



# Sociological Assessment of the Mental Health of Security Personnel Working in Communities Affected by Boko Haram in Yobe State, Nigeria

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Abstract	Original Research
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The Boko Haram insurgency in northeastern Nigeria has generated one of the most protracted security and humanitarian crises on the African continent, with Yobe State emerging as a frontline zone of sustained conflict and social devastation. While the mental health consequences of conflict have been extensively documented for civilian populations, security personnel deployed in affected communities — including military officers, police, the Nigeria Security and Civil Defence Corps, and vigilante groups — remain a largely invisible population in both research and policy discourse. This article presents a sociological assessment of the mental health of security personnel working in Boko Haram-affected communities in Yobe State, Nigeria, drawing on a substantive body of empirical literature and organised around three interconnected sociological perspectives: institutional neglect as a social stressor; social support erosion in conflict communities; and stigma, masculinity, and help-seeking behaviour. Grounded in Pearlin's Stress Process Model, Goffman's theory of stigma, and the social determinants of health framework, the article argues that the mental health burden carried by security personnel in Yobe State is not reducible to individual trauma exposure but is structurally produced by the institutional arrangements that deploy them, the social fabric that surrounds them, and the cultural norms that silence them. The implications for policy, institutional reform, and future sociological research in conflict-affected settings are discussed.

**Keywords:** mental health, security personnel, Boko Haram, Yobe State, occupational stress, stigma, medical sociology, social determinants of health

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## Introduction

The Boko Haram insurgency, which emerged in northeastern Nigeria in the early 2000s and escalated

dramatically after 2009, represents one of the most destructive episodes of political violence in contemporary African history. Yobe State, which shares borders with Borno and Adamawa — the two



states most directly associated with the insurgency's origins — has experienced sustained attacks on civilian populations, public institutions, and security infrastructure for over a decade (Loimeier, 2012; Lenshie et al., 2024). Communities across the state have been subjected to bombings, abductions, forced displacements, and the systematic destruction of social life. The human cost has been immense, and the psychological dimensions of that cost are only beginning to receive the scholarly attention they demand.

Mental health, broadly understood, refers to a state of psychological and emotional wellbeing in which an individual is able to cope with the ordinary stresses of life, maintain productive functioning, and contribute meaningfully to their community (WHO, 2022). It encompasses not only the absence of diagnosable psychiatric disorder but the presence of cognitive clarity, emotional regulation, and social connectedness — dimensions of human experience that are profoundly shaped by the social conditions in which people live. In Nigeria, however, and most acutely in the predominantly Muslim communities of the North, mental health is widely misunderstood, culturally stigmatized, and institutionally neglected. Psychological distress is commonly interpreted through spiritual and religious frameworks — as divine punishment, demonic affliction, or evidence of weak faith — rendering clinical recognition both socially inappropriate and personally shameful (Raufu et al., 2025). This cultural framing is not incidental; it is a product of deep-rooted belief systems that, while spiritually meaningful to those who hold them, have systematically foreclosed pathways to formal mental health care for millions of Nigerians. The consequence of this collective misconception has been a silent, compounding crisis — one in which suffering goes unnamed, help goes unsought, and need goes unaddressed across generations. It is precisely within this context that the mental health of security personnel in Yobe State emerges not merely as a research question but as a desperate humanitarian and institutional cry, a demand that can no longer be deferred by cultural silence, institutional indifference, or scholarly neglect.

Within this landscape of violence and cultural silence, security personnel, military officers, police, members of the Nigeria Security and Civil Defence Corps, and community vigilante groups — occupy a uniquely exposed position. They are simultaneously agents of the state's response to the insurgency and victims of its psychological consequences. They operate in environments defined by threat, uncertainty, and moral complexity, often without adequate resources, institutional support, or access to mental health services. And yet, in both the research literature and the policy responses that follow from it, their mental health needs have remained largely peripheral, a silence that this article seeks to address.

The neglect of security personnel in mental health research is not unique to Nigeria. Globally, the mental health burden among military and law enforcement populations has been consistently underestimated, in part because of the institutional cultures that discourage disclosure, and in part because research has historically prioritized civilian populations in conflict settings (Syed et al., 2020; Easterbrook et al., 2022). In the Nigerian context, this neglect is compounded by the structural underdevelopment of mental health services, the dominance of biomedical and clinical frameworks that marginalize sociological inquiry, and the particular stigma attached to psychological distress within security institutions (Abdulmalik et al., 2019; Raufu et al., 2025).

This article intervenes in this gap from the disciplinary standpoint of Medical Sociology. Rather than treating mental health as a clinical phenomenon to be measured and treated at the individual level, this study situates mental health as a social product, shaped by institutional structures, relational networks, cultural norms, and the material conditions of everyday life. In doing so, it draws on Pearlin's (1989) Stress Process Model, which maps the pathways through which social stressors are mediated, or fail to be mediated, by social support and coping resources to produce mental health outcomes; on Goffman's (1963) theory of stigma, which illuminates the social mechanisms through which mental illness is rendered invisible and untreatable; and on the social determinants of health

framework, which situates individual wellbeing within the broader structures of employment, institutional power, and social inequality (Allen et al., 2014; Gnanapragasam et al., 2021).

The article is organized around three interconnected sociological perspectives that together constitute a comprehensive analytical framework. The first examines institutional neglect as a social stressor, arguing that the security establishment itself — through absent welfare systems, silence around mental illness, and a culture of enforced resilience — is a primary source of psychological harm. The second examines social support erosion in conflict communities, arguing that the Boko Haram insurgency has systematically dismantled the relational structures — family, community, kinship, and religious networks — that security personnel rely on for psychological protection. The third examines stigma, masculinity, and help-seeking behaviour, arguing that dominant masculine norms and cultural frameworks of distress actively suppress the recognition and treatment of mental illness, ensuring that the burden documented by the first two perspectives remains largely invisible. Together, these three perspectives build a sociological argument of considerable analytical and policy relevance.

## Literature Review

### Mental Health in Conflict Settings: Scope and Scale

The global evidence base on mental health in conflict settings has expanded substantially in recent decades, establishing with considerable confidence that exposure to armed conflict generates a significant burden of psychological disorder across affected populations. Charlson et al. (2019), in a systematic review and meta-analysis commissioned by the World Health Organization, found that approximately 22.1% of conflict-affected populations experience a diagnosable mental disorder at any point in time, with depression, anxiety, and post-traumatic stress disorder (PTSD) carrying the highest burden. These figures represent a substantially elevated prevalence compared to global averages, and they are understood to

underestimate the true burden given the methodological challenges of measurement in active conflict zones.

In the African context, this burden is acute. Andersen et al. (2020), reviewing mental health and psychosocial support interventions across six African countries — including Nigeria — found high pre-intervention psychological distress among conflict-affected populations, with post-intervention improvements demonstrating both the scale of need and the feasibility of response when resources are committed. The Social Science in Humanitarian Action Platform (SSHAP, 2024), in a brief specifically addressing northern Nigeria, documented PTSD prevalence rates as high as 66% among internally displaced youth in Boko Haram-affected communities, alongside widespread cultural idioms of distress and a severely under-resourced mental health response infrastructure. Ziradzo and Netangaheni (2022) added granularity to this picture through their qualitative documentation of the experiences of ethnic minorities in Borno State, recording the deep psychological consequences of Boko Haram's systematic violence — including mass abductions, sexual slavery, and forced displacement — consequences that extended far beyond immediately affected individuals to reshape the social fabric of entire communities.

Within this broader literature, security personnel have received comparatively little attention. The global systematic review by Syed et al. (2020) on mental health in police personnel identified a pooled prevalence of mental health problems among police that was substantially higher than general population estimates, with occupational and organizational factors identified as primary risk drivers. Ataigba et al. (2024), studying defence and security forces in Northern Benin, a context with meaningful structural parallels to Yobe State, found an 11.8% PTSD prevalence among military, police, and firefighters, with only 13.9% having accessed psychiatric consultation. The Nigerian literature on security personnel's mental health specifically remains sparse, representing a gap that this article directly addresses.

## The Boko Haram Insurgency and Yobe State

Boko Haram, formally known as Jama'atu Ahlis-Sunna Lidda'Awati Wal-Jihad, emerged from the complex socio-political landscape of northeastern Nigeria, shaped by enduring inequalities, the politics of Islamic reform, and the generational marginalisation of young men in the region's urban centres (Loimeier, 2012). Zenn and Pieri (2017) traced how the group's internal doctrinal disputes, particularly over the concept of takfir, or the excommunication of insufficiently devout Muslims, drove repeated factorisations, producing a volatile organisational landscape that complicated both counterinsurgency strategy and community-level understanding of the conflict. Oriola and Akinola (2018) examined the ideational dimensions of the phenomenon, arguing that Boko Haram's ideology cannot be reduced to religious fanaticism but must be understood within the broader context of political alienation, ethnic identity, and state failure.

Oyawale (2022), in a vernacular analysis of public (in)security in Nigeria, documented through 41 in-depth interviews with internally displaced persons from the Northeast how ordinary Nigerians make sense of the conflict through ethnic and religious identity frameworks, positioning themselves in relation to Boko Haram, state security forces, and competing societal discourses. The study revealed the profound ambivalence with which security institutions are perceived by the communities they serve: army commanders described as ethnically partial, institutionally compromised, and insufficiently committed to minority protection. This perception of institutional unreliability is not merely a problem of community-security relations, it shapes the social environment in which security personnel themselves operate, affecting their sense of purpose, their moral standing, and their psychological experience of the conflict.

Lenhie et al. (2024), examining the security architecture and counterinsurgency framework in Northeast Nigeria, identified structural weaknesses that extend beyond tactical capacity to encompass welfare, accountability, and the psychological care of deployed personnel. The article documented how Nigerian security forces have operated under

conditions of chronic under-resourcing, command dysfunction, and inadequate preparation for the psychological demands of sustained counterinsurgency, conditions that directly bear on the mental health of those deployed.

## Theoretical Framework

This article is anchored in three theoretical frameworks that together constitute its sociological foundation. The first is Pearlin's (1989) Stress Process Model, which provides the primary analytical architecture. Within this model, stressors, whether acute or chronic, are understood to produce mental health outcomes not directly but through the mediating influence of social support and coping resources. When social support is robust, it buffers the individual against the full psychological weight of stressor exposure; when it is absent or eroded, the individual bears that weight unmediated. In the context of Yobe State, the stressors facing security personnel are extreme and persistent, the institutional buffers are largely absent, and the community resources that might otherwise mediate stress have been dismantled by conflict. The Stress Process Model provides the analytical language to map these dynamics with precision.

The second framework is Goffman's (1963) theory of stigma, which illuminates the social mechanisms through which mental illness is rendered invisible, discredited, and untreatable. Goffman distinguished between public stigma, the negative attitudes held by society toward stigmatized groups, and self-stigma, the internalization of those attitudes by the affected individual, producing shame and avoidance of help-seeking. In security institutions, where toughness and psychological endurance are organizational values, both forms of stigma operate with particular intensity, creating structural conditions under which mental illness cannot be acknowledged without social and professional cost.

The third framework is the social determinants of health approach, associated with Marmot and the WHO Commission on Social Determinants of Health, and elaborated in the psychiatric context by Allen et al. (2014) and Gnanapragasam et al. (2021).

This framework insists that mental health outcomes are not primarily products of individual biology or psychology but of the social conditions — employment, income, housing, institutional structures, discrimination, and community belonging — in which individuals live and work. For security personnel in Yobe State, these conditions are shaped by a security institution that under-provides welfare, a conflict that has destroyed community infrastructure, and a cultural environment that stigmatises vulnerability. Taken together, these three frameworks produce an analytical architecture that is distinctively sociological in its orientation and directly policy-relevant in its implications.

### **Institutional Neglect as a Social Stressor**

Security personnel deployed in Boko Haram-affected communities in Yobe State operate within institutional structures that are themselves a source of psychological harm. While the dominant discourse on mental health in conflict zones tends to foreground the direct trauma of violence — exposure to combat, witnessing death, and the threat of injury — a sociological reading of the evidence reveals a parallel and equally damaging stressor: the failure of the security institution itself to protect the psychological wellbeing of those it deploys. This perspective argues that institutional neglect — manifested through absent welfare systems, silence around mental illness, and a culture of enforced resilience — functions not merely as an oversight but as a structural social stressor that compounds the burden of conflict exposure among security personnel in Yobe State.

The empirical case for this argument begins with the documented gap between the scale of the mental health burden and the institutional response to it. Charlson et al. (2019) established that approximately 22.1% of conflict-affected populations experience a diagnosable mental disorder at any point in time, with depression and anxiety carrying the highest burden. When this prevalence is situated within security institutions specifically, the picture sharpens considerably. Ataigba et al. (2024), in a cross-sectional study of 305 defence and security personnel

in Northern Benin, found a PTSD prevalence of 11.8% among military, police, and firefighters. More instructive than the prevalence figure, however, is what follows from it: only 13.9% of affected personnel had consulted a psychiatrist, and coping relied heavily on informal strategies such as sport, with no systematic institutional screening in place. This is not simply a clinical gap; it is a sociological one. The institution, as the primary organizing structure of these workers' lives, had neither identified the problem nor moved to address it.

In the Nigerian context specifically, Abdulmalik et al. (2019) documented how the Boko Haram insurgency generated a substantial mental health crisis across the Northeast, yet Nigeria's institutional response remained fragmented, under-resourced, and heavily skewed toward the civilian population — with security personnel largely absent from policy consideration. This institutional invisibility reflects a broader pattern in which the mental health of those tasked with managing violence is treated as incompatible with the institutional identity they are expected to embody. Lenshie et al. (2024), examining the security architecture and counterinsurgency framework in Northeast Nigeria, identified deep structural weaknesses in how the Nigerian military and police operate in conflict zones — weaknesses that extend beyond tactical capacity to encompass welfare, accountability, and the psychological care of deployed personnel.

The sociological significance of this institutional failure becomes clearer when examined through Pearlin's (1989) Stress Process Model. Within this framework, institutional neglect functions as a chronic background stressor — not episodic like a combat encounter, but persistent, ambient, and cumulative. Easterbrook et al. (2022), in a qualitative investigation of treatment-seeking military members and public safety personnel in Canada, identified strained interpersonal relationships, altered personal identity, and moral injury — defined as shame, guilt, and a sense of betrayal by leadership — as central to the mental health experience of security workers. Crucially, much of the distress these participants described was not traceable to battlefield trauma alone, but to the institutional context in which they

worked: leadership failures, inadequate support systems, and the expectation of psychological endurance without structural provision for it.

Syed et al. (2020), in their global systematic review and meta-analysis of mental health in police personnel, identified occupational and organizational factors — including poor management, lack of support, and role conflict — as primary risk factors, often outweighing the direct effects of exposure to violence. The implication for security personnel in Yobe State is direct: in an environment where Boko Haram attacks have been persistent, where deployment is often indefinite, and where the institutional infrastructure of the Nigerian Police Force and military in the Northeast has been chronically under-resourced, the organisation itself becomes a site of stress production rather than stress buffering.

Maglione et al. (2022), reviewing Combat and Operational Stress Control programs for military and law enforcement, found that even where institutional interventions existed, their effects on PTSD, depression, and anxiety were not statistically significant. The programs showed some improvement in return-to-duty rates and immediate functioning, but failed to meaningfully address psychological outcomes. This finding is particularly sobering in the Nigerian context, where even such inadequate programs are largely absent. The evidence suggests that the institution's response to mental health, where it exists at all, tends to be instrumental — focused on maintaining operational capacity — rather than genuinely welfare-oriented.

Gnanapragasam et al. (2021) provide the theoretical scaffolding to connect these empirical observations to a broader sociological argument. Their review of social determinants of mental health demonstrates that employment conditions, institutional structures, and the quality of an individual's working environment are not peripheral to mental health — they are constitutive of it. For security personnel in Yobe State, the working environment is defined not only by the violence of the insurgency but by an institution that deploys them without adequate preparation, sustains them without adequate welfare, and expects them to absorb psychological trauma

without adequate support. When the institution that structures one's daily life, defines one's identity, and controls one's conditions of existence becomes a source of chronic stress rather than protection, the sociological consequences for mental health are profound.

It would be intellectually dishonest to suggest that governments, including Nigeria's, have made no attempts to address the welfare of their security personnel. At the federal level, the Nigerian military operates a system of medical services through the Nigerian Army Medical Corps, and the Nigeria Police Force maintains a welfare department nominally responsible for the occupational health of its officers (Lenshie et al., 2024). These structures exist on paper, and their existence acknowledges, at least formally, that the state bears some responsibility for those it deploys in its name. In several other national contexts, government-led welfare frameworks have demonstrated measurable success. The United Kingdom's Armed Forces Covenant — a formal, legally recognized commitment by the government to ensure that service personnel and veterans are not disadvantaged by their military service — has produced a structured ecosystem of mental health support, housing assistance, and employment transition programs that are funded, accountable, and institutionally embedded rather than donor-dependent (Easterbrook et al., 2022). The United States Department of Veterans Affairs, despite its well-documented limitations, represents the world's largest integrated mental health system for security personnel, offering evidence-based treatment for PTSD, depression, and substance use disorders at scale. Closer to the African context, Rwanda's post-genocide military restructuring included systematic psychological support for both soldiers and veterans as part of its broader national reconciliation architecture — demonstrating that even resource-constrained governments in conflict-affected settings can build functional welfare systems when political will exists. What these examples share is not unlimited funding but a common structural logic: welfare is embedded within the institution, accountable to law, sustained by policy rather than charity, and treated as operationally inseparable from military

effectiveness. Nigeria need not replicate these systems wholesale — but it can adopt their foundational principle, that the psychological welfare of security personnel is a non-negotiable state obligation, and begin the institutional restructuring — in policy, in budget allocation, in command culture, and in accountability mechanisms — that would make that principle real for the men and women deployed in Yobe State and across the Northeast.

### Social Support Erosion in Conflict Communities

If Institutional neglect locates the problem within the institution, then social support erosion locates it in the relational world that surrounds it. Security personnel do not exist only inside their institutions — they live in communities, maintain families, belong to kinship networks, and draw on religious and social ties for psychological sustenance. In Yobe State, however, the prolonged Boko Haram insurgency has systematically dismantled precisely these structures. This perspective argues that the erosion of social support networks — through displacement, community breakdown, family separation, and the destruction of trust — constitutes a distinct and sociologically significant pathway through which conflict generates mental health harm among security personnel. The argument is not simply that these personnel lack support, but that the support structures they once relied upon have been actively destroyed by the same conflict they are deployed to contain.

The theoretical foundation for this perspective draws on Pearlin's (1989) Stress Process Model, which identifies social support as the primary mediating resource between stressors and mental health outcomes. When social support is intact, it absorbs the psychological weight of stress exposure — buffering the individual against the full impact of trauma, role overload, and occupational strain. When it erodes, that buffering capacity disappears, and the individual is left to bear the cumulative weight of stressors without relational protection. In a conflict setting like Yobe State, where stressors are extreme and persistent, the absence of social support does not

merely reduce resilience — it transforms manageable stress into pathological distress. The sociological significance of this dynamic is that it cannot be addressed through individual-level clinical intervention alone. Restoring mental health, in this framework, requires attending to the restoration of the social fabric itself.

Grover et al. (2024), in a systematic review and meta-analysis of 35 studies involving 19,073 combat-exposed military personnel, found that lower perceived social support was consistently associated with higher rates of PTSD, depression, and anxiety. The pooled mean perceived social support score was lowest among those with probable PTSD, and the review identified unit cohesion and family support as the most significant protective factors. Crucially, the authors noted that post-traumatic growth — the capacity to recover and find meaning after trauma — was also strongly linked to the presence of robust social support. For security personnel in Yobe State, where family separation is common and community structures have fractured under insurgency, these findings carry direct implications: the very conditions that would ordinarily protect against mental health deterioration have been systematically removed.

Kaiser et al. (2020), in a mixed-methods assessment of mental health and psychosocial support needs among Boko Haram-displaced populations in Borno State — a context directly comparable to Yobe — documented not only high rates of severe distress (60% of participants) and functional impairment (75%), but specifically identified the breakdown of community and leadership structures as a key risk factor. Participants described how traditional coping mechanisms — turning to elders, community gatherings, religious practice, and extended family — had become inaccessible or destroyed. The study noted that men showed a particularly high symptom burden, a finding that carries direct significance for understanding how security personnel — predominantly male, socially positioned as protectors — experience the collapse of the very communities they are meant to safeguard. When the community disintegrates around them, the psychological toll strikes not only at their emotional

wellbeing but at the core of their social identity and sense of purpose.

Rubio-León et al. (2026), drawing on a mixed-methods study in conflict-affected municipalities in Colombia, demonstrated through network analysis that sense of community and social support were the variables most strongly associated with depression, anxiety, and stress outcomes — more so than individual exposure variables. Their qualitative data identified state abandonment, armed conflict, and economic hardship as the primary drivers of social support erosion, while community resistance and social capital emerged as the most powerful protective factors. The sociological argument embedded in these findings is directly transferable to the Yobe context: when the state is perceived as having abandoned a community — as Oyawale (2022) documented through the accounts of internally displaced persons who described army commanders as institutionally compromised and ethnically partial — the social trust that underpins community cohesion collapses. Security personnel stationed in these environments do not observe this collapse from a safe distance. They inhabit it.

Miller and Rasmussen (2024), revisiting their ecological framework fifteen years on, made an argument that is particularly salient here: in conflict settings, daily stressors — poverty, displacement, family violence, housing insecurity, loss of livelihood — often mediate and outweigh the effects of direct war exposure on mental health outcomes. This reorients the analytical lens away from dramatic combat events and toward the chronic, grinding social conditions in which security personnel live and work. In Yobe State, where insurgency has persisted for over a decade and where basic social infrastructure — schools, health facilities, markets, community gathering spaces — has been repeatedly attacked and destroyed, the daily stressor burden is immense. Security personnel navigate these conditions not as outsiders observing social breakdown, but as residents embedded within it, often trying to maintain professional function while personally experiencing the same losses as the communities around them.

Ziradzo and Netangaheni (2022), documenting the

experiences of ethnic minorities in southern Borno under Boko Haram, recorded how survivors described not only physical trauma but profound social rupture — the destruction of communal bonds, the stigmatization of survivors within their own communities, and the collapse of the trust networks through which psychological recovery ordinarily occurs. While this study focuses on civilian survivors rather than security personnel, its findings are sociologically instructive: in communities where Boko Haram has operated, the social conditions necessary for recovery — trust, belonging, reciprocity, recognition — have been actively targeted and destroyed. Security personnel working within these communities are not deployed into a neutral social environment. They are deployed into social wreckage, and that wreckage shapes their psychological experience in ways that no institutional program or clinical intervention can fully address without first attending to the relational structures that have been lost.

### **Stigma, Masculinity, and Help-Seeking Behaviour**

Institutional neglect and social support erosion established two converging pathways through which security personnel in Yobe State are rendered psychologically vulnerable: the institution that employs them fails to provide welfare, and the community that once sustained them has been fractured by conflict. Yet even where support structures exist, however inadequate, a third and equally powerful barrier prevents security personnel from accessing them. This perspective argues that the social construction of the security worker's identity, built around dominant masculine norms and reinforced by occupational culture, actively suppresses the recognition, disclosure, and treatment of mental illness. The problem, in other words, is not only that help is unavailable — it is that the very act of seeking help has been rendered socially illegitimate by the cultural and institutional world these personnel inhabit.

The sociological starting point for this argument is Goffman's (1963) theory of stigma, the process by

which particular attributes are socially discredited, reducing the bearer from a whole and usual person to a tainted or discounted one. In the context of mental illness, stigma operates at two analytically distinct but practically intertwined levels. The first is public stigma: the negative attitudes and stereotypes held by society toward people with mental health conditions, which generate discrimination, social exclusion, and reputational damage. The second is self-stigma: the internalization of these negative attitudes by the affected individual, producing shame, reduced self-esteem, and active avoidance of help-seeking. Clement et al. (2015), in a systematic review of 144 studies involving over 90,000 participants, found that stigma exerted a consistent negative effect on help-seeking behaviour, with self-stigma and treatment stigma identified as the most damaging forms. The review further found that military personnel, police officers, and other security professionals were among the populations most disproportionately affected by stigma as a barrier to care — placing the security personnel of Yobe State squarely within a well-documented global pattern of institutional silence around mental illness.

The mechanism through which stigma operates most powerfully in security institutions is the social construction of masculinity. Camacho-Ruiz et al. (2026) traced how traditional masculine norms — centred on emotional repression, self-reliance, physical endurance, and the active denial of vulnerability — create both attitudinal and structural barriers to mental health help-seeking among men. These norms do not emerge from nowhere; they are produced and reproduced through socialization, institutional culture, peer dynamics, and the reward systems that govern promotion and professional recognition. Within security institutions specifically, where toughness is not merely valued but operationally required, these norms acquire a particular intensity. The soldier or police officer who discloses psychological distress risks not only social stigma but professional consequences — the perception of being unfit for duty, unreliable under pressure, or insufficiently committed to the mission. In this environment, silence becomes a rational response to an irrational structural demand.

This dynamic takes on a distinctive character in the Yobe State context. Oyawale (2022), documenting the lived experiences of internally displaced persons from Northeast Nigeria, captured how identity — ethnic, religious, and occupational — structured the ways in which individuals positioned themselves in relation to insecurity and institutional authority. The security personnel who feature in those accounts are not abstract actors but socially embedded individuals whose sense of self is deeply tied to their role as protectors, as brothers, as men of a particular community and a particular faith. To acknowledge mental illness within this web of identity is not simply a personal admission, it is a social act with consequences for how one is perceived by peers, superiors, family members, and the community one is entrusted to defend. The stigma of mental illness, in this context, is inseparable from the stigma of masculine failure.

Easterbrook et al. (2022) gave qualitative texture to this dynamic through their investigation of treatment-seeking military and public safety personnel in Canada. Participants described how their professional identity, the job as the core self, made it extraordinarily difficult to acknowledge psychological distress, because doing so felt like a betrayal of who they understood themselves to be. Themes of shame, guilt, and moral injury ran through the accounts, alongside a profound mistrust of institutional support systems. Many participants reported delaying help-seeking for years, not because support was entirely unavailable, but because the social cost of seeking it felt prohibitive. If this pattern holds among treatment-seeking personnel in a comparatively well-resourced institutional context, its force in Yobe State — where mental health services are scarce, where stigma is reinforced by both occupational culture and community norms, and where the very concept of psychological help-seeking remains largely outside the dominant cultural repertoire — is likely to be considerably greater.

The cultural specificity of stigma in the Nigerian context adds further sociological weight to this argument. Raufu et al. (2025), examining mental health neglect in Nigeria, identified cultural stigma

and spiritual interpretations of mental illness as primary barriers to recognition and treatment across Nigerian society. Mental health conditions in many Nigerian cultural frameworks are understood not as medical or psychological phenomena but as spiritual failures, supernatural afflictions, or signs of moral weakness — interpretations that carry their own social consequences and that direct distress toward religious rather than clinical responses. For security personnel in Yobe State, operating within a predominantly Muslim cultural context where religious coping is both deeply embedded and socially sanctioned, these interpretive frameworks shape not only whether individuals seek help but what kind of help they consider legitimate. The SSHAP (2024) brief on post-trauma impacts in northern Nigeria specifically noted how cultural idioms of distress — localized expressions of psychological suffering that do not map neatly onto Western diagnostic categories — remain poorly understood and inadequately addressed by both humanitarian and institutional mental health responses.

Abo-Rass et al. (2025), reviewing mental health literacy among conflict-affected populations and refugees, found that people in active conflict zones showed moderate-to-high knowledge of mental health conditions in the abstract, but that this knowledge did not reliably translate into help-seeking behavior, a gap attributed to sociopolitical stigma, structural barriers, and the absence of culturally adapted frameworks. This distinction between knowing about mental illness and being willing to act on that knowledge is sociologically crucial. It suggests that awareness campaigns alone, the most common institutional response to mental health stigma, are insufficient without simultaneous attention to the social norms, institutional cultures, and power dynamics that make help-seeking feel dangerous or shameful.

Maglione et al. (2022) offered a sobering institutional parallel: even where stress control programs existed for military and law enforcement personnel, their failure to produce significant mental health outcomes was linked not only to program design but to the cultural environment in which they

were delivered. Programs implemented within institutions that simultaneously stigmatised psychological vulnerability sent contradictory messages — institutional support formally available, institutional culture actively discouraging its use. The result was a form of structural hypocrisy that reinforced rather than reduced stigma, because it demonstrated to personnel that the institution recognised the problem in principle while doing nothing to change the cultural conditions that made acknowledging it socially costly.

## Discussion

The three perspectives developed in this article are not parallel arguments that happen to address the same population. They are a nested, mutually reinforcing sociological structure in which each dimension of the problem compounds the others. The institution produces the occupational culture that enforces masculine silence. The conflict destroys the community that might otherwise provide relational refuge. And the individual security worker, caught between the demands of professional identity and the reality of psychological distress, finds no socially legitimate pathway through which to move from suffering to support. Together, these three dynamics produce a condition of structured invisibility: the mental health burden among security personnel in Yobe State is real, substantial, and well-supported by comparative evidence, yet it remains largely unacknowledged, unmeasured, and unaddressed.

The sociological contribution of this analysis lies in its insistence on structural causation. Dominant clinical frameworks tend to locate the problem of mental health in conflict settings within the individual, in the soldier's resilience or vulnerability, in the officer's exposure history, in the personal coping strategies available to a given person. This article has argued, by contrast, that the mental health burden carried by security personnel in Yobe State is structurally produced: by the institutional arrangements that deploy them, the social fabric that surrounds them, and the cultural norms that silence them. This reframing has significant implications for both research and intervention. If the problem is

structural, then the solution must also be structural — not simply more clinical services or individual counselling programs, but fundamental changes in how security institutions are organized, how communities are supported in conflict settings, and how the social meanings attached to psychological vulnerability are negotiated and transformed.

Beyond the humanitarian imperative, there exists a compelling operational case for attending to the mental health of security personnel that has been insufficiently articulated in Nigerian policy discourse. Military and security literature has long established that psychological fortitude — the cognitive and emotional capacity to endure sustained threat, make sound decisions under pressure, and maintain unit cohesion in the face of adversity — is not peripheral to combat effectiveness but central to it (Easterbrook et al., 2022). A soldier whose mental health has deteriorated under the cumulative weight of conflict exposure, institutional neglect, and social isolation does not simply suffer privately; his impairment has operational consequences — in the quality of his judgement, the reliability of his conduct, and the coherence of his unit's response to threat. Against an insurgency as adaptive, ideologically driven, and deeply embedded in local social geography as Boko Haram, these consequences translate directly into tactical vulnerabilities, community relations failures, and the kind of institutional dysfunction that Oyawale (2022) documented — commanders perceived as compromised, soldiers acting outside sanctioned boundaries, and security forces losing the trust of the communities they are mandated to protect. Yet soldiers are not only combatants — they are also fathers, sons, neighbours, and community members, embedded in the same social fabric that Boko Haram has systematically torn apart. Their capacity to re-enter that fabric after battle — to function as husbands, as citizens, as socially coherent human beings — depends on a level of psychological care and institutional support that the Nigerian security establishment has not yet meaningfully provided. The mental health of the soldier, in this sense, is simultaneously a matter of operational readiness, social responsibility, and fundamental human dignity.

The comparative literature provides important points of reference for understanding what effective institutional and community-level responses might look like. Rubio-León et al. (2026), in the Colombian context, found that interventions strengthening existing community networks and addressing structural inequalities were more effective in improving mental health outcomes than individually targeted clinical approaches. Andersen et al. (2020), reviewing mental health and psychosocial support interventions across African conflict settings, found that rapid intervention, proximity to care, and holistic support addressing economic needs alongside psychological ones were associated with substantially better outcomes. These findings converge on a set of principles, community anchoring, structural responsiveness, and cultural adaptation that are directly relevant to the design of mental health responses for security personnel in Yobe State.

The gender dimension of the analysis also carries significant policy implications. Camacho-Ruiz et al. (2026) argued for gender-sensitive approaches that work with, rather than against, prevailing masculine norms, finding entry points for mental health support in spaces and modalities that are already socially legitimate within masculine culture: peer support, physical activity, community leadership roles, and spiritual practice. In the northern Nigerian context, where Islamic frameworks of care and community are deeply embedded, these culturally grounded entry points may offer more traction than externally designed clinical programs that carry the dual stigma of Western origin and psychological vulnerability. Miller and Rasmussen (2024) similarly emphasized the importance of multilevel, multimodal interventions that address both the trauma of conflict exposure and the ongoing daily stressors, poverty, displacement, family disruption, that shape mental health outcomes in the months and years following acute conflict events.

A critical dimension of the institutional analysis developed in this article concerns the question of who bears responsibility for the mental and social welfare of security personnel, and whether that responsibility can be legitimately delegated to

private or humanitarian organizations. While non-governmental and humanitarian actors have played a visible role in addressing mental health needs in conflict-affected northeastern Nigeria, the evidence suggests that this delegation is neither strategically sound nor sociologically defensible as a primary welfare architecture. The misalignment of mandate is fundamental: humanitarian organizations are designed and resourced to serve civilian populations in crisis, and their frameworks, however sophisticated, are not built to address the moral injury, occupational identity disruption, and institutional hypervigilance that characterize the psychological experience of active security personnel (Easterbrook et al., 2022). When they are asked to fill the welfare gap left by the state, the tools do not fit the population, and the result is intervention that is superficial, unsustainable, and ultimately inadequate. More damaging still is what outsourcing communicates to the troops themselves. When security personnel observe that their government has contracted their psychological care to an NGO while simultaneously demanding that they risk their lives against one of Africa's most resilient insurgencies, the institutional message received, whatever the government intends, is that their welfare is a charitable afterthought rather than a state obligation (Lenshie et al., 2024). That perception corrodes institutional trust, deepens the sense of abandonment already documented in this analysis, and reinforces the culture of silence that makes mental health problems invisible and untreated. The accountability architecture collapses in equal measure: when welfare is the government's responsibility, there is a traceable line of obligation from soldier to commanding officer to ministry to legislature; when it is contracted out, that line dissolves, and the soldier falls through the gap between two systems that were never built to hold him. Private and donor-funded programs are further structurally fragile — dependent on funding cycles that are politically contingent and frequently withdrawn, leaving personnel who have begun to engage with support more exposed when it disappears than they were before it arrived. Critically, no external organization can do what only the institution itself can do: transform the command culture that produces stigma,

restructure the deployment conditions that produce exhaustion, and embed welfare as an operational rather than peripheral concern. These changes require political will, budgetary commitment, and institutional accountability — precisely the resources that only the state can provide and only the state can sustain.

## Conclusion

This article has offered a sociological assessment of the mental health of security personnel working in Boko Haram-affected communities in Yobe State, Nigeria, organised around three interconnected analytical perspectives: institutional neglect as a social stressor; social support erosion in conflict communities; and stigma, masculinity, and help-seeking behaviour. In doing so, it has made a contribution that is distinctively sociological in its orientation — one that situates mental health not as a clinical phenomenon reducible to individual exposure and treatment, but as a social product shaped by institutional power, relational structures, and cultural norms.

The argument developed across these three perspectives converges on a single, sobering conclusion: security personnel in Yobe State carry a substantial mental health burden that is structurally produced by the conditions in which they live and work, systematically unaddressed by the institutions that deploy them, and actively suppressed by the social and cultural norms that govern their professional identity. This is not a problem that can be resolved through clinical intervention alone. It demands institutional reform — in how security agencies conceptualise and respond to the psychological welfare of their personnel. It demands community investment — in the restoration of the social networks and relational structures that conflict has dismantled. And it demands cultural transformation — in the meanings attached to psychological vulnerability, masculine identity, and help-seeking within and beyond security institutions.

The implications for future research are equally clear. The sociological study of mental health among security personnel in Nigerian conflict settings

remains in its early stages, and the gaps are significant. Longitudinal studies are needed to track mental health trajectories across deployment cycles. Qualitative research is needed to give voice to the lived experiences of security personnel themselves — their own accounts of distress, coping, help-seeking, and recovery. Comparative studies across the three most conflict-affected states — Yobe, Borno, and Adamawa — are needed to establish the extent to which findings from one context generalise to others. And theoretical work is needed to develop sociological frameworks that are adequate to the specificity of the Nigerian context — frameworks that take seriously the intersection of conflict, institutional structure, gender, religion, and ethnicity in shaping mental health outcomes.

Medical Sociology, as a discipline, is well positioned to lead this research agenda. Its commitment to structural analysis, its sensitivity to social context, and its insistence on the social production of health and illness provide exactly the tools needed to illuminate a problem that clinical frameworks, working alone, have consistently failed to see. This article has sought to demonstrate what that illumination looks like, and to argue, from the evidence assembled here, that the security personnel of Yobe State deserve, at minimum, to be seen.

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