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Homicidal violence during foreign military missions — prevention and legal issues

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Objectives. The study involved Nigerian soldiers engaged in peacekeeping missions in Liberia and Yugoslavia. Using case illustrations, the study sought to describe patterns of homicidal violence among soldiers from the same country or soldiers from allied forces, and to suggest possible reasons for the attacks.

Design and setting. Nigeria was actively involved in peacekeeping missions in Liberia between 1990 and 1996. During this period, intentional homicidal attacks occurred among the Nigerian military personnel. Post-homicidal interviews conducted among the perpetrators were combined with evidence obtained at military courts to produce the case studies.

Subjects. Six Nigerian military personnel who attacked other Nigerians or soldiers from allied forces, with homicidal intent.

Results. Possible predisposing and precipitating factors for these attacks were highlighted. The possibility of recognising these factors before embarking on overseas missions was discussed, so that preventive measures could be instituted as far as possible. Finally, medico-legal implications of homicide in the military were discussed.

Conclusions. A certain degree of pre-combat selection is essential to exclude soldiers with definite severe psychopathology. A clearly defined length of duty in the mission areas and adequate communication with home could reduce maladjustment. Health personnel deployed to mission areas should be very conversant with mental health issues so that early recognition of psychological maladjustment is possible.

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Ordinarily, violence and injury inflicted on enemy forces in the war zone is regarded as normal, but the same cannot be said when it occurs among members of the same force or allied forces. Thus homicidal violence inflicted by a soldier on his fellow soldiers is a grave source of concern.

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It has been suggested that the risk of homicide is particularly high among people with post-traumatic stress disorder (PTSD).[1] Sometimes homicidal violence presents as sudden explosive rage with little or no warning and may be associated with substance use or subtle organic cerebral lesion.

Although murder is a well-recognised cause of mortality among adolescents and young adults,[2] and a vast majority of active military personnel are young, few data are available on

the incidence of homicide in military settings. In peacetime, homicide rates among military populations may be as high as 6 per 100 000 in the USA, although this mirrors the overall rate for American society.[3]

Investigations into the incidence of homicide among military personnel are of interest because they are useful for predictive and preventive purposes. However, the issue of prediction of potential assailants continues to be controversial. Munro and Rumgay[4] found that whereas only 27.5% of homicide cases were predictable, up to 65% were preventable. In a survey of those convicted for homicide in the UK Shaw and co-workers[5] found that only 44% had a lifetime history of mental disorder. It would therefore seem that a current or past mental disorder cannot be the sole factor predictive of a predisposition to homicide. Indeed, Mullen[6] showed that cultural and social factors might exert greater influence on homicide levels than mental disorders.

In light of the foregoing we aimed, using case studies, to identify the social, cultural and mental ill health factors of importance in homicide in a military population.

Method

Nigeria led the West African military peacekeeping mission (called the Economic Community of West African States Monitoring Group, or ECOMOG) to the Liberian civil war of 1990 - 1996. The war was moderate to severe in intensity and lethality, although these waxed and waned. The patterns of psychiatric disorder among Nigerian troops during the crisis have been described elsewhere.[7]

During the hostilities the first author (GTO) was located at the Base Hospital, Lagos, Nigeria, attending to psychiatric cases evacuated from Liberia and those which were complications of medical and surgical disorders. The second author was located in Liberia and later in Sierra Leone. He was in Liberia when all the homicide cases occurred and had access to the court evidence. He also interviewed some of the assailants. The sixth case was a Nigerian officer on a peacekeeping mission in Yugoslavia treated by the first author.

Case 1

A 50-year-old Major arrived at the mission area barely 3 weeks before the homicide incident. He had had repeated arguments with his driver, whose driving methods and behaviour he continually criticised. In a fit of overwhelming rage which occurred after the driver disobeyed a minor command, he fired some shots into the driver's thigh and kept telling him 'look at what you have done to yourself'. Unfortunately, the victim died within minutes of arriving at the hospital.

Case 2

A 34-year-old Lance Corporal was assigned to a checkpoint as guard commander. Many checkpoints were considered financial 'gold mines'. There were allegations of monetary extortion, and engagement of soldiers for local security by civilians. On the fateful day, the Lance Corporal entered into an argument with a senior soldier over issues probably related to money. The Lance Corporal suddenly shot and killed the Corporal.

Case 3

A 30-year-old Lieutenant was arrested for killing two Liberian currency changers. The officer arrived from his frontline battalion location and somehow got the civilians to spend the night with him, pretending he had a large sum of US dollars to change. During the night he detonated a grenade inside the room, while he hid in a wardrobe. Neighbours intervened on hearing the explosion, and found the two victims dead.

Interrogation revealed that he was trafficking in marijuana and that the victims had probably swindled him earlier. He also had a previous history of antisocial behaviour including armed robbery and murder in Nigeria, but unfortunately had escaped justice.

Case 4

A 46-year-old Sergeant had been extensively involved in the most intense military operation in Liberia, with the highest casualty figures in 1992. Three days before his death he reported to the Regimental Aid Post complaining of fatigue, restlessness and other nonspecific symptoms. The attending doctor rejected his demand for a certificate excusing him from duty but instead counselled him to see his commander for permission to withdraw from his duty location.

On the day of his death he went on board a merchant ship and ordered everyone to get out. When they hesitated he opened fire, injuring a few people. In the process he kept screaming and firing towards the mission headquarters, until the guards on duty shot him dead.

Investigation revealed that the soldier had been in the mission area continuously for 26 months, and despite repeated demands had not been able to get permission to travel to Nigeria, even from doctors, as no physical illness was diagnosed. He was said to have become very depressed before his death.

Case 5

A 34-year-old Captain shot his immediate superior officer and maintained a rather unremorseful attitude thereafter, except during his trial when he wept profusely. There had been several misunderstandings between him and the deceased. Indeed, the victim had threatened disciplinary action against him. The assailant was reported to have increased his alcohol intake since arriving at the mission area, particularly so a few weeks before the homicide. Others confirmed that he drank

heavily the night preceding the homicide while complaining bitterly about certain decisions taken by his superior officer, and about other officers.

Further investigations revealed that before the homicide the assailant had been rather detached, unfriendly and unduly aggressive. He had even threatened another officer with his pistol, but had not been sanctioned. He also complained of persistent nightmares in which his jilted Liberian girlfriend threatened him with death. This became so worrisome that he sought treatment from a local herbalist. He had a previous history of violence and disobedience to constituted authority particularly when drunk, and was alleged to have planned to kill three officers before killing himself. Unfortunately, no psychiatric intervention was sought before the attack.

Case 6

A 35-year-old Captain on a peacekeeping mission in Yugoslavia murdered an unsuspecting fellow peacekeeper from a European country by hitting him on the head. Although the officer had been moody before the episode, there had been no argument between them. The other officer was conveying him to a rear location without a second escort. The assailant had seen a psychiatrist in the mission area. He had been diagnosed as having a delusional disorder and was started on a neuroleptic before the episode. After repatriation to Nigeria he was seen by one of the authors (GTO) and diagnosed as having paranoid schizophrenia. Indeed, he believed delusionally that the victim was sent to convey him to where he was to be shot, and he wanted to pe-empt the move. The officer had a long history of cannabis use, and had tended to be suspicious of colleagues during a peacekeeping mission in Liberia. The trial arrived at a verdict of 'guilty but for reason of insanity'.

Discussion

Unfortunately, limited psychological autopsy and brief interviews were all that could be done for the assailants as they had had no psychiatric encounter before the attack, except in the case of the Yugoslavian Captain. From an examination of the cases described it would seem that the aetiological factors for homicide among military personnel in the war situation could be classified into three groups. These are predisposing factors predating the overseas mission (antecedent factors), factors operating in the mission area for variable lengths of time before the attack, and factors immediately preceding the attack.

Predisposing factors pre-dating the foreign mission

Antecedent factors include psychotic disorders and other problems that are not so obvious (for example anxiety disorders and personality disorders), as well as social and cultural factors. Violence can occur in many types of psychiatric disorders. For example, it has been suggested that about 8 - 10% of schizophrenics have a history of violence in the 12 months before being interviewed.[8] Known schizophrenics and patients with other serious conditions are unlikely to be sent to the battlefield, although some could have been missed in the screening process, as in case 6. Similarly, individuals with a past criminal history, as in case 3, should be avoided. The pre-mission screening process could easily miss patients with anxiety disorders and they could be poorly adjusted at the mission area. Personality disorders could be missed, particularly in recently enlisted personnel. The disorderly and unnatural conditions of the battlefield constitute fertile ground for the unguarded impulses of the psychopath. For example, it was reported that certain individuals enjoyed meals of human blood and the sight of slashed fetuses during the Liberian civil war. Cases 3 and 5 illustrate how the high level of violence in a war situation can mean that antisocial behaviour is tolerated. Substance-dependent persons, especially those on cannabis, might go undetected to foreign military missions, as illustrated by case 6, who also had previous maladjustment. It was rather curious that the officer mentioned in case 3 was not attended to at home for manifestations of psychopathy.

From a preventive point of view, there is a need to scrutinise the physical and mental wellbeing of individuals before sending them on foreign missions. Information obtained from fellow soldiers, unit Regimental Sergeant Majors and family members may help to exclude those prone to excessive worry, psychopathy, substance abuse, and physical disorders with mental health implications such as bronchial asthma, epilepsy, hypertension and tuberculosis. Fortunately, adequate screening for HIV is now mandatory.

Predisposing factors at the mission area

The problem of breakdown of law and order in civil society and to a lesser extent in the military during a civil war has been highlighted. This was illustrated in case 2, where threatening others with a pistol was repeatedly unsanctioned.

Periods of low-intensity combat or no combat occurred intermittently during the Liberian war. Unfortunately many soldiers remained in Liberia for several months without a break and witnessed periods of intense and low-grade fighting. Psychological problems found in such soldiers included boredom, increased alcohol consumption (including a gun-powder-alcohol concoction), and increased use of cigarettes, cannabis and cocaine. Other problems included sexual promiscuity and reckless spending. More serious problems included irritability, explosive outbursts of anger often out of proportion to the cause, and even paranoid behaviour and utterances. Some of these predisposing factors built up until the homicide behaviour was precipitated, as illustrated in case 4. Sometimes no mental disorder was apparent, and homicide resulted from an argument over financial or other matters (case 2).

In case 4, the soldier had been in Liberia without a break for 26 months. The insensitivity of frontline doctors in recognising symptoms of possible PTSD needs to be highlighted here. From a preventive point of view, health workers in the battle mission area should always be thoroughly trained to distinguish mental disorders from malingering. In Liberia doctors often missed cases of acute combat reaction because soldiers were thought to be malingering.[7]

It is possible that with a detailed mental state assessment, cases 4 and 5 might have voluntarily declared their homicidal intentions. Unfortunately where such intentions were voluntarily declared (for example case 5) no appropriate action was taken. This indicates a need for health workers at all levels not to disregard homicidal (and suicidal) threats. Indeed, changes in behaviour and tendencies, for example, increased alcohol intake, boastfulness, excessive irritability and anger, ought to be reported early by colleagues to prevent unpleasant consequences.

In battle substance use may enhance alertness, reduce boredom and promote peer group interaction,[7] but it poses a high risk for homicidal violence.[8] From a preventive point of view it would seem that short, well-defined length of duty might reduce battlefield maladjustment mental disorders.

Precipitating factors at the mission area (immediate factors)

Intense argument was perhaps the most prominent precipitating factor, as illustrated by cases 1 and 5. It is well known that certain forms of personality abnormality, substance abuse and subtle cerebral lesions may predispose to argument-related, impulsive interpersonal violence.[1] Unfortunately, the reality of the war zone and a severe dearth of mental health workers, especially psychiatrists and psychologists, made any meaningful intervention impossible even in violence-prone persons.

Military disposal of homicide cases

In the Nigerian military, psychopathy, substance intoxication and acute stress are usually not acceptable pleas for mitigation in the case of homicide, more so during extreme emergencies like war. It follows that reducing a charge of murder to a less serious one of manslaughter was impossible in most of the cases described. However, where homicide cases seem bizarre or involve extreme impulsiveness some investigations ought to be done, including electroencephalography, irrespective of the weight of evidence obtained therefrom. Premeditated killing obviously might not warrant such examination, just as killing for ritual purposes or on the basis of ethnic sentiments.

Case 4 was clearly one of PTSD with depressive features. In peacetime, such a claim could have been upheld as defence based on diminished responsibility, as for example in case 6 with paranoid schizophrenia. It is not clear whether a court in the mission area would have taken a similar decision.

Conclusion

This report has attempted to highlight some predisposing and precipitating factors for homicide during a peacekeeping military mission, using case studies of Nigerian soldiers. It is clear that conditions prevailing in the mission areas during war are far from normal and in no way comparable to a peacetime situation. Those conditions affect the mental functioning of peacekeepers, as well as the outlook of judges presiding at homicide trials. For countries with limited experience in foreign peacekeeping operations, it is worthwhile benefitting from the Nigerian experience. A reasonable degree of selection with regard to those to be sent on overseas military missions is justifiable, excluding in particular those with a history of violence, personality disorder, substance dependence or psychosis. Family and personal problems at home could lead to poor adjustment. A clearly defined length of duty, backed by adequate contact with loved ones at home may also be beneficial. Medical doctors in the mission areas should have adequate experience in mental health so that symptoms of stress-related disorders can be recognised and handled appropriately, even when patients do not present with physical symptoms. Also, threats of violence and homicide, whether overtly or covertly expressed, should not be ignored. Finally, intense cohesion and morale, achieved at home through long periods on interpersonal relationship among troops (rather than pooling strangers from different formations for the purpose of foreign operations) will promote individual psychological adjustment and minimise mental breakdown on the battlefield.

Dedication

This work is dedicated to Dr C Oguine, the second author, who was killed while on active duty during another tour in Sierra Leone.

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