Influence Of Social Support On Posttraumatic Stress Disorder Symptoms Among Disabled And Non-Disabled Biafran War Veterans

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Abstract

Numerous young men fought for Biafra during the Nigeria-Biafra War (1967-1970) but there is little research on posttraumatic stress disorder (PTSD) symptoms among these veterans. Using a sample of 46 veterans, the current study investigated the influence of social support on PTSD symptoms among disabled and non-disabled Biafran veterans. It was hypothesized that disabled veterans would report higher levels of PTSD symptoms and lower levels of social support than non-disabled veterans. It was also hypothesized that veterans high in social support would differ significantly from veterans low in social support in self-report of PTSD symptoms. Participants completed two measures, namely, the Nigerian adaptation of Social Support Questionnaire and Post-traumatic Stress Disorder Checklist - Military Version (PCL-M). Data was analyzed using t-test. Results showed that disabled veterans reported higher levels of PTSD symptoms and lower levels of social support than non-disabled veterans. It was also found that veterans high in social support reported significantly lower levels of PTSD symptoms than veterans low in social support. Suggestions were made on the need for government, philanthropists and organizations/agencies to provide more support services to the Biafran veterans.

Key words: Comorbidity. Operational Stress Injuries. Post-traumatic Stress Disorder. Social Support. Potentially Traumatic Experiences. Veterans

Introduction

Following the military coup in July 1966 in Nigeria, which was initiated by non-Igbo officers, there was movement of military troops and troop units. Military personnel of Eastern Nigerian origin returned to eastern Nigeria while those from the North and South west who were working in the east had to leave. There was also a continuous massive exodus of Igbos of Eastern extraction from other parts of Nigeria to the east, as it was the homeland to the Igbo people. This mass movement had earlier started in May 1966 as a result of the rising tensions and first wave of massacres of easterners which broke out from May 28-31, 1966 (Ikejiani-Clark, 2009). This was the genesis of the Nigeria-Biafra War or Nigerian Civil War or Biafran War. The duration of the War was 3 years (1967-1970).

Numerous young men fought the War. The Veterans encountered Potentially Traumatic Events (PTEs), (also described as Post Traumatic Events, See Sheldon, 2014), during the execution of war. PTEs are experiences that can precipitate trauma especially if the predisposition exists in an individual. In the general population, PTEs typically involve

rape, accidents, assaults, disaster and terrorism. For those in the military, PTEs include combat, imprisonment, hostage-taking, torture, witnessing atrocities, comrades being wounded or killed and mass burial of fellow comrades as well as killing enemy soldiers. It is in this regard of differential severity and duration of war experiences that military personnel may be more likely to have psychological trauma than the general population.

The situation of the Biafran experience is peculiar in its nature. In other parts of the world especially Europe and America, returnee veterans after a war are honoured and given proper attention both psychosocially and medically. The nature of their specific combat experiences is assessed with a view to enhancing their capacities to adjust. In this way, provisions are made for them and assistance is offered to guard against the negative aftermaths of combat experience. It has not been so in the Biafra case and posttraumatic stress disorder (PTSD) remains a common problem among those who fought in a war (Tanielian & Jaycox, 2008; Wortzel & Arciniegas, 2013), with a prevalence of 44% in one study (Hoge, McGurk, Thomas, Cox, Engel & Castro, 2008).

PTSD symptoms can present a constellation of psychological consequences. It is an anxiety-related neurotic condition which usually develops after exposure to a terrifying event or ordeal in which physical harm or injury occurred, was threatened or witnessed. It results from intense fear, helplessness or horror. The DSM-IV-TR gave three clusters of symptoms as re-experiencing, avoidance/ emotional numbing and hyper-arousal symptoms (APA, 2000). The International Classification of Diseases (ICD-10) in Code 43, I recognizes the diagnosis of PTSD under Reaction to Severe Stress and Adjustment Disorders (Tamunomiete, 2006). The symptoms of PTSD may persist for several months or years, cause significant distress and affect the individual's ability to function socially, occupationally and domestically (APA, 2000). There could be occurrences of PTSD symptoms in Biafran Veterans which have been ignored. Evidences for the existence of delayed onset and lifetime occurrence of PTSD in veterans abound in psychological literature and will also be highlighted in a later part of this work.

The examination of the long term risks for veterans of any war also requires an evaluation of the unique socio-economic/ cultural contexts that dynamically shape a (former) soldier's recovery and adaption across the lifespan (Friedman, 2004; Weathers, Litz, & Keane, 1995). Hence, the influence of social support remains relevant in PTSD. Social support is the "existence or availability of people on whom we can rely, people who let us know that they care about, value and love us" (Sarason, Levine, Basham, Vamp & Sarason, 1983, p. 127). By "people" in this sense, agencies, institutions, charity organizations and government are also included. The assistance that other people such as family members, friends and colleagues can provide in coping with stress is referred to as social support (Ifeagwazi, 2007). It is a network of social relationships with people who provide help (psychological, financial or material) during crises. The nature of support could be in emotional, informational or instrumental forms.

The social interactions or relationship provide individuals (or groups) with actual assistance or with a feeling of attachment of persons and groups (institutions/ agencies) that are perceived as loving or caring. These social support networks serve as protective resources that moderate responses to stressful situations (Horowitz & Bordens, 1995), and it appears to act as a psychological buffer that absorbs, cushions and diminishes the stress brought on by severe threat (Horowitz & Wills, 1985). Such support is "one of the basic building blocks of social, psychological and biological integrity" (Asogwa, 2010, p. 3). Generally, stressors might not be perceived as harmful or threatening when there are adequate social resources to help in the coping process (Gilbar & Eden, 2001; Ngoka, 2000).

Lack of social support may contribute significantly to the development of delayed onset and lifetime PTSD symptoms in disabled and non-disabled Biafran veterans. The

Biafran veterans returned to their various homes at the end of the war in 1970. For those who had no observable or obvious physical disability that directly affected normal psychosocial functioning, life went on. But who knows how well? This group is known as non-disabled veterans. However, some were not so fortunate to come out 'unhurt', at least physically, at the end of the war. The injuries sustained by majority of them had affected their quality of life and adjustment. They are the disabled veterans. The central aim of this research is to investigate the influence of social support on PTSD symptoms among disabled and non-disabled Biafran veterans. The paper also discusses the situation of the disabled Biafran veterans, highlights the literature on delayed onset of PTSD and reviews previous studies on social support and PTSD.

The Disabled Veterans of Biafra

During the Nigeria/Biafra War, wounded soldiers were usually hospitalized in various parts of the country where they received treatment. Some of these places included the Government Hospitals at Ekwereazu and Okwu Udo in Orlu, Imo state as well as some other locations in Biafran land. A good number of them sustained serious injuries that affected their mobility. In Okwu Udo, for instance, the federal troops struck about a week before the formal end of the war, thereby forcing those who took care of and fed the wounded soldiers to flee. These victims of the ill-fated war were abandoned in the hospital for about one month without adequate provision of food, drugs or water. It was at this time that through the instrumentality of the Nigerian Red Cross, the wounded soldiers from both Biafra and the federal side in hospitals in the eastern region were moved to Government Technical College (GTC), Enugu. About one week later, the wounded federal soldiers were all selected and taken to Kaduna for proper care and medical attention.

The disabled Biafran soldiers' (now Veterans) have been subjected to several relocations. They received minimal provisions of food and treatment. On several occasions, these men had to move to the then Administrator of East Central State, Mr. Ukpabi Asika, in group protests for their poor living conditions and feeding. In order to curtail this recurring decimal which was becoming constant, the government decided to build two large halls near the leprosy settlement at Oji River in the outskirts of Enugu for the relocation of the veterans. It was learnt from the Biafran Veterans that on 11th of July 1975, military men from 82 Division of Nigerian Army in Enugu were instructed to put all the wounded veterans into a long bus and take them to the present site at Oji River. The order was to shoot anyone who resists the relocation.

About 698 disabled Biafran veterans were moved to Oji River in 1975 but today, only 50 of them are alive. Out of this 50, only 16 persons were residing in the camp with their families in 2010. The rest of them (34 persons) have either gone to their village of origin because of old age and ill health or decided to live outside the camp. The two houses built for the veterans remained as open halls even as the veterans had married wives and were having children. It was in the year 2003 that a Non-Governmental Organization known as Prisoners' Rehabilitation and Welfare Action (PRAWA) in collaboration with Integrated Rehabilitation Centre for Torture Victims with support from United Nations Voluntary Fund for Victims of Torture (UNVFVT) divided the halls into small rooms with plywood for each family. The camp had pipe-borne water in 1975 but at the time of this research, the pumps were not functional. Even the electricity they use was at their own risk because the PHCN could not provide them with electric power without charges.

At present, the disabled veterans use their wheelchairs to come out and stay on both sides of the Enugu-Onitsha Expressway near Oji River junction to beg for alms from motorists. This has been their survival strategy. According to the president of the veterans' body, Mr. Lawrence Akpu, it was the toppling of General Gowon before the commissioning

of the centre that left "necessary things undone at the place" (Nweze, 2010), p. 4). The veterans constantly lament that no public office holder from the South East deems it fit to visit them in spite of their lip service that they love the Igbo race. In a study by Ezeokana, Chine, Nnedum and Omonijo (2011), there were significant differences in the the Biafran veterans' levels of posttraumatic stress disorder (PTSD). The disabled combatant Biafran war veterans had significantly high experience of PTSD than the non-disabled Biafran war veterans. Ifeagwazi and Chukwuorji (2014) found that low self-esteem significantly contributed to adverse mental health status as measured using the General Health Questionnaire among these veterans.

The aftermath of the War: Delayed onset and lifetime PTSD symptoms

PTSD symptoms constitute the trauma with the highest risk of delayed onset and less speedy resolution of symptoms (Pregerson, Maciejewski & Rosenheck, 2001). The World Health Organization views it as an enduring psychological problem which implies that it can be a lifetime experience after catastrophic experiences such as war (Shay, 1994). Delayed onset means that it may not manifest immediately after a combat experience but shows up several months or years later. Just then and without warning, a reactivation of the symptoms occurs and then may disappear only to occur repeatedly (Kessler, Sonnega, Bromet, Hughes & Nelson 1995). Numerous evidence of delayed onset and lifetime post-traumatic stress symptoms exists in literature such as a cross-sectional epidemiological multi-site sample (Frueh, Grubaugh, Yeager & Magrader, 2009); a 20 year longitudinal study (Solomon & Mikulincer, 2006); a narration of personal experience of PTSD symptomatology for over 20 years (Porplglia, 1996); National Vietnam Readjustment Study (Kulka, Schlenger, Fairban, Hough, Jordan, Marmar & Weiss, 1990), Dutch combat veterans and World War II victims (Schreuder, Kleijn, & Rorijmans, 2000); Korean War (1950-1953) male veterans 50 years later (Ikin, Sim, & Mckenzie, 2007); and nearly 50 years in World War II veterans (Porterfield, 1996).

Post-traumatic Stress Symptoms in Korean War veterans was strongly associated with increasing combat severity, low rank, service in the army, being wounded in action and to some extent, decreasing years of previous military experience (Ikin, et. al., 2007). This situation depicts the Biafra case. The veterans of Biafra have been exposed to potentially traumatizing contexts that can affect their coping capacities, adjustment and adaptation in the present day Nigeria society. However, it could be worse for the disabled veterans. Road accidents have occurred on some occasions as the disabled veterans attempt to move across the ever-busy Enugu-Onitsha expressway to beg or collect what has been dropped for them by motorists. These incidents further bastardizes their already traumatized psyche. The noise from bombs and weapons of war affected their senses and deteriorated their cognition. By constantly staying along the expressway, hearing the blaring of sirens by public office holders (who do not care for them in any way), horn of passing vehicles, constant shooting and firing of gunshots and other explosives by armed robbers, kidnappers and the police who operate almost on a daily basis and other aspects of such a noisy environment also aggravates their problems.

Social support and posttraumatic stress symptoms

Research on clinical symptomatology (e.g., Cohen & Wills, 1985; Kessler & McLeod, 1985), reported that the perception that others will provide the needed aid helps to protect people from the pathogenic effects of stressful events. Specifically, stress is positively associated with PTSD symptomatology under low levels of social support but unassociated (or less strongly associated) under high levels of social support. Lack of social support after combat exposure contributes significantly to the development of PTSD (Halgin & Whitboume, 2000). Philips, Leardman Gumbs and Smith (2010) assessed social support in

members of United States Marine who returned from Iraq or Afghanistan. Interestingly and consistent with the buffering effect of social support on post-traumatic stress disorder, it was found that reporting 5 or more friends/relations was associated with a significant reduction in the odds for PTSD. In a study of National Guard Veterans in USA, Pietrzak, Johnson, Goldstein, Malley and Southwick (2009) found that post deployment social support was negatively associated with PTSD.

The Kosovo Emergency Department Study (Ahern, Galea, Fernandez, Loci, Waldman & Vlahov, 2004) in post-war Kosovo was investigated the relationship of social support and post-traumatic stress disorder symptoms. PTSD was found to have higher detrimental effect on men. Wilcox, (2010) reported a robust relationship of social support with PTSD among combat veterans. Recently, Duax, Bohnert, Rauch and Defever (2014) examined the associations among levels of social support, and screening positive for PTSD within a sample of 536 Operation Iraqi Freedom/Operation Enduring Freedom (OIF/OEF). Approximately 30% of veterans screened positive for PTSD. Higher levels of social support were associated with a significant reduction in the odds of screening positive for PTSD. Similarly, DeBeer, Kimbrel, Meyer, Gulliver and Morissette (2014) found that when social support was low, PTSD/depression symptoms increased the risk of suicidal ideation among the OIF/OEF.

Among 835 U.S. Army and 173 National Guard soldiers, Han, Castro, Lee, Charney, Marx, Brailey, Proctor and Vasterling (2014) reported that higher levels of postdeployment social support were associated with lower levels of postdeployment PTSD symptom severity. In Portuguese war veterans, remission from PTSD was strongly associated with higher perceived social support (Ferrajao & Aragoa, 2015). There is little research on the psychosocial experiences of the Biafran War veterans, and no available study had examined the role of social support in PTSD symptoms among the veterans. The hypotheses for the present study were:

Disabled veterans would report higher levels of PTSD symptoms and lower levels of social support than non-disabled veterans (H_1).

Veterans who reported higher social support would differ significantly from veterans who reported low social support (Government, Friends and Family) in their self-report of PTSD symptoms (H_2).

Method

Participants: Forty six (46) veterans (disabled = 14; non-disabled = 32) participated in this study. A similar sample size was adopted in a previous study of veterans (e.g., Prevost, 1996). All the veterans were Igbos who fought on the Biafran side during the Nigeria/ Biafra war (1967-1970). Detailed information on the veterans' sample in this study has been reported elsewhere (see Ifeagwazi, Abaima & Chukwuorji, 2012).

Instruments: Two measures were used for the study: the Nigerian adaptation of the Social Support Questionnaire (SSQ) and Post-traumatic Stress Disorder Checklist-Military Version (PCL-M).

The Nigerian adaptation of the Social Support Questionnaire (SSQ) (Asogwa, 2010), originally developed by Sarason, et al., (1983), was used in this study to assess the level of social support networks of the veterans. It provides scores on three subscales: government support, family support and friends support. Each subscale contains 8 (eight) items. The inventory has such specific statements as: To what extent does government care about whether you succeed or fail; To what extent do you have family members you can really count on in a crisis situation; and to what extent do you have friends you can count on to listen to you when you need to talk. Respondents were required to rate the extent they agree with each statement on a five-point likert scale as follows: to a great extent (5), large

extent (4), moderate extent (3), slight extent (2), and not at all (1). Asogwa (2010) reported a Cronbach's alpha of .88 for the full scale and reported Cronbach's alpha of the three subscales as follows: family support = .91, friends support = .90 and government support = .90. In the current research, the Cronbach's alpha reliabilities of the Igbo version we used were .83, .74 and .79 for family support, friends support and government support respectively.

PTSD Checklist – Military Version (PCL-M) is a 17-item self- report measure of PTSD symptomatology. It was developed by Weathers, Litz, Herman, Huska and Keane (1993). Participants indicate the extent to which they have been bothered by each symptom in the past one month using a five-point Likert scale varying from not to all (1) to extremely (5). In the military version, unlike the civilian version, re-experiencing and avoidance symptoms apply to military- related experiences only. Using 123 male Vietnam war veterans, Weathers, et al. (1993), obtained a Cronbach's alpha reliability of .93, test-retest reliability of .96 and convergent validity as follows: .93 (Mississippi Scale for Combat-Related PTSD), .77 (Keane PTSD Scale of the Minnesota Multiphasic Personality Inventory- II), .90 (Impact of Event Scale) and. 46 (Combat Exposure Scale). The developers also reported a Cronbach's alpha of .96 and convergent validity of .85 with Mississippi scale for combat-related PTSD using 1, 006 Gulf War Veterans. Kean, Kutter, Nites and Krinsley (2008) evaluated this instrument and reported a coefficient alpha of .96 for the scale; with convergent validities of .79 (Clinician Administered PTSD Scale), .90 (Mississippi Scale) and .62 (Combat Exposure Scale). Pietrzak, et al., (2009) reported an alpha coefficient of .96 for PCL-M, and recent researches show evidence of its utility (e.g., Jones, Sundin, Goodwin, Hull, Fear, Wessely & Rona, 2015). Tamunomiete (2006) obtained an alpha reliability of .90 for the instrument in a Nigerian sample. We obtained a Cronbach's alpha reliability of .85 and split half-reliability (Spearman-Brown) of .92 for the Igbo version which we used in the current study. As evidence of its divergent validity, -.46 was obtained when the PCL-M was correlated with SSQ.

Procedure: The disabled veterans were identified and recruited for the study through personal visit to the War Disabled Camp at Oji River in Enugu state of Nigeria by the second author with the purpose of soliciting for their participation in the study. The non-disabled veterans were identified and recruited for this study by means of a church announcement in a catholic church in Awgu diocese of Enugu state. Additional non-disabled veterans were recruited through snowball sampling method. The questionnaires were translated into Igbo using the back-translation method (See, Ifeagwazi & Chukwuorji, 2012). Focused Group-Discussions (FGD) were conducted for both the disabled and non-disabled veterans to get first-hand information on the pre-war, war and post-war experiences of the veterans.

Design/ Statistics: This is a survey research adopting a cross-sectional design. T-test was used for data analysis.

Result

Table 1: Descriptive statistics for PTSD symptoms and social support with t-test comparison of PTSD symptoms and social support scores in disabled and non-disabled veterans.

Variable	No of Items	Disabled veterans(n = 14)		Non-disabled veterans (n = 32)		
		Mean	SD	Mean	SD	T
PTSD Symptoms	17	60. 86	8.8	37. 13	9.1	8.26*
Government Support	8	18.29	1.1	10. 87	9.2	8.26*

Family Support	8	12.21	5.7	24.75	4.3	8.18*
Friends Support	8	13.86	5.8	28.00	6.8	6.76*
Overall Social Support	24	34.36	10.9	40.00	9.9	9.00*

Note: *p < .001. Higher mean scores indicate higher levels of PTSD symptoms and higher levels of social support networks.

Table 1 showed that the disabled veterans reported significantly higher levels of PTSD symptoms (t = 8.26, p < .001) and lower levels of social support (t = 9.00, p < .001) in comparison with the nondisabled veterans. This result supports hypothesis 1 which stated that the disabled veterans would report higher levels of PTSD symptoms and lower levels of social support.

Table 2: T-tests of Social Support (High and Low) and PTSD symptoms

	Government Support			**Family Support**			**Friends Support**			**Overall Support**		
	High (n=31) **M** (SD)	Low (n=15) **M** (SD)	**t**	High (n=22) **M** (SD)	Low (N==22) **M** (SD)	**t**	High (n=27) **M** (SD)	Low (n=19) **M** (SD)	**t**	High (n=26) **M** (SD)	Low (n=20) **M** (SD)	t
PTSD	38.6 (10.4)	56.7 (13.1)	5.17*	38.10 (4.8)	50.8 (15.5)	3.27*	38.2 (10.9)	53.1 (13.9)	4.05*	38.3 (9.5)	52.2 (15.5)	3.75*

*p < .001

Table 2 showed that veterans high in social support reported significantly lower levels of PTSD symptoms than veterans low in social support. Thus hypothesis 2 was supported.

Table 3: Percentage (%) endorsement of PTSD symptoms by Biafran Veterans (N= 46)

	Not at all	Little	Sometimes	Often	Always
Intrusive memories	-	-	37%	-	-
Nightmares	-	-	30.4%	30.4%	-
Flash backs	-	-	41.3%	-	-
Psychological distress	-	-	26.4%	-	-
Psychological reactivity	-	-	37.0%	-	-
Thoughts/ feelings	-	-	39.1%	-	-
Activities/places/people	-	-	39.1%	-	-
Trauma-related amnesia	-	-	43.5%$^{+}$	-	-
Diminished interest	-	-	37.0%	-	-
Detachment	-	-	32.6%	-	-
Restricted affect	-	-	39.%	-	-
Fore-shortened Future	-	-	34.8%	-	-
Sleep difficulty	-	-	-	39.1%	-
Irritability/Anger	-	-	-	23.9%	-
Difficulty concentrating	-	32. 6%	-	-	-
Hyper vigilance	-	32.6%	-	-	-
Exaggerated startle response	-	43.5%$^{+}$	-	-	-

Note: Only the response options which have the highest percentage of endorsement by the veterans of each of the PCL-M symptoms were shown. $^{+}$Symptom with highest endorsement.

The veterans endorsed such symptoms as nightmares (30. 4%), sleep difficulty (39.1%) which were often experienced as well as trauma-related amnesia (43. 5%), and flashbacks (41.3%) which were sometimes experienced.

Discussion

The current study investigated whether there will be significant differences in social support and PTSD symptoms among disabled veterans and non-disabled Biafran veterans, and whether veterans with high social support will significantly differ from veterans with low social support in their self-report of PTSD symptoms. The disabled veterans reported higher PTSD symptoms than non-disabled veterans. This result is similar to the outcome of the National Vietnam Readjustment study in USA which found high lifetime PTSD rates to be as high as 67% among veterans wounded in combat (Kulka, et. al., 1990). Kobbins (2001) also found an association between being wounded in battle and PTSD symptoms. The disabled Biafran veterans disclosed that they had witnessed the death of others when their injuries occurred. Many of them must have seen the horror of death. During the Focused Group Discussion, the veterans revealed that the PTSD symptoms onset occurred many years after the war and persists chronically till the present time. More so, it could be debilitating for an adult male in Igbo land to see himself as dependent on the mercy of other people because of functional impairment. There is, therefore, no doubt that these disabled veterans are very much dissatisfied with their condition of dependency.

The finding that the non-disabled veterans had higher levels of overall social support and reported lower PTSD symptoms (in comparison with the disabled veterans), is consistent with the buffering hypothesis of social support. Veterans who are actively involved in their community, are gainfully employed, and have other rewarding social contacts may have a sense of social integration. They may be more inclined to manifest lesser PTSD symptoms. Several researchers have reported similar results (e.g., Philips, et. al., 2010; Pietrzak, et. al., 2009; Wilcox, 2010, Duax, et al., 2014; Han, et al., 2014; DeBeer, et al., 2014). Generally, the association between social support and PTSD symptoms is very robust in Combat Veterans (e.g., Brewin, Andrews & Valentine, 2000). An observation of the psychosocial status of these veterans especially the disabled ones during the Focused Group Discussions showed significant psychological and social difficulties in the process of adaptation and coping with life. There is a great concern for the prospects of their children as well as general survival. Those whose children have grown up and can provide for their ageing father (the veteran) express lesser concerns than their counterparts who still have younger children to train and hungry mouths to feed.

Family members play a very crucial role in helping a soldier dealing with PTSD symptoms. The better the member re-integrates with the family and the community, the more likely the family will be able to recognize the changes in the person. But the disabled veterans could be said to live in a world of their own where majority of their time is spent with other disabled veterans. This benefit of the family is unavailable to them. As over 60% of them were unmarried before the war, their wives met them in their situation and they have now given birth to children. These symptoms could be seen by the family as part of their usual behaviour instead of an abnormality which requires intervention. Being informed of the nature of a problem helps a family member to aid encourage the veterans take advantage of the limited resources.

Consistent with other researchers (e.g. Sutker, Davis, Uddo &Ditta, 1995), lack of family cohesion can be a serious risk factor for PTSD. Dysfunctional relationships with significant others also further aggravate PTSD symptoms. The disabled veterans, particularly, face all kinds of social isolation and rejection in the hands of close relatives in their home towns. They do not have houses at home and cannot be accommodated by their kinsmen. A friend in need, they say, is a friend indeed but outside their disabled veterans' community,

most of the veterans do not known many friends. This is because other persons do not show much concern about their plight. The disabled veterans are constantly lamenting on their ordeal and predicaments as they cry for help (See Nweze, 2010). The sense of common destiny among the veterans is however, very remarkable. They gather their individual proceeds from their daily routine of begging for alms together and distribute it among themselves according to need.

The level of support from the government also has a significant influence on PTSD symptoms. Due to the stigma that has been attached to the war, most South Eastern governors as observed by the veterans, would not want to be seen by the Nigerian federal government as pro-Biafra. This makes them to shy away from their social responsibility of providing for the veterans. The Department of Social Welfare which is situated in the same vicinity with the veteran's camp and the General Hospital at Oji River do not take care of the veterans. It is possible that the care of the needy veterans may have been one of the original intentions of the government in establishing these agencies close to the veterans' camp, but this purpose never materialized. If they visit the government-owned hospitals, the veterans must pay before they are treated. Convincing evidence is lacking to show that rehabilitation of veterans was truly a part of the post-war Reconciliation, Reintegration and Rehabilitation Programme of the Nigerian Federal government in the 1970s. Even if it was part of the scheme, it appeared that greater attention was given to the veterans who fought on the Nigerian side.

Generally a tendency to use the sources of social support as a channel to disclose personal problems and sometimes ventilate war experiences enhances adjustment/ adaptation. Non-disabled veterans have more opportunity for emotional ventilation and socially supportive relationships than their disabled counterparts. The more frequent reporting of flashbacks, nightmares and trauma-related amnesia could be understood as the side effects of so many unanswered questions concerning the war. In retrospect, the veterans now wonder what the war was all about. "What did we fight for and was it worth dying for? What has changed in Nigeria since then? Is it not possible that the incidents that led to the war are repeating themselves in the present Nigerian society?" These questions can constantly impinge on the sensibilities of the veterans. The abandonment of those veterans whose physical injuries of the war have not healed till today is a pointer to this fact.

Implications of the Findings

Social support is very important because veterans experiencing PTSD symptoms can become uncomfortable when dealing with other people because of emotional numbing. They may become reclusive as a result of avoidance. Most of the participants in this study may not understand what has been happening to them. The difficulty in meaningful social contact becomes less when there is communication between the veterans and those who have shared the same experiences or have similar attitudes. This underscores the need for the incorporation of psychotherapentic services into the monthly visits made to the disabled veterans by the War Veterans Social Action (WVSA). Mentoring by other volunteer veterans who can assist and coach their impaired comrades in order to lead fulfilled and better lives is a necessity. In the USA, the American Combat Veterans of War fulfils this vital need for US veterans. Measures must also be taken to stimulate inter-generational solidarity and awareness through youth initiatives for the welfare of veterans.

Riggs (2000) maintained that the family could be sportive of a victim in some ways which can come by way of addressing systemic disruption in relationships caused by exposure to trauma. The families of veterans can learn about the effects of trauma, as well as effective communication and problem solving skills which ensures functional relationship maintenance. This enlightenment is important because PTSD symptoms in the head of a family can have considerable effects on the mental health of other family members who might also need

assistance (Richardson, Thompson, Boswall & Rakesh, 2010). The Biafran veterans often got betrayed by their leaders in the course of the war.

Regrettably, some individuals pretend as agents of assistance for the disabled veterans. They pose as middlemen between the veterans and donor agencies only to channel the gifts for the veterans to their individual use. The veterans could not reveal the identities of such people in spite of the researchers' insistence on exposing such shameless elements. A well pronounced case of this betrayal is the abandoned Tissue Production Plant at the Disabled Camp, Oji River. The factory is an initiative of the World Igbo Congress (WIC) for the rehabilitation of Biafra Veterans. In spite of the millions of dollars that were reportedly spent on the project, the machine has never functioned. There is the need for an adequate value for this huge investment. It is also believed that the government alienates them. These traumatized individuals have a right to feel and express their anger when the need arises. Anger work just like grief work is no doubt an aspect of healing and recovery. The media (both print and electronic) should assist them to have their say. There should be statutory provisions by eastern states government for Biafra veterans both disabled and non-disabled. Legislators in the 5 eastern House of Assemblies should wake up to this social responsibility.

Conclusion

The current researchers obtained compelling evidence of the role of social support on PTSD symptoms which is usually a very long lasting aftermath of war. Sometimes, the PTSD symptoms could appear immediately after the war and sometimes there is a delayed onset and lifetime re-occurrence. But in all, the war experience is intense, emotionally shocking and has deep emotional and psychosocial scars. By this work, the researchers have engaged in what La Capra (2001) describes as 'an articulatory practice of working through the trauma' of Biafra veterans. This is done with a full realization that in spite of what happened in the past, we are living here and now with limitless possibilities of better days for Nigeria. The past must always shape the future (and the past continues to hunt the veterans), but it must not be allowed to destroy the future. Instead, there is the need for concerted efforts by government, friends, family, NGOs and the general public to enhance the welfare of the veterans. The centrality of the Nigeria-Biafra war in the identity and life of the veterans is a plain truth. This is an undeniable human aspect of the war. Even the surrender that was achieved also goes with its own long lasting psychological cost which is humiliation. PTSD in a veteran is like an "invisible" wound to their family, friends, other veterans and the society in general unlike physical disabilities. But it is within the capacity of the government, friends and family to alleviate the suffering of veterans which will also heal its wounds (PTSD symptoms).

This work is a landmark study of veterans in Biafra. There is little research work in this regard from the psychological point of view, to the best of these researcher's knowledge. However, the limited number of participants is a major weakness of this study and could affect the generalizability of the findings. Increased number of non-disabled veterans should be used for similar studies by future researchers. More knowledge can be gained if subsequent research can assess objective levels of support through reports from family and friends, and compare these ratings with participants' perceptions of support. Further clinical interviews could be carried out by researchers to assess the occurrence of clinical levels of PTSD. The cross-sectional nature of the present research is also a major limitation of this study. Hence caution is demanded in generalizing the findings. Future researchers may adopt longitudinal designs. Many of the veterans may have experienced other traumatic events in their daily lives. It is important for future research to examine the cumulative nature of such traumatic events on quality of life among the Biafran Veterans.

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