude as could merit a diagnosis of PTSD seven months after the actual trauma. This is important to note because when disasters and catastrophes occurs in this country the concern of governmental and non-governmental organizations alike is the physical distress of the victims. When such crises occur governments and NGOs rush material aids to the victims. The psychological needs of the victims are hardly attended to. It is to be hoped that more studies on the effects of the various crises in the country will open the way for policy makers to recognize the psychological needs of such victims so that in future the provision of relief will meet both the physical as well as the psychological needs of traumatized people. Meanwhile, psychologists and other relief workers need to recognize the deep cultural differences between African and Western Cultures alluded to just above. For example, rather than provide individualized therapy for affected persons, group therapy involving songs, dance and storytelling should be tried.

The degree of exposure and age were found to be important risk factors for PTSD. In fact, children traumatized by the killings and arson are having trouble concentrating in schools, and most have become withdrawn. It is worthy of note that adolescents were the so-called youths who actually took part in the killings, maiming and burnings of that period. Thus, by their very roles as either warriors or vigilantes they were more exposed to the trauma of the crisis. Those of them that survived still suffer from confusion, anxiety, depression, flashbacks, difficulty concentrating, sleep disturbances, anti-social behavior and acting out. A more harrowing future could lie in wait for these adolescents. They have become so desensitized to violence that they may kill again. Violence has so become expected and cyclical in this town and their lives that they cannot stop thinking about it. The situation is made worse by their feelings of guilt. They see the result of their violent acts every day in the burnt and destroyed buildings and lives in the town. They, therefore, daily experience re-traumatization and are unable to reintegrate full into the community. There is, therefore, an urgent need for programs to help restore, as quickly as possible, social support networks and relationships in future occurrences.

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