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Psychological Trauma, Coping Strategies, and Mental Health Outcomes Among Internally Displaced Persons in Nigeria

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Abstract

Internally displaced persons (IDPs) in Nigeria have been exposed to armed conflict, communal violence, and forced relocation, yet few studies have tested how trauma exposure and coping together relate to post-traumatic stress symptoms in this population. This cross-sectional correlational study involved 400 IDPs (214 men, 186 women) drawn from camps and host communities in Borno and Adamawa States through multistage sampling. Participants completed the Harvard Trauma Questionnaire, the Brief COPE, and the PTSD Checklist for DSM-5 (PCL-5). Data were analyzed with Pearson correlation and multiple linear regression. Trauma exposure correlated positively with post-traumatic stress symptoms ($r = .28, p < .001$), whereas coping correlated negatively with them ($r = -.19, p < .001$); trauma exposure and coping were unrelated to each other ($r = .02$). Together the two predictors accounted for 11.6% of the variance in symptoms, $F(2, 397) = 26.07, p < .001$, with trauma exposure ($\beta = .28$) contributing more than coping ($\beta = -.19$). Trauma exposure was therefore associated with higher, and coping with lower, symptom severity among displaced Nigerians, although most of the variance remained unexplained. Trauma-informed screening and coping-skills programs within displacement settings are warranted.

Keywords: Coping strategies, Internally displaced persons, Mental health, Post-traumatic stress symptoms, Trauma.

INTRODUCTION

Internally displaced persons (IDPs) are people who have been forced to leave their homes because of armed conflict, generalized violence, human rights violations, or disaster, and who have not crossed an internationally recognized border (United Nations, 1998). The scale of the problem is difficult to overstate. The Internal Displacement Monitoring Centre (IDMC, 2025) estimated that 83.4 million people were living in internal displacement at the end of 2024, including 38.8 million in sub-Saharan Africa. Nigeria is among the hardest-hit countries, where insurgency in the northeast, communal violence, banditry, and flooding have uprooted millions of people.

Losing a home is seldom the only loss. Families are separated, livelihoods disappear, and the networks that once offered support are scattered. Many IDPs then settle in crowded camps or stretched host communities where food, housing, and health services are scarce. Mental health tends to suffer under these conditions. Among young IDPs in two Abuja camps, Olufadewa et al. (2022) documented stress, sadness, anxiety, depression, and post-traumatic stress symptoms, alongside a lack of structured mental health services. Otokpa et al. (2024) drew attention to the same problem among displaced young people across the country, and David et al. (2023) described psychological symptoms and coping responses among displaced adolescents in the northeast, some of whom used religious practices to manage traumatic memories.

Post-traumatic stress is among the most frequently studied consequences. Post-traumatic stress disorder (PTSD) can follow exposure to extremely threatening events and is marked by intrusive memories, avoidance, a persistent sense of threat, and impaired functioning (World Health Organization [WHO], 2024). Reported rates among displaced Nigerians are high. Ibrahim et al. (2023) found that 94.2% of 450 IDPs in Yobe State met criteria for PTSD symptoms on the Harvard Trauma Questionnaire, and Umennuihe et al. (2025) reported PTSD in 79.7% of 474 displaced children. Meta-analyses point the same way: the pooled prevalence of PTSD among African IDPs was 51% across 14 studies (Tesfaye et al., 2024), and about 56% in a separate review of displaced people in Africa (Andualem et al., 2024). Risk is not evenly spread, however. The number of traumatic events, repeated displacement, and depression were among the factors that predicted PTSD in the Tesfaye et al. review.

Trauma exposure is only part of the picture, because people who experience similar events do not respond in the same way. Coping is one explanation researchers often turn to. It refers to the cognitive and behavioral efforts people make to manage demands that tax or exceed their resources (Lazarus & Folkman, 1984), and it is commonly grouped into problem-focused, emotion-focused, support-seeking, and avoidant or dysfunctional responses (Carver, 1997). No single style is reliably helpful. Avoidance may bring short-term relief yet prolong distress, and seeking support helps only where supportive people are actually available. Nigerian evidence fits this complexity. In Maiduguri, Salihu et al. (2024) administered the Brief COPE to 281 IDPs and 281 host-community members and found that IDPs relied more on dysfunctional coping, whereas host-community members used more problem- and emotion-focused coping. The same research group had earlier shown that living in an IDP camp was a significant predictor of depression, anxiety, and stress relative to host-community residence (Salihu et al., 2022).

Despite this growing literature, Nigerian studies have mostly examined one piece of the problem at a time: symptom prevalence (Ibrahim et al., 2023), coping styles (Salihu et al., 2024), or lived experience (Olufadewa et al., 2022). Few have tested, within a single model, how trauma exposure and coping jointly relate to post-traumatic stress symptoms among adult IDPs. The question has practical weight. Trauma exposure cannot be undone, but coping is something that services can try to strengthen.

Theoretical Framework

Two theories guided the study. Lazarus and Folkman's (1984) stress and coping theory holds that outcomes depend not on stressors alone but on how a person appraises them and on the coping options the person believes are available. Applied to displacement, the theory predicts that two IDPs with comparable trauma histories may differ in symptom severity because they appraise and manage their situation differently. It says less about structural conditions, such as continuing insecurity and poverty, that limit what coping can achieve.

Hobfoll's (1989) conservation of resources theory addresses part of that gap. It proposes that people strive to protect and build resources such as family, housing, income, and safety, and that psychological strain follows when these are lost or threatened and cannot be replaced. Displacement produces loss on many fronts at once, and one loss tends to trigger others. Within this framework, coping can be read as an attempt to preserve or rebuild resources, which suggests that more active coping should accompany lower distress. Taken together, the theories lead to two expectations: greater trauma exposure should be linked with more severe symptoms, and greater coping with less severe symptoms.

The Present Study

This study examined whether psychological trauma, operationalized as the number of trauma exposures endorsed, and coping strategies predicted post-traumatic stress symptoms among IDPs in Borno and Adamawa States. Post-traumatic stress symptoms served as the indicator of mental health outcomes. Three null hypotheses were tested at the .05 level: (1) psychological trauma will not significantly predict post-traumatic stress symptoms; (2) coping strategies will not significantly predict post-traumatic stress symptoms; and (3) psychological trauma and coping strategies will not jointly and significantly predict post-traumatic stress symptoms.

METHOD

Participants

Participants were 400 adult IDPs (214 men, 186 women; M age = 37.16 years, SD = 9.81) living in camps, settlements, and host communities in Borno and Adamawa States, North-eastern Nigeria. All had been displaced by armed conflict, communal violence, or related insecurity and were willing to take part. Sampling proceeded in four stages. First, the two states were purposively chosen because of their large IDP populations and documented conflict. Second, camps, settlements, and host communities were identified within each state. Third, eligible IDPs were listed according to the inclusion criteria. Fourth, participants were drawn by simple random sampling; where a register was available, identification numbers were placed in a container and selected by ballot until the quota was met. Two hundred participants were selected from each state.

Measures

Psychological trauma. Exposure to potentially traumatic events was measured with the trauma-exposure section of the Harvard Trauma Questionnaire (Mollica et al., 1992), which covers violence, threats, physical harm, loss of relatives, displacement, and destruction of property. Each endorsed event scored 1 and each unendorsed event scored 0. Scores were summed, so higher totals indicate exposure to more events.

Coping strategies. The Brief COPE (Carver, 1997) has 28 items covering scales such as active coping, planning, positive reframing, acceptance, emotional and instrumental support, self-distraction, denial, substance use, behavioral disengagement, venting, and self-blame. Items are rated from 1 (*I haven't been doing this at all*) to 4 (*I've been doing this a lot*). Only the overall score, the mean item rating, was analyzed; higher values indicate greater overall use of coping responses.

Post-traumatic stress symptoms. The PTSD Checklist for DSM-5 (PCL-5; Weathers et al., 2013) contains 20 items covering intrusion, avoidance, negative alterations in cognition and mood, and alterations in arousal and reactivity. Items are rated from 0 (*not at all*) to 4 (*extremely*) and summed, giving a range of 0 to 80, with higher scores indicating more severe symptoms.

All three instruments were pilot-tested with 40 IDPs who resembled the main sample but did not take part in it. Cronbach's alpha was .86 for the Harvard Trauma Questionnaire, .89 for the Brief COPE, and .91 for the PCL-5, indicating satisfactory internal consistency.

Procedure

Permission was obtained from the authorities responsible for each camp, settlement, and host community, and ethical approval was granted by the relevant institutional research ethics committee before data collection began. Participants were told the purpose, procedures, risks, and benefits of the study, and written informed consent was obtained. They were also told that participation was voluntary and that they could skip questions or withdraw at any point without penalty. The researcher and trained assistants administered the instruments in quiet locations within the displacement settings, clarifying instructions without influencing responses. Questionnaires carried codes instead of names and were stored securely. Because the items concerned traumatic experiences, assessment was stopped whenever a participant showed or reported serious distress, and the person was referred to a qualified mental health professional or an available psychosocial service.

Design and Data Analysis

The study used a cross-sectional correlational survey design, with psychological trauma and coping strategies as predictors and post-

traumatic stress symptoms as the outcome. Data were analyzed in SPSS Version 26. Means and standard deviations summarized the study variables, Pearson correlations estimated the direction and strength of bivariate relationships, and multiple linear regression tested whether the two predictors jointly and independently predicted symptoms. Model fit was judged with R^2 , adjusted R^2 , and the F statistic, and all hypotheses were tested at $\alpha = .05$.

RESULTS

Table 1 presents descriptive statistics and intercorrelations. Trauma exposure correlated positively with post-traumatic stress symptoms, $r = .28$, $p < .001$, and coping correlated negatively with symptoms, $r = -.19$, $p < .001$. Trauma exposure and coping were essentially unrelated, $r = .02$, $p = .69$, so the two predictors carried largely separate information about symptom severity.

Table 1

Means, Standard Deviations, and Correlations Among Study Variables

Variable	M	SD	1	2	3
1. Psychological trauma	11.87	2.19	—		
2. Coping strategies	2.48	0.54	.02	—	
3. Post-traumatic stress symptoms	42.05	11.20	.28***	-.19***	—

Note. $N = 400$. Psychological trauma = number of endorsed trauma-exposure items; coping strategies = mean Brief COPE item rating (1–4); post-traumatic stress symptoms = PCL-5 total (0–80). *** $p < .001$.

Table 2 summarizes the regression model. Together, psychological trauma and coping strategies significantly predicted post-traumatic stress symptoms, $F(2, 397) = 26.07$, $p < .001$, $R = .341$, $R^2 = .116$, adjusted $R^2 = .112$, $SE = 10.56$. The two predictors accounted for 11.6% of the variance in symptoms, equivalent to a small-to-medium effect (Cohen's $f^2 = .13$). The third null hypothesis was therefore rejected.

Psychological trauma was a significant positive predictor, $B = 1.46$, 95% CI [0.98, 1.93], $\beta = .28$, $t(397) = 6.03$, $p < .001$. With coping held constant, each additional trauma exposure was associated with a 1.46-point higher PCL-5 score, and the first null hypothesis was rejected. Coping strategies were a significant negative predictor, $B = -4.02$, 95% CI [-5.94, -2.09], $\beta = -.19$, $t(397) = -4.10$, $p < .001$. With trauma exposure held constant, each one-point increase in mean coping rating was associated with a 4.02-point lower PCL-5 score, and the second null hypothesis was rejected. The standardized coefficient for psychological trauma was larger in absolute size than that for coping strategies.

Table 2

Multiple Regression Predicting Post-Traumatic Stress Symptoms From Psychological Trauma and Coping Strategies

Predictor	B	SE B	95% CI	β	t	p
Constant	34.73	3.76	[27.34, 42.11]	—	9.24	< .001
Psychological trauma	1.46	0.24	[0.98, 1.93]	.28	6.03	< .001
Coping strategies	-4.02	0.98	[-5.94, -2.09]	-.19	-4.10	< .001

Note. $N = 400$. Dependent variable: PCL-5 total score. $R^2 = .116$, adjusted $R^2 = .112$, $F(2, 397) = 26.07$, $p < .001$. CI = confidence interval.

DISCUSSION

This study asked whether trauma exposure and coping jointly account for post-traumatic stress symptoms among displaced adults in North-eastern Nigeria. All three null hypotheses were rejected. Greater trauma exposure went with more severe symptoms, greater coping went with less severe symptoms, and the two variables together explained about 12% of the variance in symptoms.

Trauma Exposure and Symptoms

The positive association between trauma exposure and symptoms agrees with the African IDP literature, in which the number of traumatic events is a recurring predictor of PTSD (Tesfaye et al., 2024). One reason is cumulative burden. Among displaced people, trauma rarely ends at the moment of flight, because insecurity, deprivation, and uncertainty continue in the place of refuge. Conservation of resources theory (Hobfoll, 1989) offers a fitting reading: continuing losses keep people from recovering a sense of safety. Even so, the correlation was modest ($r = .28$). A simple count of events treats a witnessed killing and a destroyed farm as equivalent, and it cannot capture severity, timing, or meaning, all of which shape how an experience is carried.

Coping and Symptoms

Coping was inversely related to symptoms even after trauma exposure was controlled, which is what stress and coping theory would predict (Lazarus & Folkman, 1984). The result should be read with care, though. The Brief COPE total combines adaptive and dysfunctional scales, and Salihu et al. (2024) found that dysfunctional coping was more common among IDPs than among host-community members in Maiduguri. An overall inverse association therefore cannot show that every coping response lowers distress, and this study did not separate the scales. Direction of effect is also uncertain. People with milder symptoms may simply have more energy to cope. Qualitative work points to a protective role for some strategies, such as the religious coping described by displaced adolescents (David et al., 2023), but only designs that track people over time can settle the question.

Joint Prediction

The two predictors were almost uncorrelated ($r = .02$), which means that how much trauma a person had experienced said little about how much that person coped. This matters for services. Coping can be targeted whatever a person's level of exposure, and it adds to the prediction of symptoms beyond exposure itself. Still, about 88% of the variance was left unexplained. Continuing insecurity, loss of livelihood, social support, length of displacement, and depression, the last of which featured in earlier reviews (Andualem et al., 2024; Tesfaye et al., 2024), are all plausible contributors that the model omitted.

Implications

Three practical implications follow. First, humanitarian and mental health agencies could build routine screening for trauma exposure and post-traumatic stress into services in camps and host communities, giving priority to people who report multiple or severe events. Second, psychosocial programs could include structured coping-skills training that strengthens problem solving, emotion regulation, and use of social support, while discouraging avoidance. Third, mental health care should sit inside the wider displacement response, alongside protection, livelihood assistance,

and basic services, since resource loss is itself part of the psychological burden.

Limitations and Future Research

Several limitations qualify these findings. The cross-sectional design rules out causal conclusions. All measures were self-reported and may reflect recall error or reluctance to disclose distressing experiences. The sample came from two states, which limits generalization to IDPs elsewhere in Nigeria. The trauma score counted events without weighting severity, and coping was analyzed as a single overall score. Finally, important correlates of post-traumatic stress were not modeled. Future studies should analyze coping dimensions separately, follow participants over time, and add variables such as resilience, perceived social support, duration of displacement, and prior trauma. Testing whether coping moderates the effect of trauma exposure on symptoms would also be worthwhile.

CONCLUSION

Among 400 IDPs in Borno and Adamawa States, greater trauma exposure was associated with more severe post-traumatic stress symptoms, and greater coping with less severe symptoms. Trauma exposure had the larger standardized effect. Because exposure cannot be reversed while coping can be supported, services for displaced populations in Nigeria should pair trauma-informed screening with interventions that strengthen constructive coping.

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