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## Social Support and Resilience Predicting Post-Traumatic Stress Disorder among Returned Soldiers from Insurgency Areas in Nigeria

Rowland Dom Anyaegbu

Anthonia Chigozie Nwatu

Obiageli Felicia Omeje

Department of Psychology

Faculty of Social Sciences and Humanities

Enugu State University of Science and Technology (ESUT) Agbani, Enugu State Nigeria

### Abstract

*The psychological field of Post-Traumatic Stress Disorder (PTSD) has been extensively explored; nevertheless none of the studies reviewed reported demographic variables such as age, and returned soldiers from insurgency areas in Nigeria. Thus, the study investigated whether social support and resilience independently and jointly predicted PTSD among returned soldiers from the insurgency areas in Nigeria. The sample was 118 male soldiers with age range of 21 – 52 years, mean age of (35.66 years) and standard deviation of (8.4) returned soldiers from insurgency areas in Nigeria sampled from 103 Battalion and 82 Division Enugu, Enugu State Nigeria. They responded to three questionnaires: PTSD, Social Support Questionnaire and Brief Resilience Scale. Hierarchical multiple regression was used for data analysis which indicated a negative correlation between social support and the PTSD  $B = -.235$ ,  $t(118) = -11.412$   $p < .000$ . Resilience did not yield a significant prediction of PTSD  $B = -.070$ ,  $t(118) = .731$ ,  $p < .479$ . Analysis further revealed that social support and resilience jointly predicted PTSD which accounted for 49.5% of variance in PTSD. Among the five demographic variables examined, only age predicted PTSD  $B = 6.440$ ,  $t(118) = 2.350$ ,  $p < .05$ , which accounted for 9.5% of variance in PTSD. Government dimension of social support also showed a negative prediction of PTSD. It was concluded that social support offered by the government to the returned soldiers helped in alleviating their PTSD experience.*

**Keywords:** *Post-Traumatic Stress Disorder, Resilience, Social Support, Returned Soldiers and Insurgency Areas in Nigeria*

### Introduction

Over the years, concerns have been raised about the involvement of the military all over the globe in war and peace keeping operations after war have been fought. This war has led to the destruction of lives and properties as innocent civilians become victims, perpetrators become victims too, and the liberators (Military and other agencies) become more and more vulnerable. What has been happening in Nigeria are series of armed conflict across the insurgence areas in the country and in the process, a lot of soldiers have lost their lives in the course of protecting the nations territory from external aggression, and assisting the Para-militaries to maintain internal security.

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Soldiers in the operational theatre and those that have recently returned from the North East of Nigeria seem to have become social menace to the military barrack communities during the process of reintegration. In addition, increases in marital conflicts, lack of motivation with attendant negative impact on productivity and efficiency to assigned duties has been reported (Anongo, Demi & Dagona, 2009). This has further corroborated some previous findings revealing the manifestation of Post-Traumatic Stress Disorder (PTSD) among military veterans including increased marital and social problems, suicidal thoughts, respiratory and gastrointestinal problems and higher cortisol (Papazoglou & Andersen, 2014).

However, beyond the impact of trauma, research has also shown that the number of times people experience a traumatic situation is related to posttraumatic stress disorder. In this regard, soldiers who have had multiple combat experiences are found to report more distressing symptoms than the less frequently encountered trauma population (Gabriella & Punamaki, 2006; Kolassa, Kolassa & Ertl, 2010). This means that the more frequent military personnel are deployed for combat operations, the greater the possibility that they will develop posttraumatic stress disorder. The Boko-Haram operation mostly witnessed in the North East Nigeria was equally characterized by frequent deployment but not very much is known on the influence of this factor in PTSD. This raises a serious concern on our military organization and its personnel considering the level of combat exposure they have had in recent times. The recent engagement of the Nigerian armed forces with the Boko Haram insurgents have produced residual combat stress that could result in PTSD. Many of these personnel were exposed to potentially traumatic combat experiences such as watching the death of their colleagues, exposure to high improvised explosives, harsh weather, hostile incoming fire, mass burial of colleagues among others. This coupled with frequent stay and long duration of deployment could add significantly to the psychological distress symptoms suffered by Nigerian armed forces.

The term posttraumatic stress disorder (PTSD), is defined in this context, using the latest version of the diagnostic and statistical manual of mental disorders (DSM-5). Similarly the latest version of diagnostic and statistical manual of mental disorders (APA, 2013), describes PTSD as a “trauma stress –related” disorder resulting from exposure or witnessing of a potentially traumatic event such as actual or threatened death, exposure to accidents, natural disasters, combat events, etc., with symptom clusters of re-experiencing, avoidance, hyperarousal, negative alteration in cognition and mood. This definition clearly suggests that having experience of war trauma could increase PTSD vulnerability. This raises a serious

concern on our military organization and its personnel considering the level of combat exposure they have had in recent times. To this end Dagona (2015), asserted that the experience of Nigerian military with Boko-Haram is a serious menace that must be examined regularly to identify emerging perspectives that could, in addition to the combat event, contribute the development of this condition so that appropriate and timely psychological intervention such as social support and resilience can be established.

Dean and Lin (1977) considered social support as functions of primary groups that meet instrumental and expressive needs. Lin (1979) later reconstructed social support at multiple levels of social networks as support accessible to an individual through social ties to other individuals, groups, and the larger community. Kaplan, Cassel, and Gore, (1977) point out that social support is the content of social ties (i.e., the meanings that persons in the network give their relationships), and is contingent on structural and interactional characteristics of social networks (i.e., anchorage, reachability, density, range, directedness, intensity, and frequency).

House (1988) defines social support as one type of relational content, “the emotionally or instrumentally sustaining quality of social relationships. Berkman (1984) sees social support as the emotional, instrumental, and financial aid that is obtained from one’s social network. Moreover, Turner (1999) defines social support as social bonds, social integration, and primary group relations. Social support can be categorized in different ways. In terms of its content, for example, social support can be divided into emotional support (liking, love, empathy); instrumental support (goods and services); informational support (information about the environment); or appraisal support (information relevant to self-evaluation) (House, 1981). In terms of its degree of subjectivity, social support is dichotomized into perceived support and objective or actual support (Caplan, 1979). In terms of the role of relationship between the recipient and the donor (Dean & Lin, 1977; LaRocco, House & French, 1980; Thoits, 1982), social support could be kin-based (e.g., parents, spouses, children, siblings, other relatives) or nonkin-based (e.g., friends, neighbours, coworkers). Social support is a protective factor against developing PTSD, whereas the absence of social support can lead to increased risk for PTSD and higher PTSD severity (Charuvastra & Cloitre, 2008). Having explored the background of social in PTSD, the researchers also want to look at another important psychological factor (resilience).

Psychological resilience is the ability to cope with a crisis or to return to pre-crisis status quickly (de Terte & Stephens, 2014). Resilience exists when the person uses mental processes and behaviours in promoting personal assets and protecting self from the potential

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negative effects of stressors (Robertson, et al., 2015). In simpler terms, psychological resilience exists in people who develop psychological and behavioural capabilities that allow them to remain calm during crises/chaos and to move on from the incident without long-term negative consequences. Resilience is generally thought of as a positive adaptation after a stressful or adverse situation (Hopf, 2010). When a person is bombarded by daily stress, it disrupts their internal and external sense of balance, presenting challenges as well as opportunities. However, the routine stressors of daily life can have positive impacts which promote resilience. It is still unknown what the correct level of stress is for each individual. Some people can handle greater amounts of stress than others. Resilience is the integrated adaptation of physical, mental and spiritual aspects in a set of good or bad circumstances, a coherent sense of self that is able to maintain normative developmental tasks that occur at various stages of life (Richardson, 2002). It is important to note that resilience is not only about overcoming a deeply stressful situation, but also coming out of the said situation with "competent functioning". Resiliency allows a person to rebound from adversity as a strengthened and more resourceful person (Richardson, 2002). Soldiers involved in the fight against insurgency in the North East undergo high levels of stress which may eventually lead to PTSD which may require some other variables like resilience and social support in order to overcome the after effects of their experiences like PTSD.

Thus, it is suggested that shattered assumptions theory of PTSD (Janoff-Bulman, 1992) is the best theory to explain the relationship between resilience and PTSD; social support and PTSD and also among PTSD, social support and resilience. According to this theory, the world is benevolent and kind, the world is meaningful and the self is worthy. But invariably, there are some terrible events, which we would refer to as trauma, that shatter these worldviews. Such events could be wars, terrorism, the unwarranted murder of a loved one, being critically injured or losing a job and not having an income. Such events are extremely traumatic, and therefore break our assumptions that the world is a good place.

When the world view about benevolence, meaningfulness and positive self are shattered by traumatic events, the cognition about the world becomes distorted and posttraumatic stress disorder manifests. Negative effects of trauma are related to our world views, and if we repair these view, we will recover from the trauma. This is the point at which resilience and social support come into play. Social support can come in form of financial, emotional or material resources. On the other hand, being resilient i.e. having some personal attributes, family and community support/factors may help in restructuring one's cognition in order to restore the

shattered view of the world. In addition, existing studies have shown that social support and or resilience predicted PTSD.

In a study by Gros, Flanagan, Korte, Mills & Kathleen (2016), at medical University of South Carolina on relationship between social support, PTSD symptoms, and substance use in veterans. Consistent with the hypotheses, social support has a significant relation to PTSD symptoms, as well as alcohol use above and beyond the comorbid condition. Study by Dworkin, Ojalehto, Bedard-Gilliga, Cadigan and Kayen (2017), at university of Washington stated that social support predicts reductions in PTSD symptoms when substances are not used to cope. In this longitudinal study of sexual assault survivors, result of the study suggests that social support is longitudinally associated with decrease in PTSD. Only support from friends (but not family members or a “special person”) was associated with later PTSD, and this relationship was moderated by substance use coping.

In a related study by Prince, Lancaster, Gross, Legrand and Van (2018) on an examination of social support and PTSD treatment response during prolonged exposure – findings of the study suggested that social support and PTSD symptoms are related. Throughout treatment social support moderated the change in PTSD symptoms, whereas PTSD symptoms did not moderate changes in social support. Panagioti, Gooding, Taylor and Tarrrier (2014), opined that perceived social support buffers the impact of PTSD symptoms in suicidal behaviour: implications into suicidal resilience research. Early conceptualization posited that the presence of social support buffers against the development of PTSD (Cohen & Wills, 1985) and facilitates the process of recovery (Burgess & Holmstrom, 1979). In the study earlier cited, King, Taft, King, Hammond and Stone (2006) measured PTSD severity and social support in a sample of Gulf War Veterans numbering 2249 (18 – 24 months post-return) and repeated same measurement after 5 years and showed that initial PTSD predicted subsequent decrease in social support. Boscarino (1995), after controlling for trauma exposure, showed that Vietnam veterans with high levels of social support were 180% 38 less likely to develop PTSD as compared to those with low social support. This is consistent with previous suggestions that the risk of developing PTSD upon exposure to trauma was conversely related with social support. Furthermore, the moderator role of social support in the relationship between children and adolescents’ exposure to violence, victimization or maltreatment and PTSD symptoms was demonstrated by (Bradley, Schwartz & Kaslow, 2005).

### Resilience and PTSD

Lee, Ahu, Jeong and Chae (2014) in their study opined that resilience buffers the impact of traumatic events on the development of PTSD symptoms in fire fighters. In a study done by Streb, Hasler and Michael (2014), at University of Saarlandes, the study was done with paramedics. They find out that both resilience and sense of coherence (soc), were negatively correlated with symptoms of PTSD. In another study by Teche, Barros and Rosa (2017) on association between resilience and posttraumatic stress disorder among Brazilian victims of urban violence. The study find out that lower level of resilience, especially the ability to solve situations and having personal values that give meaning to life, immature defense mechanisms, and emotional and physical abuse in childhood are associated with PTSD in adult Brazilian victims of urban violence.

Study by Bibi, Kalin and Khalid (2018), at Rawalpindi and Islambad, Parkistan, on PTSD and resilience among adult burn patients in Parkistan: a cross-sectional study. The study involved 70 burn patients from the burn unit of Rowal pinch and Islamabad, Parkistan. They found a negative correlation between PTSD and resilience among burn patience.

Resilience has been suggested by studies carried out to play a role in PTSD symptoms. For example, Pietrzak, Johnson, Goldsten, Malley, Rivers and Morgan (2010) in their study of operational veterans concluded that resilience fully mediated the association between PTSD and depressive symptoms and psychological functioning. Similarly, Salami (2010) in his research on the moderating effect of resilience, self-esteem and social support on adolescents' reaction to violence using participants selected in Kwara State (Nigeria) also reported that resilience was negatively related to post-traumatic stress disorder. Consistent with previous research findings, Wooten (2012) in a study of the mediating effect of resilience on deployment cycle stressors and posttraumatic stress symptoms among national army guards indicated that the association between post-deployment stressors and posttraumatic stress symptoms was fully mediated by resilience. Another study conducted by Greeff and Lawrence (2012) to explore the roles of resilience factors in 38 African families who had lost their homes in a shack fire further confirmed the mediating effect of resilience.

Specifically, the study addressed the following questions:

1. Will social support (government, family and friends) significantly predict posttraumatic stress disorder among returned soldiers from the insurgency areas?
2. Will resilience significantly predict posttraumatic stress disorder among returned soldiers from the insurgency areas?

3. Will social support and resilience jointly predict posttraumatic stress disorder among returned soldiers from the insurgency areas?

## **Hypotheses**

The following hypotheses were tested:

1. Social support (government, family and friends) will significantly predict PTSD among returned soldiers from the North East.
2. Resilience will significantly predict PTSD among returned soldiers from the North East.
3. Social support and resilience will jointly predict PTSD among returned soldiers from the North East.

## **Method**

### **Participants:**

The participants for this study were 118 participants drawn from returned soldiers rotated from the insurgency areas serving/residing at 103 battalion barracks Awkunanaw, and 82 Divisions, all in Enugu State. They were selected through multi stage sampling technique: first criterion sampling technique was applied to reach only those that meet with the criteria mentioned below. The criteria include: that the participants have served in the insurgency area (North East Nigeria) from 2018 to 2020 and that the soldiers returned at least six months earlier to this research, (to allow for incubation period for PTSD symptoms). Second available sampling technique was used to reach those who were around at the time of visit. Some demographic variables such as age (early age 21-39 and later age 40-52, mean age = 35.66, SD = 8.40), ethnic group (Hausa, Igbo, and Yoruba), marital status (single, and married), academic qualifications (low, and high), religion (Islam, and Christianity), and sex (male) were examined in relation to the criterion variable (PTSD).

### **Instrument**

The researchers in addition to the original psychometric properties of the instruments by the developers revalidated the tests and thus obtained the following: Post-Traumatic Stress Disorder Keane Scale (PKS). The 46-item inventory developed by Keane, Malloy and Fairbank (1984), was designed to measure post-traumatic stress disorder, panic anxiety disorder, social anxiety, and environmental anxiety. Thus, in a pilot study conducted using 35 soldiers sampled from among the returnees from the insurgency areas serving at Port



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Harcourt Barrack (Bori Camp) Rivers State, obtained a Cronbach alpha of .64. High scores depict manifestation of PTSD.

Social Support Questionnaire (SSQ) by Sarason, Levine, Basham, Vamp and Sarason (1983) was developed to assess the extent to which one receives support from others. There are three subscales within the (SSQ). They include: Government (8items), Family (8 items) and Friends (8 items). The researchers conducted a pilot study to further revalidate the instrument for Nigerian use with 35soldiers sampled from among the returnees from the insurgency areas serving at Port Harcourt Barrack (Bori Camp), and obtained a Cronbach alpha of .77.

Brief Resilience Scale (BRS-6) is 6-item instrument developed by Smith, Dalen, Wiggins, Tooley, Christopher and Bernard (2008). The scale is designed to assess the ability to bounce back or recover from stress. A pilot study was also conducted by the researchers to validate the scale for Nigerian use with 35 soldiers sampled from Port Harcourt Barrack (Bori Camp) and obtained a Cronbach's alpha of .67.

### **Procedure**

The researchers obtained necessary approval letters from Commanding Officer (CO), 103 battalion barrack, Awkunanaw, Enugu and the Garrison Commander 82 division, Enugu. The researchers employed the services of the Chief Clerks in the Barracks in reaching the soldiers recently rotated from 2018 to 2020. The Chief Clerks were also trained by the researchers to assist in the distribution and collection of the test instruments. The authors sampled all the soldiers who met the criteria and also are available during the distribution and collection of the research questionnaires.

### **Design and Statistics**

The study adopted a cross-sectional survey study because participants were selected from various barracks and also data was collected to make inferences about the population of interest at one point in time. Hierarchical multiple regression analysis involving Statistical Package for the Social Sciences (SPSS), version 23.00 was employed as statistics to determine if social support and resilience will independently and/or jointly predict post-traumatic stress disorder. Other variables such as, age, ethnic group, academic qualification, marital status, and religion were controlled in this study.

## Results

**Table 1:** Means, standard deviations and inter-correlations of social support (government, family and friends), resilience, age, marital status, ethnic group, academic qualifications, and religion on PTSD

Variables	Mean	SD	1	2	3	4	5	6	7	8	9	10	11
PTSD (1)	28.76	10.01	1										
Age (2)	35.66	8.40	.282*	1									
MS (3)	.61	.49	-.068	.180***	1								
EG. (4)	.97	.74	.059	.471*	.558*	1							
AQ (5)	.47	.50	-.115	-	-	-.013	1						
R (6)	.66	.48	.211**	.190***	.319*	-.049	.286*	1					
SS (7)	63.82	31.70	-.760*	.538*	-	-.058	-.039	-	1				
RE (8)	19.17	6.80	.081	-.277*	.389*	.009	.039	.204**	-	1			
G (9)	22.82	12.47	-.698*	.009	.031	-.056	.040	.140	.178***	-	1		
FA (10)	22.21	12.87	-.602*	-.456*	.094	.078	.024	-.454*	.818*	.156***	.453*	1	
FR (11)	18.98	11.68	-.667*	-.121	.121	-.013	-.073	-.008	.841*	-.119	.644*	.7171*	1
				-.120	-.087			-.052	.911*	-.169*			
					.045								

NOTE: Age (early age is coded as 0 vs. late age 1); Marital status MS (Single = 0 vs. Married = 1); Ethnic Group EG (Hausa = 0, Igbo = 1, Yoruba = 2); Academic Qualifications AQ (Low = 0 vs. High = 1) and R = Religion (Christianity = 0 vs. Islam = 1); Social Support (SS); G = Government, FA = Family; FR = Friends; Resilience = RE) \*\*\* $p < .05$ , \*\* $p < .01$ , \* $p < .000$

Table 1 demonstrates the correlation matrix. The table revealed that age correlated positively with PTSD, indicating that participants who are in their old age were more likely to experience PTSD  $r(118) = .282, p < .000$ .

Social support and all the three dimensions (Government, Family and Friends) were negatively related to PTSD ( $r = .760$ ;  $r = -.698$ ;  $r = .602$ ;  $r = .667, p < .001$ ). This means that the higher the social support received through the government, family and friends, the lesser the PTSD experienced by the respondents.

However, resilience, marital status, ethnic groups, and academic qualifications were not related to PTSD.

**Table 2:** A table providing a summary of the hierarchical regression analysis between the two predictor variables, other demographic variables and PTSD.

**Coefficients<sup>a</sup>**

Model		Unstandardized Coefficients		Standardized Coefficients	T	Sig.
		B	Std. Error	Beta		
1	(Constant)	27.479	2.695		10.198	.000
	Age	6.440	2.741	.323	2.350	.021
	Marital Status	-2.436	2.668	-.119	-.913	.363
	Ethnic Group	-.363	1.657	-.027	-.219	.827
	Academic Qualifications	-.423	1.975	-.021	-.214	.831
	Religion	-.089	2.796	-.004	-.032	.975
	2	(Constant)	44.731	2.835		15.779
Age		1.610	1.947	.081	.827	.410
Marital Status		-1.148	1.874	-.056	-.613	.541
Ethnic Group		.126	1.127	.009	.112	.911
Aca. Qua.		.357	1.349	.018	.264	.792
Religion		-.090	1.969	-.004	-.046	.964
Social Support		-.235	.021	-.744	-11.412	.000
Resilience		-.070	.096	-.048	-.731	.467
3	(Constant)	46.287	2.966		15.606	.000
	Age	.864	1.989	.043	.434	.665
	Marital Status	-.925	1.865	-.045	-.496	.621
	Ethnic Group	.155	1.111	.012	.139	.890
	Aca. Qua.	1.178	1.377	.059	.856	.394
	Religion	-1.481	2.045	-.070	-.724	.470
	Social Support	.375	.336	1.188	1.116	.267
	Resilience	-.051	.095	-.035	-.540	.590
	Government	-.769	.353	-.958	-2.176	.032
	Family	-.578	.334	-.743	-1.733	.086
	Friends	-.512	.347	-.597	-1.474	.144

a. Dependent Variable: PTSD

**Note:** For step 1:  $R = .308$   $R^2 = 9.5\%$   $\Delta R^2 = .095$ ,  $p < .05$ ; for step 2:  $R = .768$   $R^2 = 59\%$   $\Delta R^2 = .590$ ,  $p < .000$ ; step 3:  $R = .783$   $R^2 = 61\%$   $\Delta R^2 = .613$ ,  $p < .000$ .

To investigate the demographic variables in this study, (age, marital status, academic qualifications, religion and ethnic group) were entered at step one of the regression, to

observe their effects on PTSD and further knowledge into these relationships. The hierarchical multiple regression revealed that age contributed significantly to the regression model,  $F(5,112) = 2.350, p < .05$ . The relationship between variables were strong ( $R = .308$ ) and accounted for approximately 9.5% ( $\Delta R^2 = .095$ ) of the variance in PTSD scores. Thus, age had a positive statistically significant impact,  $\beta = 6.440, t(118) = 2.350, p < .05$ . Next, social support and resilience as the predictor variables were entered at step two. Adding step 2 to the regression model accounted for an additional 49.5% ( $\Delta R^2 = .590$ ) of variation in PTSD and this change in  $R^2$  was significant,  $F(7, 110) = 22.587, p < .000$ ) and the relationship between these variables were strong ( $R = .768$ ). However, of the two predictor variables only social support was a significant negative predictor of PTSD  $\beta = -.235, t(118) = -11.412, p = .000$ . This means that the higher the social support the lesser the PTSD experienced by the participants, hence the first hypothesis which stated that “social support will significantly predict PTSD” was accepted. While resilience,  $\beta = -.070, t(118) = .731, p = .479$ ; was not a predictor of PTSD, thus the second hypothesis which stated that “resilience will significantly predict PTSD” was rejected. In the third step, Government, Family and Friends dimensions of the social support were added. Finally, the three dimensions of social support (Government, Family and Friends) were entered in step three to know their separate predictive effect on PTSD. This step three accounted for an additional 2% ( $\Delta R^2 = .613$ ) of variation in PTSD and this change in  $R^2$  was significant,  $F(10, 107) = 16.984, p < .000$ ) and the relationship between these variables were strong ( $R = .783$ ). Thus, of the three dimensions of social support, only Government component of social support was significant negative predictor of PTSD ( $\beta = -.769, t = -1.733, p < .05$ ). This means that the higher the social support received from the government the lower the experience of PTSD by the respondents. Family and friends dimensions of social support were not significant predictors of PTSD ( $\beta = -.578, t = -1.733, p = .086$ ;  $\beta = -.512, t = -1.474, p = .144$ ).

**Table 3:** ANOVA summary table the social support and resilience on PTSD

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	1113.650	5	222.730	2.350	.045 <sup>b</sup>
	Residual	10613.706	112	94.765		
	Total	11727.356	117			
2	Regression	6915.838	7	987.977	22.587	.000 <sup>c</sup>
	Residual	4811.518	110	43.741		
	Total	11727.356	117			
3	Regression	7194.646	10	719.465	16.984	.000 <sup>d</sup>
	Residual	4532.710	107	42.362		
	Total	11727.356	117			

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The most important predictor of PTSD was social support though social support and resilience jointly predicted PTSD. Thus, the third hypothesis which stated that “social support and resilience will jointly predict PTSD” was accepted. In addition, results provide more insight regarding the demographic variables as they illustrate that even before the two predictor variables are entered into the model, only age accounted for 9.5% significant amount of the variance in PTSD.

Moreover, it is also demonstrated from the change in the  $R^2$  value of the model that the predictor variables (social support) accounted for approximately a further 49.5% of variation in PTSD while government dimension of social support accounted for 2% variation in PTSD. Hence, this observation gives rise to an indirect effect between age and PTSD, thus, the higher the age of the participants the higher the experience of PTSD but with adequate social support, age ceased to be a predictor of PTSD.

## Discussion

The present research investigated the prediction of social support and resilience on PTSD. The findings illustrated that only social support predicted PTSD negatively especially government dimension, of the five demographic variables (control variables) only age was a significant positive predictor of PTSD. Thus, social support and resilience jointly predicted PTSD.

Social support was found to negatively correlate with the PTSD, revealing that the more social support individuals get from their family, friends and government the lower PTSD symptoms. Hence, the first hypothesis which stated that “social support (government, family and friends) will predict PTSD” was accepted. However, only the government dimension of social support negatively predicted PTSD, family and friends did not predict PTSD. This finding is consistent with some past findings that increased social support alleviates PTSD symptoms as suggested by (Daniel, et al., 2016). Dworkin et al., (2017) who found that social support predicts reductions in PTSD symptoms when substances are not used to cope. Only support from friends was associated with later PTSD. Other researchers such as (Prince, et al., 2018; Panagioti et al., 2014; Oberts, et al., 2019; Brewin, et al., 2000) found that perceived social support buffers the impact of PTSD symptoms in suicidal behaviour. Some of the researchers above found that negative social support may be a stronger predictor of PTSD than the absence of social support. Boscarino (1995) found that those with high levels of social support were less likely to develop PTSD as compared to those with low social

support. Consequently, this research contradicts Adams et al., (2019), which illustrated that self-efficacy may be more important to the severity and chronicity of PTSD symptoms than social support.

Therefore, it is interesting to note that the findings of the present study were still consistent with the literature above, yet this study is very necessary because although one of the studies sampled post-return veterans in Vietnam, it seems there is none of such studies in Nigeria.

The second hypothesis which stated that “resilience will significantly predict PTSD” was rejected, indicating that resilience does not either increase or decrease the manifestations of PTSD. This finding is not in line with almost all the studies reviewed, for instance, (Streb et al., 2014; Bibi et al., 2018; & Salami, 2010) found negative correlation between resilience and PTSD. Teche et al., (2017) found an association between lower level of resilience and PTSD. Numerous studies reported that resilience moderated or mediated the relationship between exposure to violence and PTSD symptoms but not a predictor variable.

However, analyses from this finding highlighted that resilience was the weakest variable, unable to account for a significant amount of the variance within PTSD. Thus, the strength of support for this relationship is limited. In most of the studies, resilience served as a mediator whereas it served as a predictor in this present study which may be a factor in this no correlation outcome.

The third hypothesis which stated that “social support and resilience will jointly predict PTSD” was accepted. This finding suggests that social support and resilience jointly increase or decrease the manifestation of PTSD. Since in their independent prediction of PTSD, social support had a negative significant prediction with PTSD and resilience had non positive significant prediction with PTSD. However, the joint prediction of both social support and resilience suggests that soldiers need adequate social support and high resilience in order to have less PTSD while low social support and low resilience may aggravate the manifestations of PTSD. Furthermore, the presence of social support increased resilience. This shows that a soldier’s ability to bounce back from trauma due to combat experiences can be attributed to the amount and quality of social support received. None of the past studies reviewed in this work had social support and resilience as a joint predictor of PTSD which created a gap to be filled with the outcome of this study.

The current findings revealed that whilst marital status, academic qualifications, ethnic group and religion had no correlation with PTSD, age held a positive relationship with the PTSD. The findings suggested that as one increases in age, the more PTSD is experienced This finding may buttress the perceived lack or inadequate government support to the aged and

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injured soldiers that increases the likelihood of PTSD as they grow older. Thus, if a soldier is sure of prompt and adequate government support growing old will bring some assurances capable of alleviating PTSD. Conversely, none of the studies reviewed in the work reported any findings on age and PTSD which made this finding very interesting. In the analyses the current study demonstrated that age accounted for some variations in PTSD. After the predictor variables (social support and resilience) were added to the model age was no longer significant, only social support held a highly negative significant association to PTSD. In other words, high age leads to PTSD in the absence of social support.

### **Implications of the findings**

The present findings of strong associations between age and PTSD provide support for this relatively new concept. The knowledge of the interaction between age and PTSD could be guide for individuals who are in their later age (40 to 52 years) during the rotating of soldiers to serve in the insurgency areas since they are susceptible to PTSD than those in their early age (21 to 39 years).

Theoretically, the findings supported the theoretical framework of this study (shattered assumptions theory of PTSD) which asserts that the world is meaningful and the self is worthy. Thus, when PTSD is experienced these worldviews are shattered except for measures like social support rendered by the government to these soldiers which reduces the experience of PTSD thereby restoring these worldviews. Empirically, the findings will add to the existing literature especially on the association between age and PTSD, social support (government dimension) and PTSD as well as returned soldiers from insurgency areas in Nigeria. Of practical implication is that there is need to consider the age of the soldiers during rotation to serve in the insurgency areas in Nigeria. For those returned soldiers who experienced PTSD, social support will help in alleviating their experience of PTSD especially when it is provided by the government.

Future research should unveil the various supports by the government to soldiers fighting insurgency in order to raise the hope of soldiers that will be rotated in future.

### **Conclusion**

Social support yielded a negative prediction of PTSD, thus the more social support a soldier gets the less PTSD is experienced especially with government dimension of social support. Resilience had no correlation with PTSD whereas, one of the control variables in this study

(age) yielded a positive prediction of PTSD, hence the more a soldier advances in age the more PTSD is experienced. Social support and resilience jointly predicted PTSD, which infer that adequate social support and high resilience attenuate PTSD.

Precisely, adequate social support especially from the government brings solace in alleviating PTSD among returned soldiers from the North East Nigeria serving in Enugu State. Again, a soldier's ability to bounce back after a traumatic exposure depends on the level of support received from the government and lastly, the hope of the serving soldiers should be raised through prompt and adequate government support to the aged and injured soldiers in order to forestall PTSD.

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