Exposure to Community Violence: Niger Delta Youth, Post-Traumatic Stress Reactions and Treatment Implications

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Opinion Paper

1. Introduction

The Nigeria’s oil delta has been a site of intense violence since oil exploration began in Nigeria in the 1950s. The Nine States that constitute the Niger Delta have been subjected to a barrage of conflicts, ranging from state violence, communal and ethnic conflicts. Youth militancy and constant attack on multinational oil companies, abductions and kidnapping (i.e. hostage taking), pipeline bombings and attack on flow stations were recurrent features of the Niger Delta region. The seriousness of youth’s exposure to violence in Niger Delta is acknowledged worldwide where violence is a pervasive form of trauma.

The high rate of crime and violence in the country has had a profound impact on youth. It is the nation’s young people particularly those from the large pool of unemployed youth, many of whom are University graduates frustrated with decades of extreme poverty, underdevelopment, and the lack of job opportunities, those from low socio-economic background, who are increasingly exposed to extreme acts of crime and violence, either as a witness or a victim. The rate of violence in Nigeria’s Oil Delta has increased dramatically over four decades of oil exploration (Osita, 2003: Akeem, 2008). Although the numbers have begun to show a decline in recent times compared with one in 2004, and last quarter of 2005. Nevertheless, the rates remain high, perhaps, than any other of Nigeria. As a consequence of this exposure, young people are at increased risk of experiencing a myriad of disturbing psychological symptoms.

One main set of problems that results in the aftermath of exposure to crime and violence is the development of
distress symptoms, particularly those associate with posttraumatic stress reactions. As a result of the high levels of psychological reactions experienced by youth who suffer from posttraumatic stress, it is necessary that interventions be formulated that will help alleviate the reactions. This paper first reviews the research literature on the relation between exposure to crime and violence and the development of posttraumatic stress reactions. The paper next discusses intervention strategies to help reduce these reactions among the youth of Niger Delta region and Nigeria in general.

2. Youth’s Exposure to Crime and Violence and Developing Posttraumatic Stress Reactions

Exposure of youth to crime and violence and individuals' reactions to it are complex and multifaceted. Although exposure to extreme acts of crime and places youth at risk for a variety of adverse psychological consequences, distress symptoms of type associated with posttraumatic stress have emerged as focal point of recent research (e.g. Davies and Flannery, 1998; Ensink et al, 1997, Glodich, 1998 and Steven et al, 2010).

The major symptoms associated with posttraumatic stress reactions include: re-experiencing the trauma such as nightmares, flashbacks, avoidance of stimuli associated with the trauma (e.g. thoughts, feelings, conversations, people, places, or things), and increased arousal (e.g. irritability, hypervigilence, easily startled, sleep and or concentration difficulties. These symptoms became a part of psychiatric nomenclature in the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM – III; American Psychiatric Association, 1980), and more specifically, in the diagnostic category, “Posttraumatic Stress Disorder (PTSD)”.

Those conversant with happenings in Nigeria in the past three decades would agree that the country witnessed all sorts of violence. (Agbu, 2003; Akeem, 2008). This may not be unconnected to heterogeneity nature of the country that is constantly manipulated by its political elites in their race for control of the state resources. The subjective experience of trauma and the subsequent expression of symptoms vary considerably in Spatial and temporal terms. A few example of trauma in the nation include, but not
limited to, electoral malfeasance and electoral fraud and political assassinations, massive corruption in high and low places with selective judicial dispositions, reign of terror and suppression of opposition and thought process, HIV epidemic with death and morbidities, unemployment, Niger Delta war–execution and death, bomb explosion and imprisonments. Psychosocial trauma and physically induced trauma include the following: Childhood emotional and physically induced trauma include the following: Childhood emotional or sexual abuse, including prolonged or extreme neglect; hostage taking, illegal oil bunkering, environment degradation, internetpedophilia e. t. c.

However, exposure to all forms of trauma is not peculiar to Nigeria alone but common worldwide. The notion of post-traumatic stress symptoms has led to increasing recognition of the global problem. The awareness has helped popular acceptance of the reality of posttraumatic stress and its sequelae. Daily stressors have been reported to play a more central role in the development and maintenance of psychological problems (Banez and Compass, 1990). Forehand et al (1991) found that as a number of stressors increase, adolescent functioning deteriorates. The prevalence and severity of chronic and everyday stressors in the lives of urban adolescents may predispose them to symptoms of psychological stress and post-traumatic stress disorder.

In addition, high rate of crime and violence have been found to had a profound impact on youth such that would make them to experience a myriad of disturbing psychological problems (Warner and Weist, 1996). South Africa is viewed as one of the most stressful countries in the world (Louw and Bach, 2009). Exposure to violence is identify as being a powerful contributor. Studies have found exposure to violence to be a strong predicator of posttraumatic stress disorder in young victims, witnesses and those who heard about violent events (Duckworth, Hale, Clair and Adams, 2000, Marza and Reynolds, 1999, Singer, Anglin, Song and Lung-hofer, 1995; Slovak & and Singer, 2001).

Proximity to a violent event has also been said to relate to the severity of traumatic symptoms. Nigerians living in and around Niger Delta have witnessed high rate of violent than any other part. Townspeople and villagers have
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experienced unprecedented level of insecurity as armed groups fought around their homes and communities couple with state military apparatus fighting the youth militant. Therefore, exposure to violence had been hypothesized to trigger more adverse psychological response suggesting an additive effect on the distressed experienced.

Moreover, it should be noted that the research summarize in this article, some studies focused on assessing the symptoms of PTSD among participants while other studies have focused not only on the symptoms but also on assessing whether full diagnostic criteria have been met to warrant a clinical diagnosis of PTSD among participants.

In a study that documented between exposure to crime and violence distress symptoms was found by Fitzpatrick & Boldizar (1993). This study involved children and adolescents. Specifically, participants were low-income African – American youth (ages = 7 to 18 years; N = 221) who were involved in a federally funded summer camp program within a large, southern central city. An adaptation of the SECV was used as well as a revised group administered version of the Purdue Posttraumatic Stress Scale (Figley, 1980), cited in Steven et-al (2010). In this sample, more than 70% of the children and adolescents reported being victims of at least one violent act. Similar to Richters and Martinez (1993), participants were more likely to have been witnessed violence than to have been victimized, with close to 85% having witnessed at least one violent act and 43.4% having witnessed a murder. In addition, of those who had been exposed either as witness or victim, 89% met at least of one of the DSM III-R Criteria for PTSD (American Psychiatric Association, 1987), with the average number of symptoms being five. Boys reported significantly more exposure to violence than girls, but girls reported more PTSD symptoms than boys.

In another study (Jenkins and Bell, 1994), 203 African American Students (ages = 13 to 18 years) from a public high school on Chicago’s south side in a high violent crime district were surveyed using SECV to assess exposure to crime and violence, and the checklist of Child Distress Symptoms to assess the effects of the exposure. Almost two-thirds of youth indicated that they had seen a shooting and almost one-half had been shot at themselves. Overall, girls
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reported more distress symptoms than boys, and boys reported more high-risk behaviours (e.g.; weapon carrying, substance use, and fighting) than girls. As Jenkins and Bell pointed out, however, the correlational nature of the data precludes one from concluding whether the boys’ high-risk behaviours represent either reactions to violence exposure or contributors that lead to exposure.

In a large sample of youth (N=2,248) using a measure devised by Schwab-stone et al (1995). The survey, referred to as “Social and Health Assessment? The questions relevance to exposure to violence (i.e. “During the past year, how many times have you seen someone get shot or stabbed?”), and the four questions about feelings of personal safety were used. The survey, which was used in the River and Delta State of Niger Delta region of Nigeria. To the question about exposure to violence more than 50% of the youth reported exposure to a shooting or stabbing in the past year. To the questions about feelings of personal safety, 90% feeling unsafe in one or more common settings (e.g. home, neighbourhood). Exposure to violence was found to be associated with increased willingness to use physical aggression, diminished perception of risk, lowered personal expectations for the future, dysphoric mood, antisocial activity and alcohol use.

Also in Bayelsa and Ondo State youth whose ages range from 18 to 38 years from a sample of 79 youth. Participants completed the adapted a Adolescent Self-Report Trauma Questionnaire”, which included questions drawn from a number of other inventories as well as several additional items written by the researcher. The PTSD Symptom Scale (Foa, Riggs, Dancu, and Rothbaum, 1993) was used to assess the adolescents’ reactions. The lowest number was 65, with a mean of 38 violent events across the participants. Approximately 55% of the sample had witnessed a shooting. The mean number of PTSD symptoms for the total sample was ten, and 77% of the participants met full DSM-III-R diagnostic criteria for PTSD.

In a study conducted in Abia and Akwa Ibom among the youth of the Niger Delta region of these two states. The sample of youth (N = 120 with 60 from each state). The participants were administered the SECV and various sections (PTSD, major depression, dysthymia, conduct disorder, and panic disorder) of a structured clinical
interview. All participants had been exposed to community violence with 56% reporting having been a victim, and 45% reporting being a witness to at least one killing. In terms of the effects of exposure, the most common DSM-III-R diagnosis assigned to youth was dysthymia (31.6%), followed by PTSD (21.6%), major depression (6.6%), and conduct disorder (1.6%). Overall, of the 60 participants, 40% were diagnosed with more or more psychiatric disorders, 42% reported psychiatric symptoms but did not meet criteria for a specific psychiatric disorder, and 18% reported no symptoms.

Overall, the research summarized in this section document that children and adolescents/youths are significantly exposed to community crime and violence and the majority of these youth experience symptoms associated with posttraumatic stress as a result of this exposure. However, most of the research on children was carried out in the United States on the Children who reside in generally medium to a large urban region. This particular area need further research to ascertain if such similar reactions would be displayed among Children from other countries as well as other regions.

3. Interventions for Youths’ Post-Traumatic Stress Reactions following Exposure to Crime and Violence

Due to the high rate of youth exposure to crime and violence and its psychological sequelae, it is important that interventions be developed that can help alleviate the distress and suffering that is likely to ensue. As earlier adumbrated that children's reactions following exposure to crime and violence have not been followed over extended periods, research in other areas have shown that a considerable proportion of children continue to display significant posttraumatic stress reactions for as long as 18 months following exposure to traumatic events (e.g. Hurricanes; La Greca, Silverman, Vernberg and Prinstein, 1996).

There is sparse research for effective interventions that can be used in the aftermath of children's exposure to crime and violence. The literature mainly consists of a small number of studies that have investigated the efficacy of
treating PTSD in young people who have been exposed to a variety of traumatic events, not necessary community violence (e.g. Albano, Miller, Zarate, Cote and Barlow, 1997; Farrell, Hains and Davies, 1998; March, Amaya-Jackson, Murray and Schulte, 1998). With these in mind, there are however intervention that can be draws on research funding obtained from clinical trials on anxiety disorders in youth with anxiety disorders (e.g. Kendall, 1994; Kendall et al; 1997, Silverman et al; 1999; 1999b).

The basic intervention would be group cognitive behavioural treatment (GCBT). Using exposure based exercise as well as cognitive and behavioural procedures in a group, GCBT, as used in the clinic (Silverman et al; 1999a), would be adapted. Others intervention such as Duncan, 1996; Goenjian et al; 1997; Osofsky, 1998; Pynoos and Nader, 1988; Warner and Weist, 1996 makes particular sense to work with youth who have been exposed to crime and violence in the school setting and who experience distress symptoms. The group format intervention would be useful for working with youth who have been a witness or victim of crime and violence (Alessi and Hearn, 1984; Frederick, 1985) because group process can facilitate the discussions of children’s reactions can be normalized and universalized (Frederick, 1985). A group format also is consistent with the fact that symptoms associated with posttraumatic violence in public places (e.g. shootings in schools, stores, or restaurants; snipers; hostage taking). Thus, even when traumatic experiences are not the same, the group format thus provides a natural setting for individual to address their shared experience. Other group processes available in GCBT include peer modeling, peer reinforcement, feedback, and social comparison. The main foci of GCBT would be the reduction of posttraumatic stress reactions through exposure-based exercises, the enhancement of the use of adaptive coping responses, and the enhancement of social support availability and utilization.

4. Exposure-Based Workout

Researchers generally agreed that systematic exposure to the traumatic cues is essential in reducing symptoms
associated with posttraumatic stress symptoms in youth and adults (e.g. Eth and Pynoos, 1985; Fairbanks et al; 1993; Foa and Kozak, 1986; Keane and Kaloupek, 1982; Lyons, 1987). Bandura (1997) posited that direct experiences with the traumatic event Children’s mastery expectation are raised. Bandura asserted that once strong expectations are have been developed through repeated success, children can tolerate the negative impact of the occasional failure. Rachman (1978) gave behavioural explanations that involve the processes of habituation and extinction. Habituation refers to the decline of the unlearned responses after repeated presentations of the traumatic stimulus. Extinction refers to the repeated presentation of the traumatic stimulus (conditioned stimulus) in the absence of the aversive stimulus (unconditioned stimulus) with a decrement in the strength of the conditioned response. Rachman (1978) stress further the varying roles of habituation and extinction in decreasing anxious responses. Rachman suggested that former is most important for reducing the physiological component, the latter is most important for reducing the behavioural component, i.e. avoidance, and both are important for reducing the subject component.

Foa and Kozak (1986) recommend the use of some type of exposure-based procedure to (1) activate the fear memory and (2) provide new information that is incompatible with the current fear structure to allow for a new memory to be formed. This procedure was also supported by Litz and Keane, 1989. Foa and Kozak (1986) proposed that the use of systematic exposure based procedures in a safe environment serves to modify the feared memory such that threat cues are reevaluated and habituated.

Further, most youths, who have experienced events as upsetting as crime and violence—either as a witness or a victim—tend to have oppressive and overpowering emotion, they usually attempt to suppress or avoid these emotions.

Moreover, working with children, adolescents and youths who have been exposed to community violence, the use of drawing/writing and reading exercises is also likely to serve as a useful exposure experience. The participants, for example, might be asked to draw pictures or write stories about their experiences. These might then be shared with the other members of the group and similarities and
differences in experiences might be elaborated upon through group discussion.

5. Coping Skills Improvement

Coping is an entical factor in competency/vulnerability models of child adolescent and youth psychopathology (Rutter, 1979; 1990). In these models, coping serves as a protective factor that helps to buffer individuals responses to stressful life events. Thus, exposure to crime and violence challenges the victim witness’ capacity to generate adaptive coping responses, and promotes the use of maladaptive coping responses. These might include self-blame, anger, withdrawal, blaming others, etc, (Schepple and Bart, 1983). These maladaptive coping responses, moreover, if sufficiently intense, may facilitate the intrusive memories and avoidance reactions associated with posttraumatic stress (Resick and Schnicke, 1992), and interfere with successful emotional processing during the exposure-based exercise. In GCBT, coping skills improvement would provide the Niger delta youth with corrective information as it relates to a particular maladaptive coping response. Hence, coping skills improvement would serve not only to improve the coping responses of the youth but also potentially moderate the reduction of posttraumatic stress symptoms.

Coping training can take different forms. As expressed above, the process of exposure in and of itself may serve to enhance children’s coping as children’s mastery expectations are raised via successful exposure experience (Bandura, 1997). Relatively, the drawing/writing and reading exercises also can be a medium by which coping skills can be enhanced as children might be asked to draw pictures or write stories not only about their experiences (i.e. an exposure) but they also might be asked to draw pictures or write stories about various ways (both adaptive and maladaptive) to handle the situations, followed by discussion about the advantages and disadvantages of these various ways.

6. Social Support Availability and Utilization Enhancement
It has been established that peers serve as a major source of social support for youth (Levitt, 1991), and traumatic events deplete social support (Kaniasty and Norris, 1993) studies have found that the broader and deeper the network of social support, the greater the chance of ameliorating the negative effects of stressful live events (Cohen and Wolls, 1985; Kaniasty and Norris, 1992). In GCBT, a main focus of the social support enhancement component would be made to enhance external sources of social support. Furthermore, an active effort would be made to enhance external sources of social support. In this effort, it would be important to enhance both perceived and received support (Kaniasty and Norris, 1992). Thus, for example, in helping youth to identify support agents it could be pointed out that they have a more support than they think they have” (perceived support), and the youth can be taught how to engage outside sources (e. g; parents, siblings, friends) as support agents (received support). To help accomplish this, behavioural strategies such as contingency contracting, modeling, role-playing, and feedback can be used.

7. Summary and Conclusion

Despite the fact that reactions to exposure to crime and violence are complex and multifaceted, distress symptoms associated with posttraumatic stress constitute a central feature of the distress reaction that youth exhibit when exposed to crime and violence. With the adverse psychological consequence, which goes with exposure to crime and violence, it also challenges the victim/witness's capacity to generate adaptive coping responses and to access and utilize social support. The populations at risk are low socio-economic, multi-ethnic urban youth who are not likely to seek help for distress symptoms associated with exposure to crime and violence through traditional modes of intervention (e.g. mental health clinics, private practice, etc.). In addition, crime and violence have become so apparent in several communities and not only in the Niger Delta region of Nigeria. It has become visible that exposure to such traumatic events among many youth has become the norm. Consequently, the effects of exposure to community violence are frequently not recognized by youth nor government as
“problem in need of psychological intervention and mental health services. Thus, the need for development and implementation of community-based intervention is desirable. The more fact that the nature and content of intervention programs has not evolved due to non-availability of empirical findings in this area. Nonetheless, the basic elements outlined in this paper for such programs include the following: First, it would be a school based group cognitive behavioural intervention; second, it would use exposure based exercises; third, it will enhance individuals’ use of adaptive coping skills, and fourth, it will enhance the availability and utilization of individuals' social support (both perceived and received).

This article has shown that there is great need for further research in this understudied area. It is hope that this article will serve to stimulate additional research that will help to reduce the Post-traumatic stress experienced by the large numbers of youth who have been witnesses to or victims of community crime and violence.

References


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