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TYPES OF TRAUMATIC EVENTS, RESPONSE TO THE EVENTS AND COPING STRATEGIES AMONGST SELECTED ADULTS RESIDENT OF INTERNALLY DISPLACED PERSONS CAMPS IN NIGERIA

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ABSTRACT: *The return of Nigeria to Civilian rule since 1999 has witnessed the killing of thousands of people through recurring inter-communal conflicts and politically motivated violence. The forced evictions resulting from these occurrences have caused significant population movements resulting in large waves of internal displacement. Therefore, this research was aimed at evaluating types of traumatic events, response to the events, and coping strategies amongst selected Adults. Residents of internally displaced persons' camp in Nigeria. The researchers adopted cross-sectional research design with the sample size determined using Taro Yamane sample size Determination formula resulting in the selection of 392 respondent using multistage sampling technique. Four (4) research questions were answered while four (4) null hypotheses were tested. Results showed that 57.8% of respondents were males while 42.2% were females most of the respondents 51.4% are Muslims as against 43.2% who are Christians. The types of traumatic experienced by the respondents included evaluation from home which was experienced by 84.8%, followed by lack of food. In term of the way they responded to traumatic events, 13.4% experienced being jumpy. The coping style widely accepted positive reinterpretation and social support. These was a significant association between the employment status of respondents and destruction of properties. It was concluded that the internally displaced persons adopted mixture of problem focused and emotional focused coping strategies.*

KEYWORDS: Traumatic Events, Internally Displaced Persons Adult Residents, Camps

INTRODUCTION

Background

In recently times, wars have become sophisticated, assuming the form of guerrilla wars. These wars take place in civilian communities inflicting adults and children alike with varying degrees of injuries and senseless killings (Ovuga & Larroque, 2012). Over a million people die globally every year due to violence in all its forms and accounting for 2.5% of global mortality. This makes violence the fourth leading cause of death worldwide for people aged 15–44 years (WHO, 2014). Recent acts of ethnic violence and organized violence following elections and religious fanaticism have affected hundreds of civilians in previously stable and peaceful African communities in Nigeria, Rwanda, Democratic Republic of Congo, Kenya, Tanzania, and Uganda (Ovuga & Larroque, 2012).

The return of Nigeria to civilian rule since 1999 has witnessed the killing of thousands of people through recurring inter-communal conflicts and politically motivated violence. The forced evictions resulting from these occurrences have caused significant population movements and

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result into consistently large waves of internal displacement. The Norwegian Refugee Council (NRC, 2012) in Armed Conflict Location & Event Dataset reported that the level of violence had increased drastically over the last few months, putting Nigeria on a par with Somalia in terms of the high number of conflict events it experiences.

Though the current levels of internal displacement are particularly high, a number of organizations noted that, in the absence of a functioning monitoring mechanism, in-depth data is extremely hard to come by (NRC, 2012). The Islamic group Boko Haram has been responsible for the majority of violence carried out in northern and central Nigeria since 2009, in the name of political objectives leading to significant displacement. According to Displacement Tracking Matrix (DTM), the total number of internally displaced persons identified in Abuja, Adamawa, Bauchi, Benue, Borno, Gombe, Kaduna, Kano, Nasarawa, Plateau, Taraba, Yobe and Zamfara as of 31 August 2016 is 2,093,030 (DTM, 2016).

The United Nations High Commissioner for Refugees (UNHCR) stated that internally displaced persons are people who are forced to flee their homes but unlike refugees, they remain within their country's borders (UNHCR, 2007). Specifically, they are persons or group of persons who have been forced or obliged to flee or to leave their homes or places of habitual residence, in particular as a result of or in order to avoid the effects of armed conflict, situations of generalized violence, violations of human rights or natural or human-made disasters, and who have not crossed an internationally recognized state border (Akhunzada, Qadir, Maqsood, Rasool & Raza ur Rehman, 2015). As internally displaced, they often live in temporary dwellings or shelters thereby taking them away from their means of livelihood, material and cultural resources, and access to traditional coping that they had previously depended on (Bang & Few, 2012). These displaced persons are faced with many challenges which include limited job opportunities, poor housing conditions, and lack of access to toilets, electricity, and water. They lack access to good health facilities leading to increase morbidity and mortality (Bang & Few, 2012).

The victims of violence certainly can have physical injuries needing medical attention, but they also experience psychological injuries with a broad range of responses (WHO, 2002; Videbeck, 2008). Some are agitated and visibly upset; others are withdrawn and aloof, appearing numb or oblivious to their surroundings. The victims often suffer in silence and continue to feel guilt and shame (Herman, 1997). The impact of conflicts on mental health is influenced by a host of factors such as the nature of the conflict, the kind of trauma and distress experienced, the cultural context, and the individuals, as well as communities' resources (WHO, 2002; Mohammed &Thabet, 2017) . Adult victims usually feel guilt or shame, degraded, humiliated, and dehumanized. Their self-esteem is extremely low, and they view themselves as unlovable (Zust, 2000). Many psychological factors also contribute to the emotional response to violence. Fear, anger, shock, sadness, and disbelief are all common and normal emotional responses. These responses may be based on the person's personality and normal coping patterns, coping reserves, and support system available. After a disaster, common responses can include sleep disturbances, and increased use of alcohol, tobacco, and illicit drugs (Videbeck, 2008)

A traumatic experience is capable of provoking fear, helplessness, or horror in response to the threat of injury or death. Such traumatic events include lack of food, water, shelter and medical care, imprisonment, combat and injury, abuse and isolation, torture, murder, death of family member as well as lack of food, water, shelter and medical care. Several studies have shown that people who are exposed to such events are at increased risk for serious mental and psychological disorders such as PTSD, major depression, panic disorder, generalized anxiety

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disorder, and substance abuse, as compared with those who have not experienced traumatic events (Yehuda, 2002; de Jong et al, 2003; Roberts, Ocaka, Browne, Oyok, & Sondorp, 2008; Asad et al., 2013; Mnookin, 2016). They may also have somatic symptoms and physical illnesses, particularly hypertension, asthma, and chronic pain syndromes. According to Halepota and Wasif (2001), trauma and torture leaves a permanent scar on the survivor with physical, psychological and social sequels.

A study from the middle east by El-Kahlout and Thabet (2017) on effects of political and community violence on mental health of adolescence in Gaza Strip shows that 30.5% have mild traumatic events 47.5% have moderate traumatic events while 22.1% have severe traumatic events Roberts et al. (2008) and Vinck et al. (2007) reported high rates of PTSD (54% and 74.3% respectively) as well as high rates of depression (67% and 44.5% respectively) among internally displaced persons in Uganda. This finding according Ovuga and Larroque (2012) may be due to the long duration of exposure to traumatic events. Pham et al (2009) reported that one-third of internally displaced persons experienced abduction

There is an overwhelming loss of perceived power and self-esteem among the displaced persons. Carballo, Smajkic, Zeric, Dzidowska, Gebre-medhin and Halem (2004) found that over 25% of displaced people reported that they no longer felt they were able to play a useful role. Widespread depression and feelings of fatigue and listlessness were common and may have prevented the displaced persons from taking steps to improve their situation. Carballo et al (2004) also observed that almost a quarter of internally displaced people had a high startle capacity and said they were constantly nervous. They found that most adverse psychosocial responses increased with age thereby posing a serious challenge to a population that includes many elderly people.

The presence of mental health problems among the internally displaced persons contribute to difficulties in coping and resettlement in normal life. Aldwin and Yancura (2004) suggested that the ways individuals cope with trauma may play a more important role in their adjustment than the traumatic event itself. The victims are reluctant to discuss trauma related events or symptoms because of painful feelings. This makes it more difficult to obtain accurate information on the traumatic events and its impact.

Coping can be conceptualized as the individual's response to stressful or traumatic events. Carver and Connor-Smith (2010) define coping as efforts to prevent or diminish threat, harm, and loss or to reduce associated distress. Coping can be classified as being either problem-focused or emotion-focused in nature (Lazarus, 1984). Problem focused coping involves activities that focus on directly changing elements of the stressful situation or conflict. Emotion-focused coping involves activities that focus more on modifying one's internal reactions or activities that seek to regulate internal emotions and may include cognitive distraction, seeking emotional support, emotional expression and cognitive restricting (Lazarus, 1984; Thabet & Vostanis, 2017). Other researchers used the terms "engagement" or "active" coping styles to describe problem focus coping while terminologies such as "disengagement" or "avoidant/passive" coping styles have been used to describe emotional focus coping (Ebata & Moos, 1994; Sandler, Tein, & West, 1994).

Different individuals however, respond differently and utilize different coping strategies to a particular traumatic event (Rafnsson et al., 2006). It has been reported in a meta-analysis by Luszczynska, Benight and Cieslak (2009) that higher coping self efficacy level is consistently associated with decrease level of distress and posttraumatic stress symptom (PTSS) level.

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Studies however have shown that emotion oriented coping is associated with poorer mental health outcomes in contrast to problem based coping which is associated with better mental health outcomes (Campbell-Sills, Cohan, & Stein, 2006; Khamis, 2015).

Despite increasing rise in the number of internally displaced persons in Nigeria dues to ethnic and political violence, there is a dearth of studies on the types of traumatic events experienced by these displaced persons and the way they cope with the trauma. Hence this study aims to fill this gap with the following research questions:

i. What are the socio-demographic characteristics of the respondents?

ii. What types of traumatic events are experienced by the respondents?

iii. How do the subjects respond to the traumatic events?

iv. What are the coping styles adopted by the respondents?

The following null hypotheses were tested by the researchers:

1. There is no significant association between employment status of respondents and selected types of traumatic events
2. There is no significant association between selected types of traumatic event and the responses to events amongst respondents
3. There is no significant association between types of traumatic event and coping styles of respondents
4. There is no significant association between the socio-demographic characteristics of respondents and selected coping styles

MATERIALS AND METHOD

Study Design

A descriptive cross sectional design was utilized for the study. The study was carried out to describe the traumatic experiences of the displaced persons in the internally displaced persons' camp in Abuja, Nigeria, their responses to the events and their coping strategies.

Study Setting

This study was carried out in Abuja, the city of Nigeria, and is situated in the middle of the country. The federal capital territory was formed from parts of three states including Nasarwa, Niger, and Kogi states with a land area of 8,000 square kilometers. It is bounded on the north by Kaduna state, the west by Niger state, the south-east by Nasarawa state and the south-west by Kogi state. The three arms zone consist of the presidential villa, the national assembly and the supreme court, all surrounded by a ring road. The city is divided into six (6) administrative units known as area councils. The area councils are Abuja municipal, Abaji area council, Gwagwalada area council, Kuje area council, Bwari area council and Kwali area council. There

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are four internally displaced person's camps in Abuja namely: Lugbe IDP Camp, Area One IDP Camp, New Kuchingoro IDP Camp and Kuje IDP Camp

Study Subjects

Subjects for the study were adult internally displaced persons in the IDP camps located in the capital city. According to the International Organization for Migration (IOM, 2016), there are 20,924 internally displaced persons in Abuja camps. Using Taro Yamane's formula for finite population

$$n = \frac{N}{1+N(e)^2}$$

Where n= corrected sample size, N= population size (20,924), and e = margin of error (0.05)

$$\text{Therefore } n = \frac{20,924}{1+20,924(0.05)^2}$$

$$= \frac{20,924}{53.31}$$

= 392. A total of 392 respondents were conveniently recruited for the study. a total of 329 respondents returned the completed questionnaire given a response rate of 84%

Instruments and Data Collection

A self-administered questionnaire was used to gather data from the respondents. The questionnaire was divided into four sections. The first part of which covers the socio-demographic data of the respondents gathered information on gender, age, religion, marital status, level of education and employment status of the respondents. The second part is a 17-item instrument used to measure the types of traumatic events experienced by the respondents. It is measured with a yes or no response indicating the frequency traumatic events experienced by the displaced persons.

The third part of the questionnaire is a 20-item instrument used to measure the responses of the respondents to the traumatic events. It is adapted from the post-traumatic symptoms checklist. The responses were rated on a 5-point scale ranging from "not at all" to "6 or more times in a week". These symptoms can be grouped into four subcategories namely: hyper-arousal, re-experiencing, avoidant and numbing. The last part of the questionnaire consists of a 14-item instrument used to measure the coping styles of the respondents. It was a yes or no response consisting of different coping styles ranging from problem-focused coping style to emotional-focused coping style. The content validity of the instrument was established by three experts and was tested before the survey. Reliability was established through a test-retest method.

The purpose of the study was explained to the respondents and their verbal consent was obtained before administering the questionnaire. Participation was made voluntary and refusal to participate in the study attracted no penalty. The respondents were assured of anonymity, and confidentiality of their information. The study was approved by the federal ministry of health.

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Instrumentation: The Instrument for this Study we arrived at after the review of Sane Standard Instruments like Hopkins Sympfrois Check list, Stressful events and Harvard trauma Quccstonaire. For the Coping techniques the Cope by Carvers and Asuzu were reviewed. Having Selected the items for the Study, the Pilot test was carried out. The lity of the instrument using test retest Reliability yielded 0.81. This was 81% reliability.

Data Analysis

The data collected were checked and cleaned by the researchers for completeness and accuThe questionnaires were coded, entered, and analyzed using SPSS version 20. The respondents' socio demographic characteristics and other variables were presented with descriptive statistics using frequency/percentages tables. Chi square was used to test for significant associations between variables. The level of significance chosen for this study was $p \leq 0.05$ and Confidence Interval was 95%.

RESULTS

Result are presented inform of frequency tables and percentage

Table 1

Table 1 Socio-Demographic Data (N= 329)

Variable	Frequency	Percentage (%)
Gender		
Male	190	57.8
Female	139	42.2
Age group		
20-29	161	49.0
30-39	71	21.6
40-49	47	14.3
≥50	50	15.2
Religion		
Islam	169	51.4
Christianity	142	43.2
Traditional	18	5.5
Marital Status		
Married	166	50.5
Single	87	26.4
Widow	27	8.2
Divorced	16	4.8
Widower	33	10.0
Level of Education		
Primary	59	17.9
Secondary	82	24.9
Tertiary	78	23.7
Quranic	51	15.5
No formal Education	59	17.9
Employment Status		

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Employed	81	24.6
Unemployed	70	21.3
Student	29	8.8
Retiree	11	3.3
Trading	87	26.4
housewife	51	15.5

Socio-demographic characteristics of the respondents are presented in table 1. The table showed that 57.8% of the respondents were males while 42.2% were females. Most of the respondents (49.0%) are within the age range of 20-29years followed by 21.6% who are within the age range 30-39. Moreover, most of the respondents 51.4% are Muslims as against 43.2% who are Christians. We observed that slightly more than half (50.5%) of the displaced persons are married while few 26.4% are still single. Considering the level of education of the respondents, 24.9% had secondary education, 23.7% had tertiary education, 17.9% had primary education, 15.5% had quranic education while 17.9% had no formal education. The table also shows that while 24.6% of the respondents are employed, 21.3% are unemployed and another 26.4% are into trading.

Table 2 Type of Traumatic Events (N= 329)

Variables	**Yes (%)**	**No (%)**
Evacuation from the home of abode	279(84.4)	50(15.2)
Lack of Food	278(84.5)	51(15.5)
Separated from loved ones	254(77.2)	75(22.8)
Carting away of possession	254(72.2)	75(22.8)
Disappearance of the loved one	254(77.2)	75(22.8)
No Shelter	253(76.9)	76(23.1)
Destruction of properties	251(76.3)	78(23.7)
Treated with violence	238(77.3)	91(27.7)
No clothing	238(72.3)	91(27.7)
Witnessed the death of family members	232(70.5)	97(29.5)
Death of family members	224(68.1)	105(31.9)
Physical injuries	223(67.8)	106(32.2)
Beaten of family members	220(66.9)	109(33.1)
Torturing	207(62.9)	122(37.1)
Ill health	192(58.4)	
		137(41.6)
Rape or sexual molestation	161(48.9)	168(51.1)

The types of traumatic events experienced by the respondents are presented in Table 2. It can be observed that evacuation from home of abode remain the most prevalent traumatic event which is experienced by 84.8% the respondents. This was closely followed by lack of food which was experienced by 84.5% of the respondents. We observed that separation from love ones, disappearance of love as well as carting away of possession each was experienced by 77.2 % of the displaced persons. Moreover, lack of shelter, destruction of properties, and lack of clothing were experienced by 76.9%, 76.3% and 72.3% of the respondents respectively.70.5% of the respondents have witnessed the death of a family member,68.1%

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witnessed the death of a family member, while another 67.8% have been inflicted with physical injuries. 66.9% have seen their family members beaten, 62.9% have seen them tortured while 58.4 % reported that they are suffering from ill health.

Table 3 Responses to the Events (N=329)

Variables	Not at all F (%)	Once in a week F (%)	2-3 times a week F (%)	4-5 times in a week F (%)	≥ 6 times per week F (%)
Unwanted upsetting memories about the event	26(7.9)	45(13.7)	133(40.4)	112(34.0)	13(4.0)
Bad dream or Nightmare related to trauma	42(12.8)	62(18.8)	100(30.4)	92(28.0)	33(10.0)
Reliving the traumatic event/feelings as if happening again	45(13.7)	52(15.8)	122(37.1)	98(29.8)	12(3.6)
Feeling very emotional upset when reminded of trauma	39(11.9)	46(14.0)	110(33.4)	108(32.8)	26(7.9)
Having physical racism when reminded trauma sweating	46(14.0)	35(10.6)	101(30.7)	134(40.7)	13(4.0)
Trying to avoid through/feeling related to trauma	51(15.5)	36(10.9)	118(35.9)	112(34.0)	12(3.6)
Trying avoid activities, situation or place of trauma or that feels mere dangerous since trauma	47(14.3)	52(15.8)	115(35.0)	93(28.3)	22(6.7)
Not being able to remember important part of the trauma	83(25.3)	29(8.8)	107(32.5)	99(30.1)	11(3.3)
Seeing yourself others or in the world in the negative way (I cannot trust people)	66(201.1)	37(11.2)	108(32.8)	95(28.9)	23(7.0)
Blaming yourself or others (besides the people that hurt you) for what happened	81(24.6)	36(10.9)	111(33.7)	88(26.7)	13(4.0)
Having intense feelings like fear, horror, anger, guilt or shame	46(14.0)	50(15.2)	116(35.2)	97(29.5)	20(6.1)
Losing interest or not participating in advices you used to do	45(13.7)	36(10.9)	136(41.3)	99(30.1)	13(4.0)
Feeling distance or cut off from other	49(14.9)	51(15.5)	119(36.2)	99(30.1)	11(3.3)
Having difficulty in experiencing positive feelings	48(14.6)	51(15.5)	104(31.6)	112(34.0)	14(4.3)
Acting more irritable or aggressive with others	52(15.8)	50(15.2)	115(35.0)	93(28.3)	19(5.8)
Taking more risk or doing things that might cause you or other harm (e.g. driving recklessly, taking drugs, having unprotected sex)	93(28.3)	57(17.3)	78(23.7)	81(24.6)	20(6.1)

Table3 shows how these displaced persons are responding to their traumatic events. It can be observed that 13.4% of the respondents experienced being jumpy or more easily distracted, 13.1% experienced being overtly alert or on guard and 10.0% experienced bad dreams or nightmare related to trauma 6 or more times per week. We also observed that more than one-third of the respondents (40.7%) have physical racism 4-5 time per week when reminded of trauma, 37.1% and 36.5% have trouble concentrating and falling or staying asleep 4-5 times per week respectively. The table also shows that unwanted upsetting memories, avoiding

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thought or feeling related to trauma as well as difficulty in experiencing positive feelings each was experienced 4-5 times per week by more than a third of the respondents (34.0%). Furthermore, 32.8% reported feeling very emotionally upset when reminded of the trauma 4-5 times per week. In addition, inability to recall important parts of the trauma, lack of interest in usual activities and

feeling distant or cut off from others were each experienced 4-5 times per week by 30.1% of the respondents. 4.3% of the respondents have trouble falling or staying asleep 2-3 times in a week. Lacking of interest in usual activities and having trouble concentrating were each experienced 2-3 times in a week by 41.3% of the respondents. 40.4% had unwanted memories, 37.1% relieve the traumatic experience, while another 35.9% try to avoid thought or feeling relating to the trauma 2-3 times a week each. Furthermore, 35.2% have intense feeling like fear, horror, anger, guilt or shame while another 35.0% try to avoid activities, situations or place that feel threatening since their traumatic experience 2-3 times a week

Table 4 Respondents Copying Styles (N= 329)

Variables	Yes (%)	No (%)
Active coping	231(70.2)	98(29.8)
Planning	252(76.6)	77(23.4)
Suppression of competing activities	197(59.9)	132(40.1)
Restraint coping	200(60.8)	129(39.2)
Seeking social support instrumental	212(64.4)	117(35.6)
Seeking social support emotional	253(76.9)	76(23.1)
Positive reinterpretation and growth	262(79.6)	67(20.4)
Acceptance	252(76.6)	77(23.4)
Turning on religion	199(60.5)	130(39.5)
Focus/Venting of emotions	232(70.5)	97(29.5)
Denial	218(66.3)	111(33.7)
Behavioural disengagement	229(69.6)	100(30.4)
Mental disengagement	231(70.2)	98(29.8)
Alcohol disengagement	229(69.6)	100(30.4)

As presented in table 4, the coping style mostly use by the respondents (79.6%) is positive reinterpretation and growth. This was closely followed by seeking social support which is been utilized by 76.9% of the respondents. Acceptance and planning are utilized by 76.6% of the respondents each while focus/venting of emotion is utilized by 70.5% of the respondents. 70.2% of the respondents reported the use of active coping and mental disengagement each while 69.6% of the internally displaced persons reported behavioural disengagement as their coping style. Table 4 also revealed that denial and seeking social support instrumental are utilized by 66.3% and 64.4% of the respondents respectively. We observed that 60.8% of the respondent utilized restraint coping, 60.5% utilized turned to religion while another 59.9% make use of suppression of competing activities in coping with their traumatic experience.

Hypotheses Testing

In order to test the hypotheses for this study, we used chi-square to determine the association between the selected variables (table 5). In testing for the first hypothesis, we observed a significant association between the employment status of the respondents and destruction of

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properties ($\chi 2$ = 11.883; p= 0.036). There is also a significant association between employment status and evacuation from home ($\chi 2$ = 11.350; p= 0.045). Those who have been employed and have worked hard to acquire properties are expected to feel bed seeing those properties destroyed. They are also not expected to be comfortable that they are evacuated from their home of abode as this will prevent them from engaging in their gainful employment.

The test for our second hypothesis revealed a significant association between evacuation from home and feeling very emotional upset when reminded of trauma ($\chi 2$ = 12.625; p= 0.013). We expect someone who have been ejected from their comfort zone to be emotionally upset anytime they remember the incidence that led to the evacuation

In order to test the third hypothesis, we observed a significant association between treatment with violence and focus on venting of emotion ($\chi 2$ = 7.557; p= 0.006). For someone that has been treated violently, expression of negative feeling is almost not out of place.

Testing our last hypothesis showed a statistically significant association between the sex of the respondents and acceptance as coping style ($\chi 2$ = 3.942; p= 0.047), a finding that is contrary to the finding of Saxon et al (2017) who observe no significant association between sex and acceptance. We also found a significant association between the religion of the respondents and use of instrumental social support ($\chi 2$ = 3.323; p= 0.190). These findings are in line with the submission of Thabet and Vostanis (2017) whose results showed that people with PTSD have higher statistically significant total coping score.

DISCUSSION OF FINDINGS

This study involves 329 internally displaced persons in the capital city of Nigeria. The socio-demographic characteristics of the respondents revealed that most of the respondents are males (57.8%). This result is similar to the findings of El-Kahlout and Thabet (2017) and Thabet and Vostanis (2017) who reported 51.5% and 53.9% male respondents respectively. The finding however contradicts that of Sheikh et al (2014) and Roberts et al (2009) who observed below average male respondents of 48.1% and 40.0% respectively. Akhunzada et al (2015) also observed that there were wore females (55.5%) than males in their study. This finding nullifies the assertion that women are more affected by traumatic events than men.

Our observation that most of the displaced persons (49.0%) falls within ages 20-29 years indicate that the many of the respondents are in their youthful age. This has serious implication on the nation's economy as these displaced youth are shot out of the labour force. The present study revealed that slightly more than half of the respondents (51.4%) are practicing Islam. A similar study (Sheikh et al, 2014) in the northern part of the country reported that all the respondents are practicing Islam. This is not unlikely as most of the displaced persons are from the northern part of the country which is predominantly Muslim community.

We observed that slightly more than half of the displaced persons are married (50.5%). Other studies reported higher proportion of married respondents. Roberts et al (2009) and Sheikh et al (2014) found that the proportion of married respondents in their studies is 76.6% and 59.7% respectively. The reason behind the lower proportion in our study may not be unconnected with the higher proportion of youth in our study. Considering the level of education of the respondents, we observed a higher proportion of respondents with tertiary education (23.7%) as against 2.2% reported by Sheikh et al (2014). Lower proportion of the displaced persons in

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our study have quranic education (15.5%) compare to 39.3% reported by Sheikh et al (2014). This disparity may be connected to the fact that 100% of the respondents in Sheikh et la (2014) are Muslims.

Lastly on the socio-demographic characteristics of the respondents, table 1 showed that 24.6% of the displaced persons were employed while 21.3% were unemployed. This finding is contrary to the findings of Sheikh et al (2014) where 66.1% of the displaced persons were unemployed. Akhunzada et al (2015) also found 31.8% of displaced persons in their Asian study to be unemployed.

Traumatic events experienced by the respondents

Similar to what was reported by Sheikh et al (2014), the most prevalent traumatic event experienced by the respondents is evacuation from home of abode. This may be explained by the inability of the respondents to perform their daily activities the way they would have done if they had being in their homes. This finding however deviate from that of Roberts et al (2009) who found lack of water as the most prevalent traumatic event reported by their respondents.

Our observation of lack of food occurring frequently high (84.5%) among the displaced persons contradict the finding of a similar local study (Sheikh et al, 2014) but is in line with a Ugandan study (Roberts et al, 2009). This may reflect the varying activities of donor agencies in the different internally displaced persons' camps across the country. Some camps may enjoy adequate and regular supply of food and other relief materials than others. It's been reported in the media that some food meant for the displaced persons are sometimes diverted by unscrupulous individuals.

The high frequency of separation from love one or disappearance of love one (77.2 %), and carting away of possession (77.2 %) in our study is similar to that reported by other studies (Roberts eta al, 2009; Sheikh et al, 2014). Other frequently reported traumatic events by the respondents include lack of shelter, destruction of properties, and lack of clothing. These findings are not surprising as most of the camps are not structurally okay, properties worth millions were destroyed especially for victims of bomb blast and because most of the victims were not prepare, they may not go to the camp with adequate clothing.

Respondents' response to the traumatic events

Table 3 presented the respondents response to the traumatic event. 13.4% of the displaced persons experienced being jumpy or more easily distracted 6 or more times per week. 13.1% experienced being overtly alert or on guard 6 or more times per week and 10.0% experienced bad dreams or nightmare related to trauma 6 or more times per week. These findings show that

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Table 5 Associations between selected variables

Employment		Destruction of properties		Df	$\chi 2$ Value	P-value
		Yes (n = 251)	No (n= 78)			
Employed	Unemployed	53 51	28 19			
Student	Retiree	21 10	8 1			
Trading	House wife	73 43	14 8	5	11.883	**0.036**
		Evacuation from the home of abode				
		Yes (n= 252)	No (n= 77)			
Employed	Unemployed	72	9 21			
Student	Retiree	49	9 3			
Trading	House	20	25	5	11.350	**0.045**
wife		8	10			
		62				
		41				
		Evacuation from the home of abode				
Feeling very emotionally upset when reminded of trauma		Yes (n= 279)	No (n= 50)			
Not at all	Once	28	11			
in a week	2-3 times	86	22			
a week	4-5 time a	99	11	4	12.625	**0.013**
week	6 or more	43	3			
time in a week		23	3			
Treated with violence		Focus/Venting of emotions				
		Yes (n= 232)	No (n= 97)			
Yes	No	178	60			
		54	37	1	7.557	**0.006**
Sex of the respondents		Acceptance as coping style				
		Yes (n= 252)	No (n= 77)			
Male		138	52			
Female		114	25	1	3.942	**0.047**
Religion of the respondent		Seeking social support instrumental as coping style				
		Yes (n= 212)	No (n= 117)			
Islam	Christianity	111	58			
Traditional		93	49	2	3.323	0.190
		8	10			

the respondents experience more hyper-arousal symptoms than other categories in line with observation of Yarvis, Yoon, Amenuke, Simien-Turner and Landers (2012). This however contradicts what Al Jadili and Thabet (2017) reported among cancer patients where avoidant category was prevalent. This indicates a high level of apprehension resulting from the traumatic

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experienced that brought them to camp. This may be due to boko haram insurgency and communal clashes experienced by the respondents.

We also observed that more than one-third of the respondents have trouble concentrating and falling or staying asleep 4-5 times per week respectively. This finding also buttresses our earlier point that hyper-arousal symptoms are prevalent among the respondents. The table also shows that re-experience and numbing symptoms also feature frequently among the internally displaced persons. This is evident as thought or feeling related to trauma as well as difficulty in experiencing positive feelings each was experienced 4-5 times per week by more than a third of the respondents. This finding is also in line with the finding of Yarvis et al (2012).

Coping styles adopted by the respondents

The most frequent coping style adopted by the respondents in this study is positive reinterpretation and growth. This is similar to the finding of other studies (Al Jadili & Thabet, 2017; Thabet & Vostanis, 2017) that was conducted among cancer patients and Palestinian adults respectively. Although Saxon et al (2017) reported planning as the most frequently used coping style (70.9%) in their study, the figure is close to 76.6% that was found in the present study (table 4). Use of emotional social support is also high among the respondents (76.9%), a result that is moderately higher than the finding of Saxon et al (2017) who reported that 63.7% of their respondent use emotional social support. This also contrasted with the finding of Thabet and Vostanis (2017).

In line with the finding of Saxon et al (2017), who reported 69.2% and 70.9%, acceptance and planning each was utilized by 76.6% of respondents in the present study. Contrary to the finding of 24.7% frequency of focus on and venting of emotion reported by Saxon et al (2017), we found that a far higher 70.5% of the displaced persons utilized same in our study. 70.2% of the respondents reported the use of active coping and mental disengagement each in our study. Similar finding was found by Saxon et al (2017). The least widely reported coping styles among the respondents are suppression of competing activities and turning on religion as against gambling and substance abuse reported by Saxon et al (2017). These displaced persons utilized both problem focused and emotional focused coping strategies in dealing with their traumatic experience.

Implication for Mental Health /Psychiatric Nursing

This study observed that internally displaced person displaced various types of traumatic events and in order to maintain status quo, majority of them employed different degrees of coping strategies whether negative or positive. It is therefore imperative for Psychiatric Nurses to understand various types of positive coping strategies which they must employ, while caring for patients that would have being resettled and prone to mental agonies. The curricula in the school of Psychiatric nursing should have an opportunity for teaching different types of coping styles and traumatic events that could make patients to develop mental illness.

CONCLUSION

The internally displaced persons in the present study experienced different types of traumatic events with evacuation from home of abode and lack of food been the most frequent. They also presented with varying degree of responses to the traumatic event with more of hyper-arousal

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symptoms. They adopted mixture of problem focused and emotional focused coping strategies prominent among which include positive reinterpretation and growth, seeking emotional social support, acceptance and planning.

REFERENCES

Akhunzada, W. A., Qadir, A., Maqsood, N., Rasool, G. & Rehman (2015). Internally displaced persons (IDPS): Anxiety and depression. Professional Med J 22(3), 337-342.

Al Jadili, M. & Thabet, A. A (2017). The Relationship between post-traumatic stress disorder and coping strategies among patients with cancer in Gaza Strip. J Nurs Health Stud 2:1

Aldwin, C., M. & Yancura, L., A. (2004) Coping and health: A comparison of the stress and trauma literatures. In: Schnurr PP, Green BL (Eds.), trauma and health: Physical health consequences of exposure to extreme stress. American Psychological Association, Washington, DC, 99-125.

Araya, M., Chotai, J., Komproe, I. H. & de Jong, J.T.V.M. (2007). Gender differences in traumatic life events, coping strategies, perceived social support and socio-demographics among post-conflict displaced persons in Ethiopia. Soc Psychiatry Psychiatr Epidemiol 42:307-315

Campbell-Sills, L., Cohan, S. L., & Stein, M. B. (2006). Relationship of resilience to personality, coping, and psychiatric symptoms in young adults. Behav Res Ther, *44*(4), 585-599. doi: 10.1016/j.brat.2005.05.001

Carballo, M., Smajkic, A., Zeric, D., Dzidowska, M., Gebre-medhin, J. & Halem, J. V. (2004) Mental health and coping in a war situation: the case of Bosnia and Herzegovina Journal of Biosocial Science, 36 (4) 463-477 doi: DOI:10.1017/ S0021932004006753

Carver, C. S. & Connor-Smith, J. (2010).Personality and coping. Annu Rev Psychol 61: 679-704.

de Jong, J., T., V., M., Komproe, I., H., van Ommeren, M. (2003). Common mental disorders in postconflict settings. Lancet 361: 2128-2130.

de Jong, J., T., V., M., Komproe, I., H., van Ommeren, M., el Masri, M., Araya, M., Khaled, N., van de Put, W. & Somasundaram D. (2001). Lifetime events and posttraumatic stress disorder in 4 post-conflict settings. JAMA 286: 555-562.

Deeny, P. & McFetridge, B. (2005). The impact of disaster on culture, self, and identify: Increased awareness by health care professionals is needed. Nursing Clinics of North America, 40(3), 431–444.

El-Kahlout, A., M, & Thabet, A., A. (2017). Effects of political and community violence on mental health of adolescence in Gaza Strip. J Cog. Psyc.1

Exline, J., J., Smyth, J., M., Gregory, J., Hockemeyer, J. & Tulloch, H. (2005). Religious framing by individuals with PTSD when writing about traumatic experiences. Int J Psychol Relig 15: 17-33

Folkman, S. & Moskowitz, J. T. (2004). Coping: pitfalls and promise. Ann Rev Psychol 55: 745-774.

Halepota, A. & Wasif, S.(2001). Hopkins Symptoms Checklist 25 (HSCL-25) Urdu translation: an instrument for detecting anxiety and depression in torture and trauma victims. J Pak Med Assoc 51(7), 255-257.

in Practice, 1,159-173

ISSN 2055-0170(Print), SSN 2055-0189(Online)

Khamis, V. (2012). Impact of war, religiosity and ideology on PTSD and psychiatric disorders in adolescents from Gaza Strip and South Lebanon. Soc Sci Med, 74(12), 2005-2011. doi: 10.1016/j.socscimed.2012.02.025

Khamis, V. (2015). Coping with war trauma and psychological distress among school-age Palestinian children. Am J Orthopsychiatry, *85*(1), 72-79. doi: 10.1037/ort0000039

Lansford, J. E., Dodge, K. A., Pettit, G. S., Bates, G. E., Crozier, J., & Kaplow, J. (2002). A 12-year prospective study of the long-term effects of early child physical maltreatment on psychological, behavioral, and academic problems in adolescence. Archives of Pediatric and Adolescent Medicine, 156(8), 824–830.

Lazarus, R.S. & Folkman, S. (1984). Stress, Appraisal, and Coping. Springer, New York.

Littleton, H., Horsley, S., John, S. & Nelson, D. V. (2007). Trauma coping strategies and psychological distress: A meta-analysis. J Trauma Stress 20: 977-988.

Luszczynska, A., Benight, C. C., & Cieslak, R. (2009). Self-efficacy and health-related outcomes of collective trauma: A systematic review. Eur Psychol 14: 51-62.

Mnookin, S., et al. (2016). Populations Mental Health in Post Conflict Contexts." Advances in Psychiatry 2: 163.

Momatrin, S., Steel, Z., Coello, M., et al. (2006). A comparison of the mental health of refugees with temporary versus permanent protection visas. Med J Austr 185:357-361.

Norwegian Refugee Council (2009). Nigeria: No end to Internal Displacement. Geneva: IDMC global project.

Norwegian Refugee Council (2012). Nigeria, a profile of the internal displacement situation June, 2012 Geneva: IDMC global project.

Office of the High Commissioner for Human Right (2007). Internally Displaced People. Retrieved 4/12/2009 from *http//:www.unhcr.org.*

Paardekooper, B., de Jong, J. T. V. M., & Hermans, J. M. A. (1999). The psychological impact of war and the refugee situation on South Sudanese children in refugee camps in Northern Uganda: an exploratory study. J Child Psychol Psychiatry 40:529-536.

Perez Sales, P., Cervellon, P., Vazquez, C., et al. (2005). Posttraumatic factors and resilience: the role of shelter management and survivors' attitudes after the earth quakes in El Salvador. J Community Appl Soc Psychol 15:368-382.

Rafnsson, F. D., Smari, J., Windle, M., et al. (2006). Factor structure and Psychometric characteristics of the Icelandic version of the Coping Inventory for Stressful Situations (CISS). Pers Individ Diff 40: 1247-1258

Sandler, I. N., Tein, J. Y., & West, S. G. (1994). Coping, stress, and the psychological symptoms of children of divorce: a cross-sectional and longitudinal study. Child Dev, 65(6), 1744-1763.

Saxon, L., Makhashvil, N., Chikovani, I., Seguin, M., McKee, M., Patel, V., Bisson, J. & Robert, B. (2017). Coping strategies and mental health outcomes of conflict-affected persons in the Republic of Georgia Epidemiology and Psychiatric Sciences, 26, 276–286. doi:10.1017/S2045796016000019

Solomon, Z., Gelkopf, M., & Bleich, A. (2005). Is terror gender-blind? Gender differences in reaction to terror events. Soc Psychiatry Psychiatr Epidemiol 40:947-954.

Steel, Z., Silove, D., Brooks, R., et al. (2006). Impact of immigration detention and temporary protection on the mental health of refugees. Br J Psychiatry 188:58-64.

Summerfield, D. (1991). The psychosocial effects of conflict in the Third World. Development

ISSN 2055-0170(Print), SSN 2055-0189(Online)

Thabet, A. A., & Vostanis, P. (2017). Relationships between traumatic events, religious coping style, and post-traumatic stress disorder among Palestinians in the Gaza Strip. J Nurs Health Stud. 2:1

Townsend, M. C. (2011). Psychiatric mental health nursing: Concepts of care in evidence-based practice 6th edn F.A. Davis Company Philadelphia

Videbeck, S. L. (2003). Foundations of psychiatric-mental health nursing (2nd Edition), Lippincott Williams & Wilkins, Philadelphia

Wadsworth, M. E., Santiago, C. D., & Einhorn, L. (2009). Coping with displacement from Hurricane Katrina: predictors of one-year post-traumatic stress and depression symptom trajectories. Anxiety, Stress, & Coping, 22(4), 413-432.

World Bank (2016). Forcibly Displaced: Toward a development approach supporting refugees, the internally displaced, and their hosts. Washington, DC: World Bank. © World Bank. https://openknowledge.worldbank.org/handle/10986/25016 License: CC BY 3.0 IGO

World Health Organization (2014). Global status report on violence prevention

Yarvis, J. S., Yoon, E., Amenuke, M., Simien-Turner, S., & Landers, G. D. (2012). Assessment of PTSD in older veterans: The Posttraumatic Stress Disorder Checklist: Military Version (PCL-M) Advances in Social Work Vol. 13(1),185-202

Yehuda, R. (2002) Post-traumatic stress disorder. (Review Article) N Engl J Med, 346 (2), 108-114.

Zust, B. L. (2000). Effect of cognitive therapy on depression in rural, battered women. Archives of Psychiatric Nursing, 14(2), 51–63.

2014.http,//www.who.int/violence_injury_prevention/violence/status_report/2014/report/report/en/

ISSN 2055-0170(Print), SSN 2055-0189(Online)