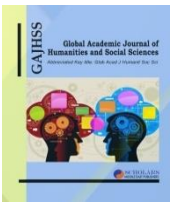
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Review Article

Post-Traumatic Stress Disorder in the Nigerian Army, Military Operations, and National Security, 1999–2020

Yusuf Salisu[1]*
[1]Postgraduate School, National Defence Academy, Kaduna, Nigeria

***Corresponding Author**
Yusuf Salisu
Postgraduate School, National Defence Academy, Kaduna, Nigeria

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Abstract: This article examines post-traumatic stress disorder (PTSD) among personnel of the Nigerian Army (NA) and its implications for national security between 1999 and 2020. The article argues that PTSD should not be treated solely as an individual medical problem because the mental health of military personnel is connected to operational effectiveness, family stability, troop availability, discipline, and the wider capacity of the state to provide security. The study employed historical, narrative, and analytical approaches and drew on primary and secondary materials. The research identifies prolonged deployment, combat exposure, death and injury of colleagues, captivity, sleep deprivation, fatigue, fear, violent encounters, and other operational experiences as important sources of trauma. It also identifies stigma, inadequate mental health personnel and facilities, weak data systems, low awareness, fragmented management arrangements, and insufficient collaboration as barriers to effective PTSD management. The article further examines the effects of PTSD on the protection of lives and property, troop availability, citizen well-being, family relationships, and socio-economic activity. Drawing on systems theory, it demonstrates how difficulties within the individual military subsystem can spread through the family, organizational, and societal systems and eventually affect national security. The article concludes that effective PTSD management requires a coordinated mental health policy, improved specialist capacity, and stronger inter-service and civilian collaboration.

Keywords: Post-Traumatic Stress Disorder, Nigerian Army, Military Operations, Combat Stress, Mental Health, National Security.

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INTRODUCTION

The nature of military service has changed considerably in recent decades. Armed forces that were once organized mainly around conventional warfare between states are now routinely called upon to perform a much wider range of duties. These include internal security operations, counter-insurgency, counter-terrorism, peace support, and peace enforcement missions, often involving long periods away from home. Such deployments expose soldiers to experiences that can leave effects well beyond physical injuries and battlefield casualties. Fear, prolonged uncertainty, witnessing death or serious injury, captivity, destruction, exhaustion, lack of sleep, and the loss of colleagues can all have lasting psychological consequences. For some personnel, these experiences may continue to affect their lives long after they have returned from the operational theater. It is against this background that the present article examines the Nigerian experience, with particular attention to the Nigerian Army between 1999 and 2020.

The Nigerian Army occupies a particularly important place in the country's national security system (Adler *et al*., 2015; McDermott 2016). Since the return to democratic government in 1999, it has become increasingly involved in security operations both within Nigeria and in international peace-support missions. This period also witnessed significant changes in the country's security environment. Insurgency, terrorism, communal violence, banditry, and other forms of internal insecurity either emerged or became more pronounced, placing additional demands on the military. Research on banditry and responses to its threat in northwestern Nigeria provides further context for understanding the security challenges confronting Nigerian security institutions during this period (Sarkin Gulbi *et al*., 2024). The choice of 1999 as the starting point is therefore significant because it marks the return of the Nigerian Army more clearly to its constitutional role under civilian authority. The year 2020, on the other hand, provides a useful endpoint because by then concerns about PTSD among military personnel, particularly those involved in operations in north-eastern Nigeria, had become increasingly visible. The establishment of a centre at Jaji to deal with such cases was also an important development during this period (Department of Peace Support Operations 1960–2017).

At the heart of the study is a fairly straightforward but important question: what happens to national security when the psychological well-being of the personnel responsible for providing security is seriously affected? The paper identifies an inverse relationship between PTSD and national security. In practical terms, poorly managed PTSD can reduce personnel availability and undermine operational effectiveness, while effective prevention, early identification, treatment, and rehabilitation can help maintain the Army's capacity to carry out its security responsibilities. This relationship provides the main thread running through the discussion that follows. It would, however, be misleading to suggest that PTSD automatically leads to indiscipline, aggression, or violence. The evidence in the source study does not support such a simple conclusion. Instead, it points to these outcomes as possible risks associated with particular cases and experiences. There is also a need to draw a clear line between ordinary operational stress, short-term combat reactions, and clinically diagnosed PTSD. These conditions are related, but they are not necessarily the same thing. The study acknowledges that it did not distinguish between the different stages or forms of PTSD and instead considered the identified cases collectively. That limitation is retained here. Consequently, the article does not treat every sign of stress, behavioural change, or emotional difficulty among soldiers as evidence of a clinical PTSD diagnosis.

The paper examines PTSD in the Nigerian Army between 1999 and 2020 and its wider implications for national security. It first discusses the concepts of PTSD and national security and applies systems theory to explain their relationship. It then traces the historical background of military trauma and examines combat exposure and operational stress. It further considers the effects of PTSD on security and socio-economic well-being before assessing institutional challenges and prospects for improving PTSD management in the Nigerian Army.

Conceptual and Theoretical Discussion

Understanding PTSD in the Nigerian Army requires moving beyond the individual soldier and examining the wider institutional and social environment in which military service takes place. The condition may begin with an individual's exposure to a traumatic event, but its consequences do not necessarily remain at the individual level (Florence and Inakwu 2022, 402–406). They can extend to the soldier's family, military unit, wider army organization, and, ultimately, the society that depends on the armed forces for protection. It is within this broader relationship that the present study applies systems theory as its principal theoretical framework.

Systems theory views society as a collection of interconnected parts whose activities and conditions influence one another. A change in one part of the system can therefore produce consequences elsewhere. Applied to the Nigerian Army, the individual soldier, family, military unit, Army, Armed Forces of Nigeria, and wider society can be understood as interconnected levels of a single system. The usefulness of this perspective lies particularly in its ability to show how what initially appears to be an individual mental-health problem can gradually acquire organizational and national-security implications. For example, a soldier who has experienced severe trauma may require psychological or medical intervention. Where such support is unavailable or delayed, symptoms may persist and begin to affect the soldier's behavior, relationships, and ability to perform routine duties. The consequences can then move outward. Family relationships may become strained, while prolonged absence or reduced capacity for duty can place additional pressure on other members of a unit. At the organizational level, repeated cases may affect manpower availability, morale, unit cohesion, and operational effectiveness. Beyond the military institution itself, any significant reduction in the capacity of security personnel to perform their

responsibilities may have implications for the state's ability to respond effectively to security threats. In this sense, mental health is not simply a private or medical matter; under particular circumstances, it can become part of the functioning of the wider security system (Gibson 2020).

The framework also helps explain why the management of PTSD cannot be restricted to treating individual symptoms after they have appeared. Prevention, early identification, professional treatment, rehabilitation, family support, personnel management, and institutional policy are connected components of the same process. A weakness in one area can place additional pressure on others. For instance, inadequate awareness may contribute to delayed reporting; delayed reporting may lead to more serious or persistent difficulties; and the resulting condition may require longer periods of treatment or absence from duty. The problem, therefore, needs to be considered as a chain of interconnected relationships rather than as an isolated clinical event. At the same time, systems theory has its limitations. Its emphasis on relationships, adaptation, and the functioning of interconnected parts does not, by itself, adequately explain why some institutions respond to psychological trauma more effectively than others. Issues of institutional culture, leadership, resources, professional capacity, military attitudes towards mental health, and the wider socio-cultural environment also shape the way PTSD is understood and managed. These wider social and cultural conditions are relevant in the Nigerian context, where changes in traditional social relationships and community cohesion may influence the support networks available to individuals and families (Sani, Shehu, and Bazango 2025). The theory is consequently used here primarily as an organizing framework, rather than as a complete explanation of the causes or clinical dimensions of PTSD. Clinical, social, organizational, and cultural factors remain important to the analysis. The central implication of the framework is nevertheless clear. Supporting the mental health of military personnel can have consequences beyond the individual soldier. Effective mental-health management can contribute to personnel availability and organizational functioning, help reduce pressures on military families, and, indirectly, support the capacity of the security system as a whole. This provides the theoretical basis for examining PTSD not only as a health concern but also as an issue with wider institutional and national-security implications (Gibson 2020; Akpeninor 2012; Brown 1983).

The research draws on definitions of PTSD associated with the Mayo Clinic, the National Institute of Mental Health, and the American Psychiatric Association. Although the wording differs among these sources, they broadly connect PTSD with exposure to frightening, shocking, or dangerous experiences followed by persistent psychological responses. The American Psychiatric Association formulation used in the study is particularly relevant to military personnel because it recognizes war- and combat-related experiences among potential traumatic events and notes that symptoms may continue for months or even years. Such symptoms can affect relationships, concentration, judgement, productivity, and everyday functioning. In the context of the Nigerian Army, the source study presents PTSD as a serious psychological condition associated with recurring memories of frightening, tragic, or violent experiences. It identifies a range of manifestations, including anxiety, depression, suicidal tendencies, aggression, substance abuse, withdrawal, and difficulties in maintaining stable personal and family relationships. These manifestations are particularly significant in a military environment because the soldier is expected to function effectively within a highly disciplined and demanding organization (American Psychiatric Association, n.d.; Mayo Clinic 2022; Salisu 2023, 17–20).

The study adopts a broad conception of national security rather than limiting the concept to military defense or the protection of Nigeria's territorial boundaries. Security is understood to include the protection of lives and property, territorial integrity, socio-economic well-being, psychological and mental health, and the ability of citizens to live and pursue legitimate activities without persistent fear or danger. This broader understanding is important for the present discussion because the consequences of military mental-health problems may extend beyond the barracks. A soldier's psychological condition can affect family relationships, workplace performance, and unit functioning, while weaknesses in military effectiveness can have consequences for the wider population. National security, therefore, is not produced by military force alone. It also depends on the well-being and functional capacity of the personnel who constitute an important part of the state's security apparatus (Holmes 2015; Brown 1983; Akpeninor 2012).

The relationship between PTSD and national security can be understood as a series of connected processes rather than a simple cause-and-effect relationship. At the individual level, a soldier experiencing serious psychological difficulties may require treatment, may be temporarily unavailable for deployment, or may experience difficulties with concentration, judgement, interpersonal relationships, and routine responsibilities. Where such cases become sufficiently numerous or remain

inadequately managed, their effects may extend to the military organization. At the unit level, personnel shortages can increase the workload placed on other soldiers, while persistent psychological difficulties may affect morale, cohesion, and the ability of personnel to function effectively together. At the institutional level, these pressures may influence manpower management, deployment patterns, and operational effectiveness. The family represents another important part of this system. Prolonged deployment and psychological distress can place pressure on spouses and other family members, particularly where behavioral changes continue after a soldier returns from an operation. The wider implications become more apparent when these effects are considered against the security responsibilities of the Nigerian Army. Where personnel are unavailable, poorly supported, or unable to perform their duties effectively, the state may face additional difficulties in responding to security threats. In turn, weaknesses in the security environment can affect the safety and well-being of civilians and disrupt normal social and economic activities. The relationship is therefore best understood as a feedback process: operational environments can expose soldiers to trauma; trauma can affect personnel and families; weaknesses in mental-health management can affect military functioning; and reduced military effectiveness can, under particular circumstances, contribute to wider security pressures (Florence and Inakwu 2022, 402–406). This does not suggest that PTSD, by itself, determines national-security outcomes. National security is shaped by numerous interacting factors, including leadership, intelligence, training, equipment, logistics, political authority, economic conditions, institutional capacity, and the actions of armed groups and other security threats. The contribution of this study is narrower but important: it places the mental health of military personnel within that larger security system. PTSD should consequently not be treated solely as a medical problem affecting individual soldiers. Where it is widespread, poorly recognized, or inadequately managed, it can also become an organizational concern with potential implications for military effectiveness, family stability, and the wider security environment.

Historical Background of Trauma and Nigerian Military Operations

The relationship between warfare and psychological trauma is not a new phenomenon. Long before post-traumatic stress disorder became an established clinical term, military physicians and soldiers had described emotional and behavioral disturbances associated with combat. Soldiers returning from war were reported to experience persistent fear, nightmares, insomnia, exhaustion, anxiety, withdrawal, irritability, and difficulties in readjusting to ordinary life. What changed over time was less the existence of these reactions than the language used to describe and understand them. Terms such as "soldier's heart," "shell shock," "war neurosis," "battle fatigue," and "combat exhaustion" appeared at different periods in the development of military psychiatry. During the First World War, for example, shell shock became a major military-medical problem, with symptoms including fatigue, tremors, confusion, and nightmares. The British experience eventually encouraged the development of approaches that emphasized early psychological intervention and treatment close to the operational area (Florence and Inakwu 2022, 402–406).

The historical development of military psychiatry is important because it demonstrates that the psychological consequences of combat have often been closely connected to the way armed forces organize, deploy, and support their personnel. Industrial warfare, mass mobilization, and prolonged exposure to artillery, bombardment, and battlefield casualties during the First and Second World Wars made psychological casualties increasingly difficult to ignore. By the Second World War, the British and American militaries had developed more systematic approaches to combat stress, including forms of forward psychiatry that sought to return affected personnel to their units where appropriate. The later emergence of PTSD as a recognized psychiatric diagnosis therefore represented the culmination of a much longer history of attempts to understand how exposure to extreme violence can affect those who fight wars. This wider history provides a useful starting point for examining the Nigerian case.

Military service in Nigeria has itself been shaped by repeated exposure to conflict, internal security operations, and expeditionary deployments. The experience did not begin with the Fourth Republic. Nigerian soldiers had already served in major overseas campaigns during the colonial period. During the Second World War, Nigerian troops fought as part of British imperial forces in East Africa and Burma. The 81st and 82nd West African Divisions included substantial numbers of Nigerian soldiers and operated under extremely demanding conditions involving jungle warfare, disease, difficult terrain, monsoon weather, and sustained combat. The National Army Museum describes the Burma campaign as one of the most demanding theatres of the war and notes the particular conditions faced by West African troops.

The experience of Nigerian troops in Burma is especially relevant to a history of military trauma. Their service involved prolonged separation from home, exposure to combat, and witnessing the death

and injury of fellow soldiers. Accounts of individual Nigerian veterans, including soldiers who were wounded in Burma, provide a more personal sense of the dangers involved. Although the available historical record does not allow the psychological condition of these soldiers to be retrospectively classified as PTSD, their experiences demonstrate that Nigerian military personnel had been exposed to severe combat stress long before the contemporary language of PTSD became part of military health policy. The point is therefore not to impose a modern clinical diagnosis on historical actors but to recognize the continuity of exposure to potentially traumatic military experiences.

Independence did not bring an end to such exposure. Indeed, Nigeria quickly acquired an important role in international peacekeeping. In 1960, the same year the country gained independence, Nigerian personnel participated in the United Nations operation in the Congo. Nigeria subsequently became one of the more sustained contributors to international peace operations, serving in numerous missions over the following decades. The United Nations records that Nigeria has participated in dozens of peace operations since the 1960s. The Congo experience was particularly significant because the operation itself involved a volatile political and military environment. More generally, peacekeeping was not always a low-risk activity. Depending on the mandate and local circumstances, Nigerian personnel could find themselves exposed to armed confrontation, civilian violence, unstable ceasefires, humanitarian emergencies, and the threat of attack.

The experience of the Nigerian military in West African peace enforcement became even more demanding with the emergence of the Economic Community of West African States Monitoring Group (ECOMOG). Nigeria played a major role in the Liberian conflict from the early 1990s. The United Nations records that ECOMOG was established in 1990 and that Nigerian troops formed the largest component of the force during important phases of the operation. By 1995, Nigeria was contributing nearly 5,000 personnel to ECOMOG in Liberia. The operation was considerably more dangerous than the conventional image of peacekeeping might suggest. ECOMOG personnel operated in a country experiencing continuing armed conflict, shifting alliances, attacks, and serious insecurity. Nigerian and Ugandan soldiers were, at different points, abducted and held by armed factions.

The human cost was substantial. In a 1998 briefing at the United Nations, Nigeria's Permanent Representative reported that the Liberian operation had resulted in the deaths of approximately 200 Nigerian soldiers and injuries to about 1,000 military personnel. These figures are significant for the present argument because they illustrate the intensity of the operational environment in which Nigerian personnel served. They also complicate any simple distinction between "peacekeeping" and combat. In practice, Nigerian troops could move between monitoring, patrols, protection duties, and direct military engagements within the same broader mission.

The experience in Sierra Leone followed a similar pattern. ECOMOG became involved in the country's conflict and, in 1998, launched a military operation that resulted in the collapse of the military junta and the restoration of President Ahmad Tejan Kabbah to office. The United Nations subsequently established the United Nations Observer Mission in Sierra Leone (UNOMSIL) and later the United Nations Mission in Sierra Leone (UNAMSIL). These operations exposed Nigerian personnel to another prolonged and unstable conflict environment. The cumulative effect of repeated deployments of this kind is important when considering the psychological burden carried by military personnel. A soldier who has experienced one difficult deployment may subsequently be sent to another operational theatre with little opportunity for psychological recovery.

The Nigerian Civil War of 1967–1970 represents an even more important point in this historical trajectory. The conflict involved sustained conventional and irregular fighting, large-scale casualties, displacement, and prolonged deployment. For Nigerian soldiers, the war was not simply an overseas mission; it was a conflict fought within their own country and, in many cases, in environments with which they had personal or familial connections. The psychological burden of fighting a prolonged civil war could therefore involve not only fear of death and physical injury but also separation from family, exposure to civilian suffering, and the difficulties associated with fighting within a deeply divided society.

It is important, however, to avoid projecting today's clinical categories too readily onto the Civil War generation. The existence of trauma does not in itself demonstrate that particular soldiers suffered from clinically diagnosed PTSD. Rather, the Civil War is relevant because it formed part of the institutional history through which the Nigerian military accumulated experience of prolonged combat, casualties, and psychological strain. The available historical literature also suggests that the Nigerian military inherited and retained a strong internal-security orientation, rather than developing solely as a conventional war-fighting institution. This background became important because the Army

repeatedly found itself deployed against domestic disturbances after independence.

These deployments were numerous. Historical accounts of Nigerian Army internal-security operations identify engagements ranging from the Nigerian Civil War to the Maitatsine disturbances of the 1980s, the Zango-Kataf crisis, the Ogoni crisis, communal conflicts, and other domestic security operations. The significance of this pattern is that Nigerian soldiers were repeatedly required to move between conventional military duties and operations involving civilians, public disorder, and irregular forms of violence. Such environments can generate distinctive psychological pressures because the boundaries between soldier, peacekeeper, and internal-security actor become less clearly defined.

By the beginning of the Fourth Republic in 1999, therefore, the Nigerian Army was not entering an entirely new operational environment. It was carrying forward a long history of combat, peacekeeping, internal-security deployment, and exposure to violence. What changed after 1999 was the scale, duration, and diversity of the operational demands placed upon the force. The return to democratic government coincided with an expanding security agenda that increasingly required military involvement in domestic operations. Insurgency in the Northeast, terrorism, communal conflict, oil-related insecurity, militancy, and, later, banditry and other forms of armed violence meant that soldiers were repeatedly deployed for extended periods. Research on banditry in northwestern Nigeria, including accounts of the actors involved and the challenges of addressing the threat, provides additional context for understanding the complex security environment confronting Nigerian security institutions during this period (Sarkin Gulbi *et al*., 2024).

The Northeast became particularly important. Operations against Boko Haram placed soldiers in an environment characterized by asymmetric warfare, ambushes, improvised explosive devices, suicide attacks, attacks on military formations, and the persistent threat of civilian casualties. Unlike a conventional war with a clearly defined front, counter-insurgency could involve uncertainty over where and when an attack might occur. Soldiers could spend long periods in isolated locations, experience inadequate sleep, witness the deaths of colleagues and civilians, and remain under the threat of attack even when not engaged in active combat. These conditions are relevant to the study of PTSD because repeated exposure to danger and traumatic events can accumulate over time.

The operational environment was also complicated by the length of deployment. Repeated or prolonged deployment can mean that personnel have limited opportunities to return home, recover psychologically, and reconnect with family life. Fatigue, sleep disruption, and separation from spouses and children may compound the effects of combat exposure. The issue is particularly important in the Nigerian context because military operations have often been conducted alongside peace support, internal security, and humanitarian responsibilities. The soldier is therefore not simply exposed to one isolated traumatic incident but may experience a succession of demanding assignments. This historical trajectory provides an important context for understanding the emergence of PTSD as a more visible military-health concern in Nigeria. The problem should not be interpreted as something that suddenly appeared with Boko Haram or the post-1999 security environment. Rather, the contemporary concern represents the intersection of an older history of military exposure with a changing understanding of psychological trauma. Earlier generations of Nigerian soldiers experienced war and other forms of extreme operational stress, but the institutional language and mechanisms available for identifying and managing these experiences were more limited. By the Fourth Republic, however, international developments in military psychiatry and growing awareness of PTSD provided a stronger conceptual basis for recognizing the psychological consequences of military service.

The historical record also points to an important institutional question. Nigeria's military has accumulated considerable operational experience, but operational experience does not automatically translate into an equally developed system for managing psychological casualties. The history of Nigerian participation in the Congo, Liberia, Sierra Leone, and other missions demonstrates the extent to which personnel have repeatedly been exposed to difficult environments. Yet the existence of repeated exposure does not, by itself, establish that adequate psychological support was available after each deployment. This distinction is central to the present study. The period from 1999 to 2020 can consequently be understood as a new phase in a much longer history. The Nigerian Army entered the Fourth Republic with decades of experience in combat, peacekeeping, and internal security operations behind it. It then encountered a security environment that required even more sustained deployment, particularly in counter-insurgency operations. The growing recognition of PTSD during this period therefore reflected not simply a new medical diagnosis but a deeper institutional challenge concerning how an army that is repeatedly exposed to traumatic environments

preserves the psychological well-being, operational effectiveness, and long-term resilience of its personnel. Seen from this historical perspective, PTSD becomes part of the broader story of Nigerian military development. The issue connects the experiences of earlier generations of soldiers with the demands placed on the Army during the Fourth Republic. It also helps explain why psychological health deserves attention alongside conventional military concerns such as weapons, intelligence, logistics, training, and manpower.

Military Operations, Combat Exposure, and Sources of Trauma

The post-1999 period marked a significant expansion in the operational responsibilities of the Nigerian Army. In addition to its conventional defense role, the Army became increasingly involved in internal security operations, counter-insurgency, counter-terrorism, peace support, and peace-enforcement missions. These operations exposed personnel to a range of experiences capable of producing considerable psychological strain. The distinction between peacekeeping and combat was, in practice, often blurred. Missions initially conceived as peace support could become peace enforcement when armed groups resisted intervention, placing soldiers in situations involving hostile fire, explosions, casualties, death, captivity, and the loss of colleagues. The psychological consequences of such experiences could therefore extend well beyond the immediate period of deployment. (Department of Peace Support Operations 1960–2017; Akinola 2015.)

The source research identifies several interconnected stressors associated with military operations. Soldiers may spend prolonged periods in dangerous environments, experience sleep deprivation and physical exhaustion, hear sustained battle noise and explosions, witness the death or serious injury of colleagues, encounter near-death situations, endure captivity, or operate under difficult climatic and environmental conditions. These experiences can generate immediate physical and psychological reactions. The study refers, for example, to shaking, palpitations, sweating, weakness, and disorientation among the reactions that may follow exposure to extreme danger. Historically, military personnel have described similar reactions through terms such as "shell shock," "battle fatigue," and "war neurosis." In the Nigerian context, the source material connects such experiences with different periods of military operations, including the Civil War and later campaigns against Boko Haram and banditry (McDermott 2016; Gates *et al.,* 2016). What makes these experiences particularly important is that psychological trauma is not necessarily confined to the moment in which the traumatic event occurs. A soldier may survive an attack, return to base, and continue with military duties while still experiencing the psychological effects of what happened. Memories of a devastating explosion, the death of a colleague, an ambush, or a narrowly avoided death may remain intrusive long after the immediate danger has passed. The source research associates prolonged trauma with symptoms such as recurrent re-experiencing, avoidance, heightened arousal, and difficulties with concentration. These symptoms, which are persistent and clinically significant, can interfere with both personal life and military responsibilities. (American Psychiatric Association, n.d.; Mayo Clinic 2022).

The duration of deployment is another important part of this problem. The experiences of Nigerian troops in ECOMOG operations in Liberia and Sierra Leone illustrate the pressures associated with extended and sometimes irregular deployment. Soldiers operating for long periods in unstable environments may have limited opportunities for rest, rotation, and psychological recovery. The cumulative effect can be substantial. Fatigue is not simply a physical condition; when combined with continuing exposure to danger, separation from family, and uncertainty about when a deployment will end, it may contribute to emotional exhaustion and difficulties in readjusting to normal life. This becomes particularly important in operations where soldiers move repeatedly between theaters of conflict rather than receiving sufficient time to recover between deployments. (Akinola 2015; Thandi *et al*., 2020).

Some experiences are considerably more severe than others. Captivity, for instance, represents an extreme form of military trauma because it combines loss of control, physical vulnerability, and continuing exposure to the threat of violence. The source research discusses the experience of Nigerian soldiers captured during the Bakassi crisis and the case of Corporal Shantali, who was captured during an operation in Somalia and witnessed the killing of colleagues. Such experiences demonstrate that the psychological consequences of military service cannot be measured only by whether a soldier was physically wounded. A soldier may return without an obvious physical injury and nevertheless carry powerful memories of captivity, fear, humiliation, injury, or the death of fellow personnel. In this respect, survival itself does not necessarily mark the end of the traumatic experience (Florence and Inakwu 2022, 402–406).

The loss of comrades is another recurring source of psychological distress. Military units are built around strong bonds of trust and solidarity, so

the death or serious injury of a colleague can have an effect that goes beyond ordinary grief. The source study discusses what it refers to as "Sergeant's Syndrome," describing a situation in which repeated exposure to the deaths of fellow soldiers may contribute to depression and an exaggerated sense of personal responsibility for not having been able to save them. Such reactions may be particularly difficult for soldiers because military culture often places considerable emphasis on courage, endurance, and the ability to continue performing one's duties under pressure. Consequently, a soldier may experience serious emotional difficulties while feeling reluctant to acknowledge them. (Okechukwu 2017; McDermott 2016).

Another major issue is behavioral changes associated with severe operational stress. These include excessive alcohol consumption, drug use, increased smoking, aggression, depression, withdrawal, and other changes in normal behavior. Such changes can affect not only the soldier but also relationships with colleagues and family members. A soldier who becomes withdrawn or unusually irritable after returning from deployment may find it difficult to resume ordinary family interactions. In other cases, substance use or aggressive behavior may create additional problems within the household or military unit. These manifestations are significant for the present study because they demonstrate the way in which operational trauma can move from the battlefield into the social and institutional environments to which the soldier returns. At the same time, these behavioral changes should not automatically be interpreted as evidence of clinically diagnosed PTSD. Excessive drinking, insomnia, aggression, depression, or social withdrawal can arise from different psychological, social, or occupational circumstances. PTSD requires appropriate clinical assessment, and the source research itself acknowledges limitations in distinguishing different stages or forms of the condition. The value of the evidence, therefore, lies not in treating every reported behavior as a diagnosis, but in demonstrating the range of difficulties that may accompany prolonged exposure to traumatic military environments. (American Psychiatric Association; Florence and Inakwu 2022, 402–406)

The Nigerian experience also suggests that the psychological burden of operations cannot be explained by exposure to combat alone. Individual resilience, the frequency and duration of deployment, the nature of the traumatic experience, the availability of social and institutional support, family circumstances, and access to professional treatment may all influence how personnel respond. Two soldiers exposed to the same incident may not necessarily experience or process it in the same way. Likewise, a soldier who receives timely support may experience a different trajectory from one who returns to his unit without adequate psychological assistance. (Adler *et al*., 2015; Thandi *et al*., 2020). This is where the systems perspective adopted in the study becomes particularly useful. Trauma begins with an experience at the individual level, but its consequences can spread through several interconnected levels. A soldier may experience psychological difficulties; the family may subsequently face tension or behavioral changes; the military unit may experience reduced availability or altered interpersonal relations; and the wider organization may face additional demands for treatment, replacement, and personnel management. Where these pressures accumulate across a large number of personnel, they may have implications for operational effectiveness. The issue, therefore, is not simply the number of traumatic incidents experienced by Nigerian soldiers. It is the interaction between exposure, duration, individual resilience, family circumstances, military culture, institutional support, and access to appropriate treatment. This interaction is particularly important in the Nigerian Army because the post-1999 security environment required personnel to remain operational over extended periods and across multiple theaters. The psychological consequences of such service consequently form part of the broader human and institutional costs of maintaining national security. (Florence and Inakwu 2022, 402–406).

Effects of PTSD on National Security

The relationship between PTSD and national security is best understood through the effects that untreated or inadequately managed psychological trauma may have on the personnel responsible for providing security. The source study identifies four broad areas of concern: the protection of lives and property, the security environment experienced by citizens, the general well-being of the population, and socio-economic activity. These effects should not be interpreted as evidence that PTSD directly causes insecurity. Rather, the argument is that where significant psychological difficulties among military personnel are poorly recognized or inadequately managed, they may reduce personnel availability, affect operational performance, and place additional pressure on the wider security system. (Holmes 2015; Brown 1983).

The first concern is the capacity of the Nigerian Army to protect lives and property. Military effectiveness depends not only on weapons, equipment, intelligence, and logistics but also on the physical and psychological readiness of the personnel who use them. A soldier experiencing serious and persistent psychological difficulties may require

medical attention, temporary removal from operational duties, or longer-term rehabilitation. In some cases, symptoms may also affect concentration, judgement, interpersonal relations, and the ability to carry out routine responsibilities. When such cases accumulate, the organization may have fewer personnel available for deployment or may have to redistribute responsibilities among those who remain operational. (Gates *et al*., 2016; McDermott 2016). This has implications for an army that has been required to operate simultaneously in several security theaters. The source study therefore treats the management of PTSD as part of the broader question of maintaining military manpower and operational readiness. The concern is not that every soldier affected by PTSD becomes incapable of performing military duties. Rather, the issue is whether an institution that does not adequately identify and manage psychological injuries can sustain the level of personnel readiness required for prolonged security operations. From this perspective, mental-health support becomes one element of maintaining the state's capacity to protect its citizens and territory.

The second concern relates to the security conditions experienced by civilians. Where personnel availability or operational effectiveness is reduced, the ability of security institutions to respond to threats may also come under pressure. Nigeria's security environment during the period under consideration involved terrorism, armed robbery, kidnapping, banditry, and other forms of violence. These threats are not caused by PTSD, and it would be misleading to establish a direct causal relationship between the psychological condition of soldiers and the existence of such threats. The more limited argument is that poorly managed mental health problems may constitute one of several organizational factors affecting the capacity of security institutions to respond to existing threats. (Holmes 2015; Akpeninor 2012). This distinction is important. Security outcomes are produced by several interacting variables, including intelligence, leadership, equipment, logistics, training, manpower, terrain, political decisions, and the capabilities of armed groups. PTSD is therefore only one possible element within a much larger system. Nevertheless, because military personnel constitute an important part of Nigeria's security architecture, their psychological condition can have practical consequences for the organization's ability to sustain operations. Where personnel are repeatedly exposed to traumatic conditions without adequate psychological support, the resulting pressures may contribute to absenteeism, reduced availability, difficulties in concentration, or problems of adjustment. These possibilities make mental-health management relevant to operational effectiveness.

A third dimension concerns the well-being of citizens, particularly the families of military personnel. The source research recognizes that the consequences of military trauma do not necessarily end when a soldier leaves the operational theater. Behavioral changes associated with severe psychological distress may affect spouses, children, and other members of the household. Irritability, withdrawal, depression, substance abuse, sleep difficulties, and strained interpersonal relationships can place considerable pressure on family life. In more serious cases, persistent domestic tension may contribute to separation or other forms of family disruption. (Thandi *et al*., 2020). The family is therefore an important part of the wider system within which military personnel operate. A soldier's psychological well-being can affect the family, while family support can also influence the soldier's ability to cope with the pressures of military service. This relationship reinforces the need for a mental health policy that does not focus exclusively on the individual service member. Where appropriate, families should also have access to information, counselling, and support mechanisms that help them understand the psychological consequences of prolonged military deployment and traumatic exposure. The implications extend beyond individual military households. Families form part of the wider social environment, and persistent family distress can generate additional social and economic pressures. A soldier who is unable to adjust successfully after deployment may require continuing medical or psychological support, while family members may themselves experience emotional and financial difficulties. The cumulative effect may become significant where large numbers of military personnel are repeatedly deployed in high-risk environments. For this reason, the source study's concern with the well-being of military families should be understood as part of the broader human-security dimension of national security (Akpeninor 2012).

The fourth area identified by the research is the potential effect on socio-economic activities. Economic activity depends, among other things, on a reasonable degree of physical security and public confidence. Farmers need to reach their fields, traders need to move goods, businesses need to operate, and communities need to maintain normal patterns of social and economic interaction. Where insecurity persists and citizens lack confidence in their safety, these activities can be disrupted. The source research consequently connects the effectiveness of security institutions with the wider socio-economic environment. Again, PTSD should not be presented as an independent cause of economic decline. The relationship is more indirect. Where psychological difficulties among military personnel

contribute to reduced availability or effectiveness, this may place additional pressure on security institutions that are already dealing with complex threats. If security responses become less effective, the consequences may be felt in communities through restricted movement, disrupted trade, reduced investment, displacement, and declining confidence in local economic activity. Numerous other factors can produce these outcomes, so the argument here is one of potential contribution rather than direct causation (Holmes 2015; Brown 1983).

These four dimensions provide a broader understanding of the relationship between military mental health and national security. The protection of lives and property depends partly on the readiness of security personnel; the ability of citizens to live without persistent fear depends partly on the effectiveness of security institutions; social well-being is influenced by the stability of families and communities; and economic activity requires an environment in which people can move, work, and trade with reasonable confidence. The psychological condition of military personnel intersects with each of these areas, even though it does not determine them on its own. The central point, therefore, is that PTSD should not be viewed exclusively as a medical problem affecting individual soldiers. Nor should every security failure be attributed to the psychological condition of military personnel. Rather, the evidence presented in the source research suggests that mental health forms part of the human infrastructure of national security. An army requires physically capable personnel, but it also requires personnel who are psychologically supported and able to sustain the demands of prolonged service. Effective prevention, early identification, treatment, rehabilitation, and family support can consequently contribute to personnel resilience and organizational capacity.

Challenges and Prospects in Managing PTSD in the Nigerian Army

Managing PTSD within the Nigerian Army presents a combination of institutional, professional, cultural, and financial challenges. The problem is not simply that traumatic experiences occur during military operations; it is also a question of what happens after exposure. If personnel have limited access to diagnosis, treatment, and follow-up care, psychological difficulties may remain hidden for long periods. The research identifies several weaknesses in the existing system, including fragmented policy arrangements, inadequate specialist capacity, stigma, weak data systems, limited funding, and insufficient collaboration. At the same time, it points to a number of practical avenues through which these difficulties could be addressed (Florence and Inakwu 2022, 402–406). One of the most significant problems identified by the study is the absence of a sufficiently unified mental-health policy across the Armed Forces of Nigeria. Historically, the Services have operated with their own arrangements for dealing with mental health issues, while within the Army some cases have been handled at divisional or unit levels. Such arrangements may provide immediate responses, but they can also create differences in procedures, standards, referral systems, and record keeping. More importantly, fragmentation makes it difficult to develop a consistent approach to prevention, diagnosis, treatment, and rehabilitation across the military. A soldier's access to care should not depend excessively on the formation, location, or administrative structure to which he or she happens to belong. The development of a coherent Armed Forces-wide policy would therefore provide a common framework while still allowing individual services to respond to their particular operational circumstances. (WHO 2022)

The shortage of mental health professionals and specialized facilities presents another serious difficulty. The source research indicates that military medical facilities attend to mental health cases, but that dedicated capacity remains limited. The research also involved visits to psychiatric facilities outside the military system, suggesting the importance of the civilian health sector in filling some of these gaps. The problem is not restricted to psychiatrists alone. A functioning military mental health service requires a broader professional team, including clinical psychologists, psychiatric nurses, counselors, and other appropriately trained personnel. Without adequate staffing, even a well-designed policy may remain largely on paper. Shortages can affect early identification, diagnosis, treatment, follow-up, and rehabilitation, while personnel in existing facilities may themselves become overstretched (Florence and Inakwu 2022, 402–406).

Stigma makes the situation even more difficult. Military culture places a strong emphasis on courage, discipline, endurance, and the ability to function under pressure. These qualities are essential to military service, but they can sometimes make personnel reluctant to admit that they are experiencing psychological difficulties. A soldier may fear being regarded as weak, unstable, or unsuitable for operational duties. Some may simply choose to remain silent and attempt to cope privately. The result is that a condition requiring professional attention can remain hidden until it begins to affect work, family relationships, or general behavior. The research also identifies limited awareness of PTSD among personnel as an additional problem. It is difficult to encourage early help-seeking when soldiers do not fully understand the symptoms or are uncertain about where to obtain assistance.

(McDermott 2016). This makes mental health education particularly important. Awareness should not be limited to a once-off lecture or campaign. It needs to become part of the broader military training environment. Officers, soldiers, and their families should have a basic understanding of the psychological consequences of combat exposure, the warning signs that may require professional attention, available treatment options, and the procedures for seeking help. Training should also make clear that requesting psychological assistance is not, in itself, evidence of professional failure. Where confidentiality can be guaranteed within the limits of military requirements, personnel are more likely to discuss their experiences before problems become more difficult to manage (American Psychiatric Association).

Another weakness is the limited availability of reliable and coordinated data. Without accurate records, it becomes difficult to determine the actual scale of PTSD within the military, identify differences between formations or operational theaters, plan specialist staffing, and evaluate whether existing interventions are working. A soldier may receive treatment at one level of the organization without information being effectively integrated into a broader system. This can make institutional planning unnecessarily difficult. The development of ICT-supported mental health databases could help address this problem by allowing relevant authorities to monitor cases, treatment, and outcomes over time. Such systems would, however, have to be carefully designed around confidentiality and data protection. Military personnel may be particularly concerned that disclosure of a psychological condition could affect their careers or future deployment. The research therefore points to the value of learning from countries such as the United Kingdom and South Africa, particularly in the areas of professional development, record keeping, treatment, and institutional coordination. The purpose should not be to copy another country's system wholesale. Nigeria has its own military culture, institutional arrangements, operational realities, and socio-cultural environment. International experience is more useful when adapted to local circumstances rather than simply transplanted. (Adler *et al*., 2015)

The World Health Organization's Mental Health Gap Action Programme (mhGAP) is identified in the source research as another possible avenue for strengthening capacity. The program provides a framework for expanding access to services for mental, neurological, and substance-use disorders, particularly in settings where specialist resources are limited. For Nigeria, the relevance of such an approach lies in the possibility of strengthening mental health capacity beyond a small number of specialist centers. Defense and health authorities could explore ways of connecting military mental health planning with wider national mental health initiatives and relevant international support mechanisms. This could be particularly useful in areas where specialist personnel are scarce (Thandi *et al*., 2020). International military partnerships could also contribute to professional development. The research specifically identifies the United Kingdom and South Africa as possible partners. Existing defense relationships and defense attaché networks could provide opportunities for professional exchanges, training, mentorship, and collaborative research. Such cooperation could also extend to veterans' affairs, rehabilitation, and the development of institutional procedures for dealing with personnel exposed to repeated operational trauma. The important point is that international cooperation should build Nigerian capacity rather than create permanent dependence on external expertise (Florence and Inakwu 2022, 402–406).

Prevention deserves equal attention. PTSD management should not begin only after a soldier develops severe symptoms. The source research proposes preventive approaches that take account of Nigeria's military, cultural, and religious environment. This is an important consideration because psychological responses to trauma are shaped not only by the traumatic event itself but also by social expectations, family relationships, cultural beliefs, and the ways in which individuals understand distress. Approaches developed elsewhere can provide useful lessons, but they need to be adapted carefully to the Nigerian setting while maintaining appropriate professional and clinical standards.

Professional capacity remains central to all these proposals. The recruitment of psychiatrists, clinical psychologists, psychiatric nurses, counselors, and other mental health specialists would provide the personnel required to translate policy into practice. The source research proposes incremental recruitment based on a strategic assessment of need rather than treating manpower development as a one-time exercise. This would allow the Armed Forces to expand specialist capacity gradually while also developing professional networks among practitioners working in different formations and locations. Regular professional forums, whether physical or online, could further improve communication and encourage the exchange of experience. (Thandi *et al*., 2020)

Funding is another unavoidable issue. Mental health programs require more than the construction of facilities. Resources are needed for personnel, training, medication, counselling, rehabilitation, information systems, research, and

family-support programs. The source research therefore calls for broader funding arrangements involving public and, where appropriate, private-sector support. Such arrangements would need clear institutional oversight, particularly because military mental-health services involve sensitive personnel information. Nevertheless, without sustained financing, improvements in policy and professional capacity are unlikely to be maintained. Collaboration is closely connected to funding and professional capacity. Mental health practitioners within the different services, military medical institutions, civilian hospitals, universities, research organizations, and relevant international partners can contribute different forms of expertise. Stronger collaboration could reduce duplication, improve referral pathways, and create opportunities for research into the particular psychological pressures experienced by Nigerian military personnel. It could also encourage the development of a more complete evidence base on PTSD, combat stress, and post-deployment adjustment.

The family should remain part of this collaborative approach. The source research indicates that psychological difficulties can affect spouses and other family members, particularly where behavioral changes persist after deployment. Families therefore need information about what to expect following prolonged operational service and where to seek assistance when difficulties emerge. Family support should not replace professional treatment, but it can provide an important first line of social support and may help personnel adjust after returning from difficult deployments.

CONCLUSION

This article examines the central argument that military service, particularly in prolonged and demanding operational environments, exposes personnel to experiences that can have consequences long after they leave the immediate theater of operations. Combat, the death or serious injury of colleagues, captivity, prolonged deployment, sleep deprivation, physical exhaustion, fear, and repeated exposure to violent situations all form part of this experience. The psychological effects of such exposure may not always be immediately visible, but they can influence the soldier's behavior, relationships, and capacity to function over time. One of the important contributions of the study is its effort to move the discussion of PTSD beyond the individual soldier. The problem is not confined to the person who experiences trauma. A soldier is at the same time an individual, a member of a family, a colleague within a military unit, and part of a much larger national institution. Difficulties at one level can therefore create pressures at another. Psychological distress may affect family relationships; prolonged absence from duty may place additional demands on a unit; and accumulated personnel difficulties may eventually have implications for the organization's operational capacity. This is where systems theory becomes particularly useful. It provides a way of understanding the connections between the individual, family, military institution, and wider society, even though it cannot by itself explain all the clinical, cultural, and organizational dimensions of PTSD.

The research also makes clear that the problem is institutional as much as individual. The management of PTSD is constrained by a number of weaknesses, including shortages of mental-health professionals and specialized facilities, fragmented policy arrangements, limited awareness, stigma, inadequate data systems, insufficient funding, and weak collaboration among relevant institutions. These difficulties become particularly important in an operational environment where soldiers are repeatedly deployed and may spend extended periods exposed to traumatic conditions. Treating individual cases without addressing these wider institutional weaknesses is unlikely to provide a sufficiently sustainable response. At the same time, the study identifies several possibilities for strengthening the system. These include drawing on appropriate international mental-health initiatives, developing partnerships with countries that have experience in military mental-health management, improving mental-health information systems, recruiting and training specialist personnel, incorporating mental-health education into military training, supporting military families, strengthening professional networks, and developing preventive approaches that are sensitive to Nigeria's cultural and religious environment. None of these measures is sufficient on its own. Their value lies in bringing prevention, identification, treatment, rehabilitation, and follow-up into a more coordinated framework.

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