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Stigma, social support, and trauma exposure as predictors of mental health among conflict-affected adolescents in Benue State, Nigeria

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Abstract: This study examined the influence of trauma exposure, stigma, and perceived social support on mental health outcomes among conflict-affected adolescents in Benue State, Nigeria. A cross-sectional survey design was employed, involving 169 adolescents aged 12–19 years selected from seven conflict-affected local government areas. Standardized instruments (DASS-42, Stigma Scale, and ISEL-12) were used for data collection. Data were analyzed using One-Way ANOVA and multiple linear regression. Results showed that adolescents with first-degree trauma exposure reported significantly higher levels of depression, anxiety, and stress than those with second-degree exposure. Stigma significantly predicted poorer mental health outcomes, while perceived social support, particularly belongingness and tangible support, was associated with reduced psychological distress. Jointly, stigma and social support accounted for a substantial proportion of variance in mental health outcomes. This study provides context-specific evidence from a conflict-affected region in Nigeria, highlighting the dual role of stigma as a risk factor and social support as a protective factor. Findings underscore the need for integrated psychosocial interventions focusing on stigma reduction and strengthening social support systems among conflict-affected adolescents.

Keywords: conflict-affected adolescents; Benue State Nigeria; DASS-42; mental health; perceived social support; stigma; trauma exposure

Introduction

Adolescent mental health is a growing global public health concern, with about 13% of young people worldwide experiencing at least one mental disorder (Kuehn, 2021; UNICEF, 2021). The challenge is particularly acute in Sub-Saharan Africa (SSA), where adolescents aged 10–19 constitute nearly 23% of the population, yet mental health resources remain critically limited (Sequeira et al., 2022; WHO, 2021a). Prevalence estimates indicate high rates of depression, anxiety, emotional and behavioral difficulties, PTSD, and suicidal ideation among adolescents in the region, underscoring substantial unmet needs

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(Jörns-Presentati et al., 2021). These vulnerabilities are intensified in conflict-affected settings, where adolescents exposed to armed violence experience cumulative trauma, displacement, and social exclusion (Aluh et al., 2018).

This study is conceptually grounded in the Stress-Buffering Hypothesis, which posits that social support mitigates the adverse psychological effects of stressors such as trauma and stigma. Although MHL is increasingly recognized as central to improving adolescent mental health outcomes (Zenas et al., 2020; Zare et al., 2022), Nigerian research has largely concentrated on university populations, leaving younger adolescents underrepresented. Family dynamics and gender norms strongly influence mental health awareness and help-seeking, with girls generally exhibiting higher literacy and willingness to seek support, while parental attitudes shape coping styles and openness to care (Coles et al., 2016; Onah et al., 2023). Stigma remains a major barrier across Nigeria and Africa (Abege et al., 2024), rooted in religious beliefs, gender expectations, and cultural interpretations that frame mental illness as spiritual or moral failure (Ras, 2023; Africa Polling Institute & EpiAFRIC, 2020). Such beliefs shape shared social knowledge and perpetuate stigmatizing attitudes from childhood into adulthood (Oladunni et al., 2021; Ahmad et al., 2021). Adolescent help-seeking is further constrained by emotional competence, social expectations, and systemic barriers, leading many to rely on peers or family rather than professionals (Radez et al., 2021). Cultural preferences for spiritual or traditional healing and limited-service availability reduce engagement with formal care (Emenyi, 2023). Supportive family environments promote help-seeking, whereas stigmatizing homes encourage concealment of distress (Onah & Mataluwo, 2025; Adeyemi, 2024). Addressing these intersecting factors is critical for designing culturally responsive interventions for vulnerable adolescents, including those affected by armed conflict.

Despite growing research on adolescent mental health in Sub-Saharan Africa, limited studies have simultaneously examined trauma exposure, stigma, and perceived social support within conflict-affected populations. Existing studies often focus on single predictors or general populations (Africa Polling Institute & EpiAFRIC, 2020; Abreu et al., 2025), with little attention to adolescents associated with armed groups in Nigeria. Furthermore, the mechanisms through which stigma and social support interact to influence mental health outcomes remain underexplored. This study addresses this gap by providing an integrated analysis of these variables within a high-risk, conflict-affected population.

This study seeks to determine whether significant differences exist in mental health outcomes among conflict-affected adolescents based on their level of trauma exposure. It also examines the predictive effect of stigma on mental health outcomes and evaluates the extent to which perceived social support contributes to adolescent psychological well-being. Finally, the study investigates whether stigma and perceived social support jointly predict mental health outcomes and how their interaction influences psychological distress among conflict-affected adolescents.

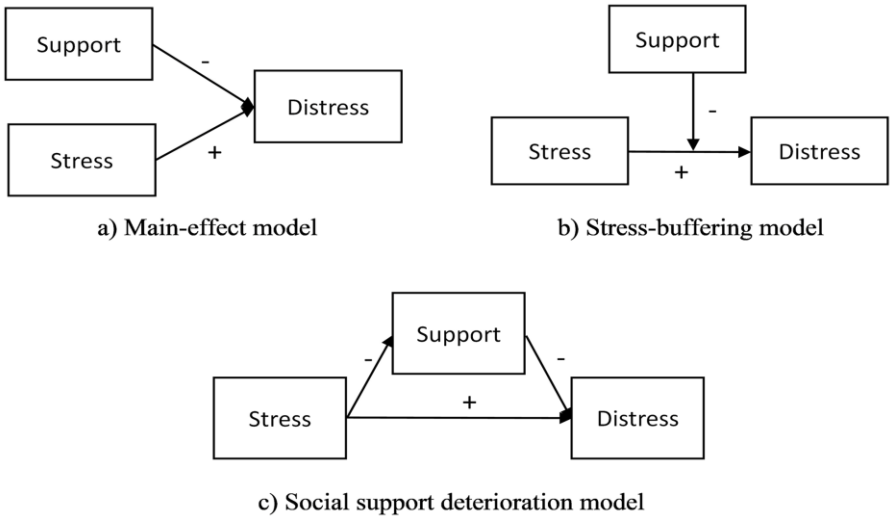
Theoretical Framework

This study is anchored on the Stress-Buffering Hypothesis (Cohen & Wills, 1985), which posits that social support mitigates the negative psychological effects of stress. Among conflict-affected adolescents in Benue State, exposure to violence, displacement, and stigma constitutes high-stress events, yet greater perceived social support, particularly belongingness and tangible assistance was associated with lower

depression, anxiety, and stress (Chen et al., 2021; Lam, 2024; Kim et al., 2025). Stigma intensified mental health difficulties, but social support weakened these effects, highlighting its buffering role (Hartley & Coffee, 2019). Appraisal support was less effective, indicating practical and relational support are more protective in post-conflict, low-resource settings (Kaden et al., 2024; Rosen et al., 2020).

Diagram 1

Interactive Effect of the Stress-Buffering Hypothesis (Cohen & Wills, 1985)



Methods

Design

The study adopted the quantitative cross-sectional survey design. Data obtained from the Ashli Foundation for Education, Healthcare, Welfare, and Social Justicea Non-Governmental Organization (NGO) operating within Internally Displaced Persons (IDP) camps in seven of the most affected Local Government Areas in Benue State revealed that, as of May 16, 2025, there were a total of 3,562 adolescents associated with armed groups residing in the camps. Of this number, 1,945 (54.6%) were female and 1,617 (45.4%) were male. These figures were distributed across the seven Local Government Areas accordingly. Although the cross-sectional design limits causal inference, it is appropriate for identifying associations among variables in hard-to-reach, conflict-affected populations.

Sampling Technique

The purposive sampling approach was used to select adolescents who met the inclusion criteria those exposed to violence and who were identified as having associations (direct or indirect) with armed groups. While purposive sampling may introduce selection bias, it was necessary due to the specialized nature of the population. To minimize bias, participants were drawn from multiple locations and stratified by gender and exposure level.

From the foregoing, in details, the study involved 169 adolescents identified as adolescents associated with armed groups in Benue State. Their ages ranged from 12 to 19 years, with an average age of 13.48 years (SD = 3.01). Participants were drawn from seven Local Government Areas in Benue State, with the following distribution: Guma (48 participants, 28.4%), Logo (37, 21.9%), Gwer-West (28, 16.6%),

Agatu (7, 4.1%), Katsina-Ala (16, 9.5%), Ukum (28, 16.6%), and Apa (5, 3%). Of the total participants, 76 (45%) were male, and 93 (55%) were female. A total of 63 adolescents (37.3%) had experienced abduction by armed groups, while the remaining 106 (62.7%) had not been abducted but had endured various forms of violence - Destruction of properties, Ambushes on roads, looting, and resource exploitation linked to insurgency activities in the region, Benue State.

Table 1

The Demographics of Adolescents Associated with Armed Groups in Benue State

Variable	Category	n	%
Age (years)	M = 13.48, SD = 3.01		
Gender	Male	76	45.0
	Female	93	55.0
Local Government Area	Guma	48	28.4
	Logo	37	21.9
	Gwer-West	28	16.6
	Ukum	28	16.6
	Katsina-Ala	16	9.5
	Agatu	7	4.1
	Apa	5	3.0
Abduction Experience	Abducted	63	37.3
	Not Abducted	106	62.7

Note. M = Mean; SD = Standard Deviation

Procedure

Ethical approval for this study was obtained from the Ministry of Health and Human Services, the body responsible for overseeing all hospitals in Benue State. Additional authorization was secured from the Research Ethics Committees of the Faculty of Social Sciences, Rev. Fr. Moses Orshio Adasu University, Makurdi. The study employed a multi-stage sampling technique for participant selection. In the first stage, a stratified sampling method was used to identify adolescents associated with armed groups across the seven affected Local Government Areas in Benue State and to categorize them by gender.

Proportionate samples of male and female participants were then drawn from each Local Government Area to constitute the total study sample. In the second stage, purposive sampling was applied to recruit adolescents associated with armed groups who met the inclusion criteria. This approach was appropriate given the study's focus on adolescents aged 19 years and below who were capable of responding to the questionnaire independently or with assistance from research assistants or caregivers. Written informed consent was obtained from all participants, and where direct consent was not possible, caregivers provided the required information and consent. The study adhered strictly to ethical guidelines governing psychological research, including confidentiality, risk assessment, and data handling procedures. Participant exposure to violence was classified as first-degree or second-degree exposure based on the severity and life-threatening nature of their experiences.

Thus, first-degree trauma exposure was defined as direct personal experience of life-threatening events such as abduction, physical violence, or armed attacks. Second-degree exposure referred to

indirect experiences, including witnessing violence, displacement, or loss of property without direct physical harm.

Instruments

Stigmatization among adolescents associated with armed groups was measured using the 28-item Stigma Scale (King et al., 2017), assessing Discrimination (12 items), Disclosure (11 items), and Positive Aspects (5 items), rated on a 5-point Likert scale, with higher scores indicating greater stigma. Positive aspect items were reverse-scored. Internal consistency was strong, $\alpha = 0.87$ overall. Perceived social support was assessed using the ISEL-12 (Cohen et al., 1985), measuring Appraisal, Belonging, and Tangible Support on a 4-point scale. Mental health disorders were measured with the DASS-42 (Lovibond & Lovibond, 1993), comprising Depression, Anxiety, and Stress subscales, with high internal consistency ($\alpha = 0.87–0.90$) and higher scores indicating greater symptom severity. The instruments used in this study have demonstrated acceptable reliability in previous African contexts. Minor contextual adaptations were made to ensure cultural relevance and comprehension among adolescents in conflict-affected communities.

Data analysis

For data analysis, both descriptive and inferential statistical techniques were employed. Descriptive statistics, including frequencies, percentages, means, and standard deviations, were used to summarize the demographic characteristics of the participants. Missing data were minimal (<5%) and handled using listwise deletion. Data were screened for response bias and outliers prior to analysis. Normality test, linearity test, multicollinearity test, and heteroscedasticity test were conducted and met the basic assumption as outlined. Inferential analyses included the use of One-Way Analysis of Variance (ANOVA) and multiple linear regression.

The ANOVA was utilized to determine whether there were significant differences in mental health disorders between adolescents associated with armed groups in Benue State who experienced first-degree versus second-degree exposure to violence. Additionally, multiple linear regression was conducted to assess both the independent and combined effects of stigmatization and perceived social support on mental health outcomes among the adolescents associated with armed groups in Benue State.

Results

Normality test, linearity test, multicollinearity test, and heteroscedasticity test were calculated. In addition to significance testing, Confidence intervals (95%) were also computed to complement statistical significance and enhance interpretation of effect sizes. It was discovered that the normality of residuals was tested using the One-Sample Kolmogorov-Smirnov test, and the results showed the following; The assumption of normality was assessed using the Kolmogorov-Smirnov (K-S) test on unstandardized residuals. The results revealed a non-significant value (K-S $Z = 0.943$, $p = .287$), indicating that the residuals were normally distributed.

Linearity was evaluated by analyzing scatterplots of the standardized residuals against predicted values. The plots showed that residuals were randomly and evenly dispersed, without a discernible curve or pattern. The statistical test for deviation from linearity yielded non-significant results for both

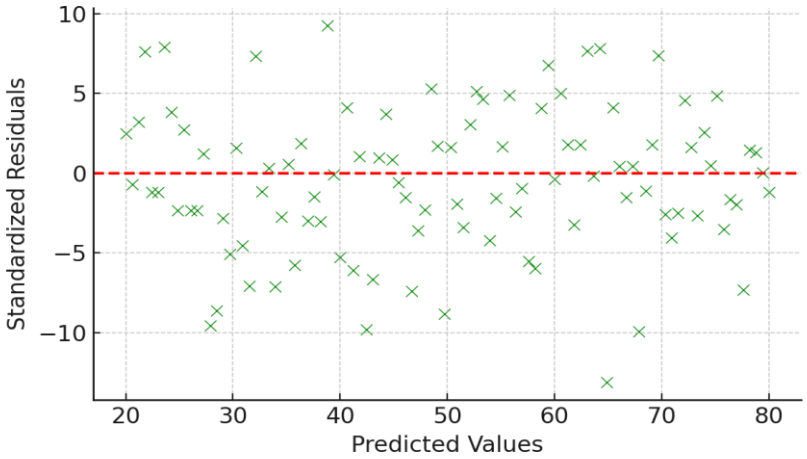
predictors (F = 1.053, p = .413 for stigma; F = 1.231, p = .369 for social support), confirming the linearity assumption.

To test for multicollinearity, the Variance Inflation Factor (VIF) and Tolerance values were examined. All predictors had VIF values well below the threshold of 10 and Tolerance values above 0.1. For example, VIF for stigma was 1.322 and for social support was 1.411, with corresponding Tolerance values of .757 and .709. These results indicate that multicollinearity is not a concern in this model.

Homoscedasticity was assessed using a scatterplot of standardized residuals against predicted values. The residuals appeared randomly spread, with no visible funnel-shaped distribution or pattern, indicating constant variance of errors across all levels of the predicted values.

Figure 1

Scatterplot of Residue Vs Predicted Value Mental Health



The figure 1 above shows the scatterplot for the heteroscedasticity test, showing the standardized residuals plotted against predicted values. The points are randomly distributed around the zero line, with no clear pattern, indicating homoscedasticity.

Table 2

One-Way ANOVA Comparing Mental Health Outcomes by Degree of Trauma Exposure Among Conflict-Affected Adolescents in Benue State

DV	Exposure to violence	N	Mean	Std.	Df	F	Eta Square	Sig.
Mental health disorders	First degree	93	129.90	17.85	(1,167)	143.46	0.49	.001
	Second degree	76	90.15	17.59				
Depression	First degree	93	47.74	8.48	(1,167)	166.81	0.39	.001
	Second degree	76	34.86	6.64				
Anxiety	First degree	93	39.99	9.38	(1,167)	49.75	0.29	.001
	Second degree	76	29.84	10.09				

Stress	First degree	93	37.24	13.01	(1,167)	28.81	0.17	.000
	Second degree	76	27.43	11.73				

Findings in Table 2 indicate a significant difference in overall mental health disorders between adolescents with first-degree and second-degree exposure to violence, $F(1,167) = 143.46$, $p < .001$. Adolescents with first-degree exposure scored substantially higher ($M = 129.90$, $SD = 17.85$) than those with second-degree exposure ($M = 90.15$, $SD = 17.59$), with a large effect size ($\eta^2 = 0.49$). Significant differences were also observed for depression, $F(1,167) = 166.81$, $p < .001$, anxiety, $F(1,167) = 49.75$, $p < .001$, and stress, $F(1,167) = 28.81$, $p < .001$. Across all domains, adolescents with first-degree exposure reported higher symptom levels, confirming Hypothesis one. The effect sizes ($\eta^2 = 0.17$–0.49) indicate moderate to large practical significance, suggesting substantial differences between exposure groups.

Table 3

Multiple Linear Regression Analysis Showing Influence of Stigmatization on Mental Health Disorders Among Adolescents Associated with Armed Groups in Benue State

DV	Predictors	R	R^2	df	F	Sig.	β	T	Sig.
Mental health disorders	Constant							4.17	.002
	Discrimination	.867	.752	3,165	167.82	.001	.605	11.04	.002
	Disclosure						.331	5.04	.001
	Positive aspect						.129	3.06	.003
Depression	Constant							4.63	.001
	Discrimination	.711	.505	3,165	76.18	.001	.571	8.51	.000
	Disclosure						.284	2.68	.006
	Positive aspect						.017	.044	.957
Anxiety	Constant							-.49	.655
	Discrimination	.809	.654	3,165	112.05	.000	.238	4.03	.001
	Disclosure						.312	4.02	.001
	Positive aspect						.309	5.12	.001
Stress	Constant							1.68	.052
	Discrimination						.370	3.67	.000
	Disclosure						.081	.705	.481
	Positive aspect						.154	1.20	.174

Findings in Table 3 demonstrate a significant influence of stigmatization on mental health disorders among adolescents associated with armed groups. The regression model showed a strong overall effect, $R = .867$, $R^2 = .752$, $F(3,165) = 167.82$, $p < .001$, indicating that discrimination, disclosure, and the positive aspect of stigma jointly explained 75.2% of the variance in overall mental health disorders. This represents a substantial proportion of explained variance according to conventional benchmarks. Discrimination emerged as the strongest predictor ($\beta = .605$, $p = .002$), followed by disclosure ($\beta = .331$, $p = .001$) and the positive aspect of stigma ($\beta = .129$, $p = .003$), indicating a positive association between stigmatization and psychological distress. For depression, stigmatization accounted for 50.5% of the variance, $R^2 = .505$,

F(3,165) = 76.18, p < .001. Discrimination (β = .571, p = .000) and disclosure (β = .284, p = .006) significantly predicted depressive symptoms, while the positive aspect of stigma was not significant. Anxiety was also significantly influenced, R^2 = .654, F(3,165) = 112.05, p < .001, with all predictors contributing meaningfully, particularly disclosure and positive stigma. For stress, stigmatization explained a smaller but significant proportion of variance, R^2 = .176, F(3,165) = 11.753, p < .01, with discrimination as the only significant predictor. Overall, the findings support Hypothesis two, highlighting discrimination as the most consistent and impactful contributor to adverse mental health outcomes.

Table 4

Multiple Linear Regression Analysis

DV	Predictors	R	R^2	df	F	Sig.	β	t	Sig.
Mental health disorders	Constant							30.97	.001
	Appraisal sup.	.702	.493	3,165	53.48	.000	-.082	-1.18	.264
	Belongingness						-.391	-3.59	.001
	Tangible sup.						-.417	-3.57	.000
Depression	Constant							28.15	.000
	Appraisal sup.	.527	.273	3,165	20.62	.000	-.069	-0.92	.433
	Belongingness						-.279	-1.80	.044
	Tangible sup.						-.279	-3.96	.001
Anxiety	Constant							-0.15	.000
	Appraisal sup.	.538	.286	3,165	22.06	.000	-.014	-1.98	.882
	Belongingness						-.327	-3.16	.002
	Tangible sup.						-.259	-3.09	.002
Stress	Constant							14.17	.000
	Appraisal sup.	.450	.202	3,165	13.93	.000	-.087	-0.916	.351
	Belongingness						-.256	-2.681	.010
	Tangible sup.						-.170	-1.370	.017

Overall, these findings support Hypothesis three, confirming that belongingness and tangible support are consistent protective factors against depression, anxiety, and stress among adolescents associated with armed groups.

Table 5

Multiple linear regression analysis showing joint influence of stigmatization and perceived social support on mental health disorders among adolescents associated with armed groups in Benue State

DV	Predictors	R	R^2	Df	F	Sig.	β	t	Sig.
Mental health disorders	Constant	.769	.774	2,166	285.30	.000		6.48	.000
	Stigmatization						.720	13.64	.002

Findings in Table 5 showed a significant joint influence of stigmatization and perceived social support on overall mental health disorders among adolescents associated with armed groups, R = .769, R^2 = .753, F(2,166) = 285.30, p < .01, accounting for 77.4% of the variance. This indicates a strong combined predictive model of mental health outcomes. Individually, stigmatization had a strong positive effect, β =

.720, p < .01, indicating that higher stigma is associated with greater mental health problems. Conversely, perceived social support had a significant negative effect (β = −.232, p < .01), indicating that stronger social support reduces mental health difficulties. These results confirm Hypothesis four, highlighting stigma as a risk factor and social support as protective.

Discussion

Hypothesis one indicated a significant difference in overall mental health disorders between adolescents associated with armed groups who experienced first-degree exposure to violence and those exposed to second-degree violence. Beyond confirming the stress-buffering hypothesis, this study extends the theory by demonstrating that not all forms of social support are equally protective, particularly in low-resource, conflict-affected environments. Within the broader context of structural violence, political instability, and chronic marginalization in Benue State, these findings demonstrate that unequal trauma exposure differentially shapes psychological outcomes among vulnerable adolescents (Adeniji, & Ogubuike, 2025; Onah et al., 2019). The magnitude of these differences, ranging from moderate to large effect sizes, suggests that the observed patterns are robust and unlikely to be due to chance (Ughasoro et al., 2022; Africa Polling Institute & EpiAFRIC, 2020; Jibril, 2023; Emenyi, 2023). These results align with the stress-buffering hypothesis, which posits that intense stressors heighten vulnerability to mental health disorders, particularly in the absence of protective resources such as social support (Cohen & Wills, 1985; Hartley & Coffee, 2019). However, these findings may also be influenced by unmeasured factors such as socioeconomic status, access to education, and family stability, which are known to affect adolescent mental health in conflict settings.

First-degree exposure, involving direct participation in or witnessing traumatic events, carries a heavier psychological burden than second-degree exposure. Consistent evidence from Nigeria and other conflict-affected settings shows that adolescents exposed to violence and terrorism report significantly worse mental health outcomes (Zenas et al., 2020; Zare et al., 2022; Poudel et al., 2020), influenced by contextual factors such as gender, poverty, and living conditions (Anne et al., 2021; Kadri et al., 2024; Olugbenga-Bello et al., 2024). These findings underscore the need for trauma-informed, socially responsive interventions targeting conflict-affected adolescents.

Hypothesis two demonstrated that stigmatization significantly influences mental health disorders among adolescents associated with armed groups in Benue State, functioning as a powerful social stressor that compounds prior trauma. Adolescents who experienced social rejection, exclusion, or unfair treatment reported significantly higher levels of depression, anxiety, and stress, highlighting stigma as a critical determinant of psychological distress. Disclosure of past involvement with armed groups, although often necessary for reintegration and access to services, was associated with increased emotional distress due to judgment, shame, and social rejection. In this way, stigma operates not only interpersonally but also structurally, undermining recovery and social belonging (Ogwuche et al., 2021). Adaptive responses such as cognitive reframing showed weak and inconsistent protective effects, with minimal impact on depression and stress, hence, individual coping strategies alone are insufficient to counter pervasive stigma (Emek, 2021).

This pattern aligns with the stress-buffering hypothesis, which conceptualizes stigma as a chronic stressor that amplifies psychological distress in the absence of adequate social support. Consistent with findings from Benue State and other conflict-affected contexts, high levels of internalized and public stigma have been linked to severe mental health outcomes, including depression, anxiety, PTSD, and maladaptive coping behaviors (Mpem & Mase, 2024; Oteyi & Toyin, 2013; Shindi et al., 2019). Widespread stigmatizing attitudes among adolescents further reinforces social exclusion. Collectively, these findings underscore the need for stigma-sensitive, diversity-informed interventions addressing relational, community, and structural sources of harm.

Hypothesis three established that perceived social support significantly influences overall mental health outcomes among adolescents associated with armed groups in Benue State, underscoring its role as a culturally embedded protective factor in conflict-affected settings. Among the dimensions examined, belongingness and tangible support emerged as the most influential. Adolescents who reported stronger feelings of acceptance, connectedness, and inclusion within family, peer, or community networks experienced significantly lower levels of depression, anxiety, and stress (Ngwu et al., 2024). This sense of belonging appears to counteract the isolating effects of violence exposure and stigma by restoring social identity and relational bonds. Tangible support, including material resources and practical assistance, was also associated with fewer mental health difficulties, highlighting the importance of material stability in psychological recovery following conflict (Guusu et al., 2025). In contrast, appraisal or emotional support alone did not show a statistically significant effect, showing that reassurance without concrete assistance may be insufficient in contexts marked by deprivation and social exclusion (Ogwuche et al., 2020).

These findings align with the stress-buffering hypothesis, which posits that perceived social support reduces the psychological impact of trauma and chronic stressors (Kaden et al., 2024). Consistent evidence from Nigeria and other conflict-affected contexts demonstrates that structured social networks, family support, and caregiver relationships mitigate PTSD, emotional distress, and behavioral problems among war-affected adolescents (David et al., 2021; Onah & Dele, 2022; Edeh et al., 2023; Scharpf et al., 2024; Wong, 2022). Collectively, these findings emphasize the need for interventions that strengthen belongingness, community inclusion, and access to tangible resources (Ikuteyijo et al., 2025; Shindi et al., 2019).

Hypothesis four confirmed a significant combined effect of stigmatization and perceived social support on overall mental health disorders among adolescents associated with armed groups in Benue State. Stigmatization emerged as a strong positive predictor of psychological distress, with adolescents who experienced labeling, devaluation, or social exclusion reporting higher levels of depression, anxiety, and stress. Disclosure of past involvement with armed groups often intensified distress by exposing adolescents to shame, judgment, and rejection. In contrast, perceived social support was negatively associated with mental health disorders, such that adolescents who felt supported by family, peers, or community resources reported fewer symptoms (Neem Foundation, 2021), even in the presence of high stigma. This interaction demonstrates a buffering effect in which social support mitigates the harmful psychological impact of stigma, consistent with the stress-buffering hypothesis (Song et al., 2023).

These findings align with evidence from conflict-affected contexts, where stigma operates across interpersonal and structural levels but can be countered through meaningful social inclusion (Hartog et al., 2022). Nigerian studies similarly show that stigma contributes significantly to depression, anger, and reduced help-seeking, while supportive relationships and empathetic systems facilitate psychological resilience and care engagement (Kola et al., 2020; Chukwunonso et al., 2024). Persistent stigmatizing attitudes among adolescents further reflect deep-rooted societal norms rather than simple knowledge deficits. Collectively, the evidence underscores the need for integrated interventions that simultaneously reduce stigma and strengthen social support through education, social contact, and structural inclusion (Folayan et al., 2022; Kirabira et al., 2020).

Conclusions

This study examined the roles of trauma exposure, stigma, and perceived social support in predicting mental health outcomes among conflict-affected adolescents in Benue State, Nigeria. The findings demonstrate that adolescents with first-degree trauma exposure reported significantly higher levels of depression, anxiety, and stress compared to those with indirect exposure. Stigma emerged as a strong positive predictor of psychological distress, with discrimination and disclosure contributing significantly to adverse mental health outcomes. In contrast, perceived social support particularly belongingness and tangible support was associated with reduced levels of psychological distress, while appraisal support showed no significant effect.

Furthermore, stigma and perceived social support jointly accounted for a substantial proportion of the variance in mental health outcomes, highlighting their combined influence as risk and protective factors. These findings provide empirical evidence for the stress-buffering hypothesis within a conflict-affected adolescent population and contribute context-specific insights from a Nigerian setting. Overall, the study underscores the central role of social processes in shaping mental health outcomes among adolescents exposed to armed conflict.

Recommendations

Based on the study's findings, several strategic recommendations emerge to improve mental health and reintegration outcomes for adolescents affected by armed conflict in Benue State. *First,* trauma-informed, adolescent-focused mental health interventions are urgently needed, particularly for those with first-degree exposure to violence. Services should be culturally sensitive, accessible within IDP camps and affected communities, and integrated into primary healthcare systems. Mobile mental health clinics and trained community health workers delivering TF-CBT, narrative exposure therapy, and psychosocial first aid can strengthen local capacity. *Second,* comprehensive anti-stigma interventions are critical. Community sensitization campaigns, school outreach, radio programs, and engagement with religious and traditional leaders can challenge harmful stereotypes and promote empathy. Psychotherapy should include stigma-reduction modules addressing internalized shame and safe disclosure.

Third, perceived social support particularly belongingness and tangible assistance must be strengthened. Peer support groups, linked to NGOs and mental health services, can rebuild social connections and coping skills. Psychotherapeutic approaches should emphasize relational techniques, trust-building, and communal healing. Fourth, government agencies should fully implement the National

Mental Health Act, integrating school-based mental health literacy, trauma-responsive counselling, and relational support. Tangible resources, including safe housing, food, and educational materials, are essential for psychological stability, with conditional cash transfers supporting engagement in therapy and schooling. *Last,* robust monitoring and evaluation, including longitudinal data, is necessary to guide scalable, context-specific reintegration models. Overall, dual-focused interventions addressing stigma and strengthening social support alongside trauma-focused psychotherapy can enhance psychological wellbeing and successful reintegration.

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