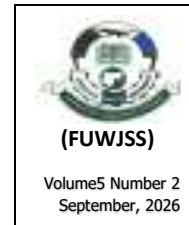


**PSYCHO-TRAUMA AND SOCIAL ISOLATION
AS PREDICTORS OF SYMPTOMATIC POST-
TRAUMATIC STRESS DISORDER (PTSD)
AMONG VICTIMS OF ETHNO-RELIGIOUS
CONFLICT IN JOS-SOUTH LOCAL
GOVERNMENT AREA, PLATEAU STATE,
NIGERIA**



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Abstract

This study examines psycho-trauma and social isolation as predictors of symptomatic Post-Traumatic Stress Disorder (PTSD) among victims of ethno-religious conflict in Jos-South Local Government Area, Plateau State, Nigeria. A cross-sectional survey design was used. The research assessed psycho-trauma and social isolation as independent variables and symptomatic PTSD as the dependent variable. A total of two hundred and eighty adults participated in this study, including males (N=137) and females (N=143), between the ages of 18 and 65 years, who were selected from communities affected by conflict, such as Bukuru, Gyel, Vwang, Du, Zawan, Kuru, Vom, and Chugwi, to ensure diverse representation. Data were collected using three standardized instruments: the Psycho-Trauma Scale adapted from the Harvard Trauma Questionnaire (HTQ), the UCLA Loneliness Scale Version 3 Short Form (UCLA-LS3-SF10), and the PTSD Checklist for DSM-5 (PCL-5). Multiple linear regression analysis was used to test three hypotheses. Results showed that psycho-trauma was a significant predictor of symptoms of PTSD ($\beta = .53, t = 12.69, p < .001$). Similarly, social isolation significantly predicted symptomatic PTSD ($\beta = .41, t = 9.82, p < .001$). Results further revealed that psycho-trauma and social isolation jointly and significantly predicted symptomatic PTSD, accounting for approximately 70% of the variance in PTSD symptoms ($R^2 = .699, F(2, 277) = 321.675, p < .001$). The study recommends that relevant authorities and mental health practitioners develop trauma-focused intervention programmes and community-based psychosocial support systems that address both trauma exposure and social disconnection among ethno-religious conflict survivors in Nigeria.

Keywords: Psycho-trauma, social isolation, PTSD, ethno-religious conflict, Jos-South

Introduction

In today's world, the pattern of violent conflict has undergone a paradigm shift. Unlike the conventional wars between nations that dominated earlier centuries, modern conflicts are now largely internal, prolonged, and deeply rooted in ethnic, religious, political, and territorial dimensions (Stockholm International Peace Research Institute [SIPRI], 2023). This ugly trend has defiled the ingenuity of all and sundry, research experts, as to what could be the possible solution to this endemic confronting the world. In spite of the numerous research and exposition done to minimize the associated challenges, unfortunately, the problem persists. In the aftermath of many of these conflicts, civilians are the main victims, while communities and urban centers are transformed into battlegrounds marked by fear, destruction, and instability (Kaldor, 2020). Across regions such as the Balkans, the Middle East, and Sub-Saharan Africa, long-standing grievances tied to identity, inequality, power struggles, and access to resources are often expressed through ethnic and religious divisions (Adeleke, 2021; Ojewale, 2023). Beyond the physical destruction of lives and property, the psychological wounds have far-reaching implications on individuals and populations affected (Miller & Rasmussen, 2021; Betancourt et al., 2022).

Nigeria is extremely diverse with 250-plus ethnically distinct groups and multiple religious identities that contribute to the cultural richness on one hand, and on the other hand, have led to chronic bloodletting triggered by ethnic and religious intolerance (Adenuga et al., 2023; Eze, 2021). Since independence, there has been a deep-seated animosity between one ethnic or religious group against another, which has taken the form of riots, maiming, farmer-herder clashes, sabotage, assassinations, and guerrilla warfare (Joshi, 2024). Survivors are often left with severe emotional and psychological disturbances that persist long after the violence has ended (Awa et al., 2024). However, this infamy has heightened the suspicion and lack of cordiality amongst various ethnic components, and in fact, the increased vulnerability of affected populations to trauma-related psychological conditions (Gambo et al., 2025; Adesina et al., 2020).

The unpredictability of violent conflict shatters victims' core cognitive assumption of existential safety, and thus constitutes a major threat to psychological well-being, particularly in low- and middle-income countries where mental health services remain inadequate (Carpiniello, 2023). Exposure to armed conflict, terrorism, and forced displacement has been strongly associated with increased rates of depression, anxiety, and Post-

Traumatic Stress Disorder (PTSD) among civilian populations (Jain et al., 2022; Mesa-Vieira et al., 2022). Repeated exposure to ethno-religious violence leaves many victims in persistent fear and psychological distress. Akanni et al. (2024) noted that survivors often struggle to regain a sense of safety even after conflict ends, while Awa et al. (2024) found that repeated violence increases the severity and persistence of PTSD symptoms. More so, David et al. (2021) showed that trauma exposure, displacement, and poor social support worsen long-term psychological outcomes. Other studies also highlight that the destruction of homes and social support systems undermines emotional stability and coping over time (Gotip & Akosu, 2024; Ojewale, 2023).

PTSD is a psychiatric condition that develops after an individual experiences or witnesses highly distressing or life-threatening events such as war, physical assault, or the sudden loss of loved ones (Ressler et al., 2022). It is commonly characterized by intrusive memories, nightmares, hypervigilance, emotional numbness, avoidance of trauma-related stimuli, and sleep disturbances (Ressler et al., 2022; Duek et al., 2022). These symptoms impair emotional functioning, interpersonal relationships, and overall quality of life. Studies across conflict settings have consistently shown that repeated exposure to violence and traumatic loss significantly increases the likelihood of developing PTSD (Tesfaye et al., 2024; Khalil et al., 2024). The unpredictable and often sudden nature of identity-based violence can leave victims in a constant state of fear, where they remain overly alert and struggle to feel safe even in normal daily situations (Williamson & Murphy, 2025; Zedan, 2025).

One major factor associated with symptomatic PTSD among conflict survivors is psycho-trauma, which refers to the emotional and psychological injury resulting from distressing experiences that overwhelm an individual's capacity to cope (Zoromba et al., 2024). Victims of ethno-religious conflict may experience psycho-trauma through direct exposure to killings, physical attacks, destruction of property, and forced displacement, eroding their sense of safety and emotional stability (Zhylin et al., 2024). Research has consistently shown that such traumatic exposure significantly increases PTSD risk among survivors of communal violence (Tesfaye et al., 2024; Carpinello, 2023).

Another important factor is social isolation, defined as the absence or reduction of meaningful social interaction and community connectedness (Holt-Lunstad, 2024). Violent conflict tends to stretch the bonds of unity to a breaking point, while numerous hotspots across the country remain volatile and may still be waiting to erupt. In conflict settings, social relationships are disrupted by displacement, fear, and mistrust, depriving victims of the emotional support needed for psychological recovery (Nguyen et al., 2024).

Social isolation has also been found to worsen trauma symptoms by increasing loneliness and vulnerability to chronic PTSD (Cruwys et al., 2025; Wahyuriko et al., 2025). Similarly, *Tadesse et al. (2025)* show that the breakdown of community support systems leaves many vulnerable people, such as widows and orphans, without the emotional help they need to cope. When people lose social connection or withdraw from others, it can worsen stress responses in the brain and make it harder to regulate fear and emotions (Vlachos, Papageorgiou, & Margariti, 2020). Contrarily, supportive social relationships serve as protective factors that reduce trauma-related disorder severity (Sippel et al., 2024; Alita, 2025).

Plateau State is among the most conflict-affected states in Nigeria, with Jos South being the flashpoint for repeated episodes of violent clashes characterized by killings, property destruction, displacement, and community breakdown (Gambo et al., 2025; Ojewale, 2023). Such repeated exposure increases vulnerability to symptomatic PTSD among affected residents (Shipurut et al., 2024; Kumswa et al., 2022). It is worth mentioning that this problem has persisted for over two decades, and many victims still live with insufferable psychological pain caused by repeated violence, displacement, fear, and the loss of loved ones (Akanni et al., 2024; Awa et al., 2024).

Although efforts have been made to restore peace and provide relief materials, the emotional and psychological suffering of survivors is often overlooked. Many communities sleep with one eye closed and remain fearful as several hotspots of conflict are still tense and vulnerable to fresh outbreaks of violence. As a result, survivors are repeatedly exposed to traumatic experiences that continue to worsen the severity of symptomatic PTSD (Adesina et al., 2020). It is surprisingly baffling that, to the best of our knowledge, there is a dearth and little to no empirical attention given to the combined role of psycho-trauma and social isolation as predictors of symptomatic PTSD in this context. It is however, on this premise that this study examines psycho-trauma and social isolation as predictors of symptomatic PTSD among victims of ethno-religious conflict in Jos South. The findings are useful in informing trauma-focused mental health interventions and psychosocial rehabilitation programs for conflict-affected populations in Nigeria.

Trauma Exposure, Social Fragmentation and PTSD Symptomatology in Conflict Settings

When communities tear apart along ethnic or religious lines, the psychological damage goes far beyond just the shock of the initial violence, which sometimes manifests as PTSD (Subica & Link, 2022; Tuller, 2020). The manifestation and chronicity of Post-Traumatic Stress Disorder (PTSD)

symptomatology cannot be fully understood through an individualistic, intrapsychic clinical perspective alone; instead, it must be examined through an eco-systemic lens where *trauma exposure* and post-crisis *social fragmentation/isolation* are seen as compounding predictors. Direct exposure to atrocities such as communal killings, physical assault, and forced displacement shatters survivors' sense of safety and triggers chronic neurobiological hypervigilance on one hand (Ressler et al., 2022; Toledo & Carson, 2022), and on the other, the subsequent breakdown of community structures creates an equally devastating secondary stressor (Thamotharampillai et al., 2025; Somasundaram et al., 2023; Sihombing et al., 2025). A global meta-analysis of 22 surveys estimated a PTSD prevalence of 26.51% among adult war survivors, with an extrapolated 316 million people affected worldwide as of 2019 (Hoppen et al., 2021). Similarly, a recent meta-analysis involving more than 64,000 civilians living in conflict-affected areas found that approximately 23.7% of participants were diagnosed with PTSD, with prevalence rates highest during active conflict and in low- and middle-income countries (Ahmed et al., 2024).

In Nigeria, PTSD prevalence in conflict-exposed communities ranges from 55.5% to 73.9%, far exceeding the global war-affected baseline of 15.3% (Awa, 2024). Ethno-religious conflicts are now a major cause of social instability and psychological suffering, with between 1999 and 2021 alone recording over 2,811 incidences of ethnic conflict resulting in tens of thousands of fatalities (Adenuga et al., 2023). These crises have resulted in killings, forced displacement, and breakdown of social relationships, leaving many survivors emotionally traumatized (Adesina et al., 2020). While humanitarian responses frequently focus on physical relief, the psychological consequences experienced by survivors often receive inadequate attention (Amodu et al., 2020).

Edeh et al. (2023) looked at posttraumatic stress disorder in Two Post-Conflict Communities in Benue State, Nigeria. They employed a cross-sectional comparative study and utilized a multistage cluster design using socio-demographic questionnaires and the PTSD module of the Composite International Diagnostic Interview (CIDI) to gather data from 413 participants, of which 135 individuals from Uikpam (directly exposed to the Tiv–Fulani conflict) and 278 from Daudu (with indirect exposure). The results showed community who are directly exposed had a higher prevalence

of PTSD (16.3%) compared to the community that was indirectly exposed (4.3%), with both groups also reporting sub-threshold PTSD symptoms.

Similarly, Dumke et al. (2021) investigated Patterns of Conflict-Related Trauma Exposure and Their Relation to Psychopathology in the Eastern Democratic Republic of Congo. A cross-sectional survey was used to gather data from 1,000 adults who were selected from 100 villages through multistage random cluster sampling. After conducting the Latent class analysis, they identified patterns of trauma exposure that include low exposure (51.4%), non-physical trauma (39.1%), and interpersonal trauma (9.5%). Based on the findings, it was established that the highest symptom burden was observed in the interpersonal trauma group. Thus, interpersonal violence is mostly associated with severe psychopathology.

In another related study, Nwoye and Nweke (2024) conducted an ex post facto study on Trauma Exposure and Hopelessness as Predictors of Post-Traumatic Stress Disorder and Depression among War Veterans in South-East Nigeria. Using an ex post facto study, they gathered data from 470 retired military veterans, males (N=240) and females (N=230). Findings revealed that trauma exposure significantly predicted PTSD ($F(1,468) = 38.88, p < .01$), but not depression ($F(1,468) = 0.302, p = .583$). Similarly, hopelessness significantly predicted PTSD ($F(1,468) = 10.87, p < .01$), but not depression ($F(1,468) = 0.239, p = .625$). Thus, the conclusion is that trauma exposure and hopelessness are a strong predator of PTSD than depression among veterans.

On the other side of the pendulum, it has been established by various research that trauma and social isolation due to conflicts are associated with the severity of symptoms of PTSD, especially with populations who are at risk and have been exposed to conflict.

In their meta-analysis, Zalta et al. (2020) conducted a study on the moderators of the relationship between social support and self-reported PTSD symptoms. Evidence from 139 cross-sectional studies was synthesized with 38 effect sizes (N = 25,792) and 37 longitudinal studies (145 effect sizes; N = 62,803) of adults exposed to trauma. From the result, it was established that higher scores of social supports were consistently associated with decrease in severity of PTSD, with near-moderate effect sizes in both cross-sectional ($r = -.27, 95\% \text{ CI: } -.30 \text{ to } -.24$) and longitudinal results ($r = -.25, 95\% \text{ CI: } -.28 \text{ to } -.21$). This indicates that when

there is a weak social connectedness in conflict settings then there is a high tendency of increased PTSD symptom levels.

Likewise, Revranche et al. (2022), in their study on Social Support, Social Isolation and Mastery Among Adults Exposed to Traumatic Events, studied 4,445 trauma-exposed adults living in France, drawn from a larger sample ($N = 22,138$). Trauma exposure included interpersonal violence ($N = 2,987$) and non-interpersonal trauma ($N = 1,458$). The study used the CIDI-SF to assess PTSD and found that social isolation was a significant risk factor for PTSD within a period of 12 months, especially when people had experienced interpersonal violence. Also, Social isolation was strongly associated with increased risk for developing PTSD, and the combination of social isolation and low mastery was associated with an increased risk for symptom development. The authors found that both a lack of adequate social relationships and perceived disconnection increase the vulnerability for PTSD.

Pollmann et al. (2022) studied changes in Perceived Social Support and PTSD Symptomatology Among Danish Army Military Personnel of soldiers deployed to Afghanistan. They utilized a longitudinal design to track from pre-deployment to two and a half years post-deployment. Findings revealed that social support was a predictor of PTSD symptom severity, with moderate PTSD ($OR = 1.99$, $CI: 1.51-2.57$) and high PTSD ($OR = 2.71$, $CI: 1.94-3.78$) symptoms associated with a negative change in social support. It was also revealed from the findings that over time, when there is a weakness in social ties, it can lead to increased vulnerability to PTSD, which explains why social isolation can lead to problems with post-conflict adjustment.

Similarly, Thomas et al. (2022) in their study Examining Bidirectional Associations Between Perceived Social Support and Psychological Symptoms in the Context of Stressful Event Exposure. They assessed German soldiers before and after deployment. The study revealed that soldiers reported higher perceived support from the workplace ($t(344) = 5.51$, $p < .001$). However, an increase in PTSD symptoms was associated with lower scores for perceived social support ($MR = 0.95$, $95\% CI: 0.91-0.99$). This suggests a reciprocal process where social disconnection is not only a consequence of PTSD, but can also exacerbate a sense of reduced support and increased social withdrawal.

Awa et al. (2024) examined Correlates of Post-Traumatic Stress Disorder among Adult Residents of Conflict-Affected Communities in Cross River State, Nigeria. They employed a cross-sectional survey to obtain a total sample of 486 adults from Odukpani LGA, selected through

probability and non-probability sampling. They found that PTSD was very common and that affected approximately 73.9% of participants. Factors such as higher levels of education, larger family size, discrimination, and a family history of mental illness increase the risk of PTSD. The study stressed the need for better mental health care and social support in conflict-affected communities.

Abiama et al. (2021) studied the Rates of Occurrence and Influence of Trauma Exposure on Posttraumatic Stress Disorder Symptoms Among Survivors of Terrorist Attacks in Northeast Nigeria, among *1,059 internally displaced persons (54.8% male; M = 34.30 years, SD = 13.69)* affected by terrorist attacks. Trauma exposure was assessed using the Hausa version of the *Harvard Trauma Questionnaire (Part I)*, while PTSD symptoms were measured with the *PCL-5*. Findings showed a high PTSD prevalence of 65.72%, with the most common traumatic experiences including lack of basic needs, loss of loved ones, torture/maltreatment, and exposure to violent deaths. Trauma exposure significantly and independently predicted increased severity across all PTSD symptom clusters.

In another study by Umar et al. (2023), a cross-sectional study on the Prevalence of Boko Haram Crisis Related Depression and Post-Traumatic Stress Disorder Symptomatology among Internally Displaced Persons in Yobe State, North East Nigeria. Their objective was to examine the burden and predictors of PTSD and depression among IDPs. The study sampled *450 internally displaced persons* using multistage sampling, with data collected through the *Hopkins Symptom Checklist* for depression and the *Harvard Trauma Questionnaire* for PTSD assessment. Findings revealed extremely high prevalence rates, with *94.2% meeting criteria for PTSD symptoms* and *98.4% meeting criteria for depressive symptoms*.

Rafique et al. (2026) conducted a systematic review and meta-analysis on Posttraumatic Stress Symptoms and Posttraumatic Stress Disorder in Adolescents Exposed to Continuous Traumatic Stress in Sub-Saharan Africa. The focus of this study was on adolescents aged 10–24 years exposed to ongoing collective violence. The study systematically screened 460 papers, with 10 studies meeting inclusion criteria, and synthesized data on PTSD and posttraumatic stress symptoms (PTSS) across Sub-Saharan African settings. The result showed a pooled prevalence of clinically significant PTSS/PTSD of 32.0% (95% CI: 20.7%–46.0%). The conclusion was that when there is continuous traumatic stress, it can be strongly

associated with substantial PTSD symptom burden among adolescents in conflict-affected African contexts, but emphasized the need for culturally valid measures and further research distinguishing CTS exposure from PTSD outcomes to improve intervention planning.

Theoretical Framework

This research paper is anchored on two related theories that explain how psycho-trauma and social isolation contribute to symptomatic PTSD among victims of ethno-religious conflict in Jos South. The first is the Cognitive Model of PTSD developed by Ehlers and Clark (2000). Based on the assumption of this theory, PTSD persists when an individual interprets traumatic experiences such that it creates a constant sense of danger and fear. The theory is also anchored on the assumption that traumatic memories are often poorly organized, which can lead to intrusive thought patterns, flashbacks, nightmares, and emotional distress.

Survivors or victims of conflict may develop negative beliefs about themselves and the world, such as feelings of hopelessness, self-blame, or believing that nowhere is safe (Wiedemann et al., 2023; Patronick et al., 2025). In the same note, victims of ethno-religious violence, exposure to killings, destruction, and displacement are prone to developing negative thoughts which may manifest into symptoms like hypervigilance, fear, emotional numbness, and avoidance (Ressler et al., 2022). Thus, the theory, therefore, helps explain how psycho-trauma predicts PTSD symptoms among conflict survivors.

The study is also supported by Weiss's Social Provisioning Theory (1974), which buttressed the importance of social relationships for psychological well-being. The theory posits that people are not designed to live in isolation and that, more often than not, they depend on social support, attachment, a sense of belonging, and reassurance from others to cope effectively with stressful experiences. However, when violent conflict happens it severe family ties, friendships, and community networks, so much so that survivors are socially isolated.

It has been established that when social support is lacking after traumatic experiences, psychological distress increases, which invariably may worsen PTSD symptoms (Holt-Lunstad, 2024; Nguyen et al., 2024). Again, due to fear and the intensity of emotional experiences, victims may withdraw and isolate, and while in isolation, the trauma symptoms increase, thus creating

a harmful cycle (Cruwys et al., 2025; Wahyuriko et al., 2025). On the other hand of the pendulum, strong social support has been found to reduce PTSD symptoms and promote recovery (Sippel et al., 2024). Together, these theories provide a clear explanation of how both psycho-trauma and social isolation independently and jointly predict symptomatic PTSD among victims of ethno-religious conflict in Jos South, Plateau State.

Research Methodology

This study adopted a cross-sectional survey research design to investigate psycho-trauma and social isolation as predicting factors for the development of symptomatic Post-Traumatic Stress Disorder (PTSD) among victims of ethno-religious conflict in Jos South. The survey design was deemed suitable as it allowed the researchers to collect data from the participants in one instance from a standardized set of survey questions.

The study was carried out in Jos South Local Government Area (LGA) of Plateau State, Nigeria. The Jos South area has suffered from repeated ethno-religious conflicts throughout the years, leading to the displacement of people, psychological trauma, destruction of property, and social disruption of the residents of this area. The selected communities studied in Jos South include those that have been impacted by ethnic and religious conflict, such as Bukuru, Rayfield, Vom, Kuru, Vwang, Gyel, Du, and Zawan.

The target population for this study were adults residents of Jos South who had either been directly or indirectly affected by the ethno-religious conflict. Participants were those who reported being witnesses to violence, losing a loved one, being displaced, had their property destroyed, and experiencing traumatic events relating to the conflict. A total of 280 participants were selected for the study, of which 137 were males (48.9%) and 143 females (51.1%). The sample size was deemed adequate for conducting multiple regressions, and the number was sufficient for testing the predictive effect of psycho-trauma and social isolation on symptomatic PTSD.

Purposive sampling and convenience sampling were used in this study. We employed purposive sampling to identify persons who have experienced ethno-religious conflict in Jos South. Convenience sampling was also used to select participants who were easily accessible, willing, and available to participate in the study throughout the data collection period.

Data for this study were collected using a structured questionnaire composed of four sections (A–D). The questionnaire integrated demographic information and three standardized psychological scales

relevant to the constructs of psycho-trauma, social isolation, and symptomatic posttraumatic stress disorder.

As per the information obtained in the demographic section, include age, gender, religion, marital status, educational level, occupation, area/community of residence in Jos South, nature of conflict exposure, duration since conflict exposure, psychological support received, living arrangement, and current social relationship status.

The Psycho-Trauma Scale was adapted from the Trauma Event Section of the Clinical Psychology Harvard Trauma Questionnaire by Mollica et al. (1992). The scale examined the trauma experiences and trauma distress related to ethno-religious conflict. They were measured on a 4-point scale from 1 (Not at all) to 4 (Extremely), consisting of 10 items. Higher scores reflect more trauma-related distress. The scale has been validated in various studies over a variety of cultural and conflict-affected populations with good psychometric properties. Previous studies have reported Cronbach's alpha coefficient of .88 to .96, thus showing high internal consistency reliability (Mollica et al., 1992; Rofo et al., 2023; Sharma et al., 2022). In this study, the scale demonstrated higher internal consistency ($\alpha = .96$.)

Social isolation was measured by the 10-item short form of the UCLA Loneliness Scale Version 3 (UCLA-LS3-SF10). The instrument was designed by Russell (1996). The instrument measured subjective reports of loneliness and social isolation, which refer to how far individuals feel that they do not have enough quality social relationships. The items on the scale are answered on a 4-point scale: 1 = Never, 2 = Rarely, 3 = Sometimes, 4 = Always. With regard to psychometric properties, the scale has high Cronbach's alpha of .89 to .94 in the original validation study, 10-item short form has demonstrated good convergent validity with high ($r = .97$) correlation with the full 20-item version; excellent psychometric properties in African community samples, both Cronbach's alpha (Arimoto & Tadaka, 2019; Pretorius & Padmanabhanunni, 2022) and reliability (Russell, 1996), and being unidimensional and reliable in African community samples (Arimoto & Tadaka, 2019; Pretorius & Padmanabhanunni, 2022; Russell, 1996).

Posttraumatic stress disorder symptoms were assessed using the PTSD Checklist for DSM-5 (PCL-5; Weathers et al., 2013). The instrument was developed by Weathers et al. (2013). The instrument assesses the 20 DSM-5 diagnostic criteria for PTSD along the four symptom clusters: intrusion, avoidance, negative alterations in cognition and mood, and alterations in arousal and reactivity. Each item is rated on a 5-point scale, with the total scores ranging from 0 to 80, with higher scores reflecting more severe symptoms associated with PTSD: 0 = Not at all, 1 = A little bit, 2 = Moderately, 3 = Quite a bit, 4 = Extremely. In terms of psychometric

properties, the scale has been found to have good psychometric properties in various populations. In a systematic literature review, internal consistency scores ranged from .83 to .97, and test-retest reliability scores ranged from .58 to .91, with moderate to strong convergent validity shown by significant correlations with other PTSD measures (Forkus et al., 2023).

Before data collection, an introductory letter was obtained from the Department of Psychology and presented to the community leaders and relevant authorities in the selected communities in Jos South. The participants were informed about the purpose of the study, and informed consent was obtained before the administration of the questionnaire. Researchers and trained research assistants personally administered the questionnaires. Confidentiality and anonymity were assured, and participation was voluntary.

The data obtained were coded and analyzed with SPSS Statistics 27. Descriptive statistics such as frequency counts, percentages, means, and standard deviations were used to summarize the demographic characteristics and study variables. For inferential statistics Multiple linear regression analysis was performed to test three hypotheses of the predictive role of psycho-trauma and social isolation on symptomatic PTSD. The assumption of normality, linearity, homoscedasticity, multicollinearity, and absence of significant outliers were checked before the regression analysis, and they were reasonably met. All analyses were performed at the .05 (two-tailed) level of statistical significance.

Table 1
Demographic Characteristics of Participants

Variable	Category	Frequency (f)	Percentage (%)
Age Group	18–25	59	21.1
	26–35	81	28.9
	36–45	67	23.9
	46–55	54	19.3
	56 and above	19	6.8
Gender	Male	137	48.9
	Female	143	51.1
Religion	Christianity	181	64.6
	Islam	83	29.6
	Traditional	9	3.2
	Others	7	2.5
Marital Status	Single	101	36.1
	Married	128	45.7

Variable	Category	Frequency (f)	Percentage (%)
Educational Level	Widowed	20	7.1
	Divorced	15	5.4
	Separated	16	5.7
	No formal education	13	4.6
	Primary	41	14.6
	Secondary	139	49.6
Occupation	Tertiary	87	31.1
	Employed	73	26.1
	Self-employed	81	28.9
	Unemployed	61	21.8
Area of Residence	Student	65	23.2
	Bukuru	56	20.0
	Gyel	35	12.5
	Vwang	43	15.4
	Du	32	11.4
	Zawan	30	10.7
	Kuru	19	6.8
	Vom	23	8.2
	Chugwi	20	7.1
	Other	22	7.9
Nature of Conflict Exposure	Witnessed violence	85	30.4
	Lost a family member	51	18.2
	Physical injury	26	9.3
	Destruction of property	41	14.6
	Forced displacement	31	11.1
	Threat to life	37	13.2
	Others	9	3.2
Time Since Conflict	Less than 1 year	30	10.7
	1–3 years	71	25.4
	4–6 years	101	36.1
	7 years and above	78	27.9
Received Psychological Support	Yes	61	21.8
	No	219	78.2
Current Living Arrangement	Living alone	32	11.4
	Living with family	179	63.9
	Living with friends/relatives	51	18.2
	Other	18	6.4

Variable	Category	Frequency (f)	Percentage (%)
Social Relationship Quality	Very Poor	23	8.2
	Poor	41	14.6
	Fair	99	35.4
	Good	78	27.9
	Very Good	39	13.9

Table 1 showed that participants aged 26–35 years constituted the largest age group (28.9%), followed by 36–45 years (23.9%), 18–25 years (21.1%), 46–55 years (19.3%), and 56 years and above (6.8%). Females (51.1%) were slightly over-represented compared to males (48.9%). The majority of the respondents were Christians (64.6%), followed by Muslims (29.6%), traditional worshippers (3.2%), and others (2.5%). The married participants were 45.7%, the single participants were 36.1%, the widowed were 7.1%, the separated were 5.7%, and the divorced were 5.4%. The majority of the participants had secondary education (49.6%), followed by tertiary (31.1%), primary (14.6%), and those with no formal education (4.6%). In terms of occupation, 28.9% of the respondents were self-employed, 26.1% were employed, 23.2% were students, and 21.8% were unemployed.

In terms of conflict exposure, 30.4% had seen violence, 18.2% had lost a family member, 14.6% had had a property destroyed, 13.2% had been threatened with death, 11.1% had been forced out of their homes, 9.3% had been physically injured by conflict, and 3.2% had had other conflict experiences. Most participants experienced the conflict 4–6 years ago (36.1%), followed by 7 years and above (27.9%), 1–3 years (25.4%), and less than one year (10.7%). Most of them did not receive psychological support (78.2%), but 21.8% did. The majority of participants resided with family (63.9%), and the quality of the social relationships was mostly assessed as fair (35.4%) and good (27.9%).

Table 2:
Means, Standard Deviations, and Inter-Correlations Among Study Variables

Variable	<i>M</i>	<i>SD</i>	1	2	3
1. Symptomatic PTSD	36.72	15.00	—		
2. Psycho-trauma (Trauma Distress)	26.21	6.37	.77***	—	
3. Social Isolation	25.16	5.56	.72***	.61***	—

Table 2 showed that symptomatic PTSD had a mean score of 36.72 (*SD* = 15.00), psycho-trauma had a mean of 26.21 (*SD* = 6.37), and social

isolation had a mean of 25.16 (SD = 5.56). Psycho-trauma was positively and significantly related to symptomatic PTSD ($r = .77, p < .001$), while social isolation was also positively and significantly related to symptomatic PTSD ($r = .72, p < .001$). In addition, psycho-trauma was positively associated with social isolation ($r = .61, p < .001$). Thus, this shows that participants with higher trauma distress also tended to report higher levels of social isolation.

Inferential results

Three hypotheses were tested using multiple linear regression analysis at the 0.05 level of significance. The results of the regression analysis are presented in Table 3.

Table 3:
Multiple Linear Regression Predicting Symptomatic PTSD

Predictor	<i>B</i>	<i>SE</i>	β	<i>t</i>	<i>p</i>	95% Confidence Interval	
						Lower Bound	Upper Bound
(Constant)	-23.33	2.45		-9.53	< .001	-28.15	-18.51
Psycho-trauma	1.24	0.10	.53	12.69	< .001	1.05	1.43
Social Isolation	1.10	0.11	.41	9.82	< .001	0.88	1.32

A multiple linear regression analysis was conducted to examine whether psycho-trauma (trauma distress) and social isolation predict symptomatic PTSD among victims of ethno-religious conflict in Jos South, Nigeria. Assumptions of linearity, homoscedasticity, and multicollinearity were met, with VIF values of 1.58 indicating no multicollinearity concern.

The model was significant, $F(2, 277) = 321.675, p < .001$, explaining 69.9% of the variance in symptomatic PTSD ($R = .836, R^2 = .699, \text{Adjusted } R^2 = .697$). Note. $R = .836, R^2 = .699, \text{Adjusted } R^2 = .697, F(2, 277) = 321.675, p < .001$. Dependent Variable: Symptomatic PTSD.

Result of Hypothesis one (Table 3) shows that psycho-trauma significantly predicted symptomatic PTSD ($B = 1.24, \beta = .53, t = 12.69, p < .001, 95\% \text{ CI } [1.05, 1.43]$). This indicates that higher levels of psycho-trauma are associated with increased symptomatic PTSD; therefore, Hypothesis One was supported. Result of Hypothesis two revealed that social isolation significantly predicted symptomatic PTSD ($B = 1.10, \beta = .41, t = 9.82, p < .001, 95\% \text{ CI } [0.88, 1.32]$), showing that greater social

isolation is associated with higher PTSD symptoms; hence, hypothesis two was also supported. As per the result in Hypothesis three, the overall model showed that psycho-trauma and social isolation jointly predicted symptomatic PTSD, with both variables making significant independent contributions to the model (psycho-trauma: $B = 1.24$; social isolation: $B = 1.10$; $p < .001$). Therefore, hypothesis three was supported.

Generally, hypothesis one proposed that psycho-trauma would significantly predict symptomatic PTSD. The results supported this hypothesis ($B = 1.24$, $\beta = .53$, $t = 12.69$, $p < .001$, 95% CI [1.05, 1.43]). This is consistent with Nwoye and Nweke (2024), who found that trauma exposure significantly predicted PTSD among war veterans in South-East Nigeria ($F(1,468) = 38.88$, $p < .01$), and with Abiama et al. (2022), who reported that trauma exposure independently predicted increased PTSD symptom severity among survivors of terrorist attacks in Northeast Nigeria. Broader reviews by Tesfaye et al. (2024) and Carpinello (2023) similarly confirm that repeated exposure to violence significantly elevates PTSD risk in conflict-affected populations. These findings are theoretically grounded in Ehlers and Clark's (2000) Cognitive Model of PTSD, which explains that traumatic experiences overwhelm the individual's capacity to process distressing events, resulting in intrusive symptoms, negative appraisals, and persistent emotional dysregulation. Among conflict victims in Jos South, direct exposure to killings, displacement, and property destruction constitutes exactly the kind of psycho-traumatic experience this model predicts will sustain PTSD over time.

Hypothesis two proposed that social isolation would significantly predict symptomatic PTSD. The results also supported this hypothesis ($B = 1.10$, $\beta = .41$, $t = 9.82$, $p < .001$, 95% CI [0.88, 1.32]). This aligns with Revranche et al. (2022), who found social isolation to be a significant PTSD risk factor among trauma-exposed adults, particularly those with interpersonal violence histories, and with Zalta et al. (2021), whose meta-analysis of over 62,000 trauma-exposed adults showed that higher social support consistently predicted lower PTSD severity. Pollmann et al. (2022) similarly found that weakening social ties over time increased PTSD vulnerability among deployed military personnel. These findings are explicable through Weiss's (1974) Social Provisioning Theory, which holds that people depend on social relationships for attachment and psychological regulation. In Jos South, where conflict has fractured community ties and deepened mistrust, survivors are deprived of the relational resources needed for recovery, sustaining PTSD symptoms in the process. As Cruwys et al. (2025) observed, social isolation and trauma can reinforce each other cyclically, making disconnection both a consequence and an amplifier of PTSD.

Hypothesis three held that psycho-trauma and social isolation would jointly predict symptomatic PTSD. The results supported this hypothesis, with the overall model being statistically significant ($F(2, 277) = 321.675, p < .001$) and explaining 69.9% of the variance in symptomatic PTSD ($R^2 = .699$, Adjusted $R^2 = .697$). Psycho-trauma ($\beta = .53$) contributed slightly more than social isolation ($\beta = .41$), though both were significant. This joint effect is consistent with Dumke et al. (2021), who found that the interpersonal trauma pattern, combining direct trauma with disrupted social relationships, produced the highest symptom burden in a conflict-affected Congolese sample. Theoretically, Ehlers and Clark's (2000) cognitive model accounts for the internal maintenance of PTSD through trauma appraisals, while Weiss's (1974) Social Provisioning Theory explains the external vulnerability pathway through relational deprivation. When conflict simultaneously inflicts psycho-trauma and ruptures social bonds, the conditions for severe and persistent PTSD are compounded, a conclusion the present data make empirically clear. The variation in findings across studies nonetheless calls for further research to better understand how these two variables interact across different conflict contexts and populations.

Conclusion and Recommendations

This study investigated psycho-trauma and social isolation as predictors of symptomatic PTSD among victims of ethno-religious conflict in Jos South, Plateau State, Nigeria. Three objectives guided the study. One, to determine whether psycho-trauma predicts symptomatic PTSD among victims of ethno-religious conflict in Jos South. Two, to find out whether social isolation predicts symptomatic PTSD among victims of ethno-religious conflict in Jos South. Three, to ascertain whether psycho-trauma and social isolation jointly predict symptomatic PTSD among victims of ethno-religious conflict in Jos South.

Based on what the result revealed, we established that psycho-trauma significantly predicted symptomatic PTSD, with higher levels of trauma distress associated with greater PTSD severity. We discovered that social isolation significantly predicted symptomatic PTSD, with greater social disconnection associated with higher PTSD symptoms. We further discovered that psycho-trauma and social isolation jointly and significantly predicted symptomatic PTSD, together accounting for approximately 70% of the variance in PTSD symptoms among the sampled participants. However, our conclusions, therefore, are that psycho-trauma predicts symptomatic PTSD, that social isolation predicts symptomatic PTSD, and that both variables jointly predict symptomatic PTSD among victims of ethno-religious conflict in Jos South.

In light of these findings, it is recommended that future research should be conducted to examine the interactive and longitudinal roles of psycho-trauma and social isolation in the onset and progression of PTSD among conflict-affected populations in Nigeria, to provide a more comprehensive understanding of the outcomes of post-conflict. More so, Government and non-governmental organizations at all levels should strengthen and fund accessible, community-based mental health services, especially in areas like Plateau State that have experienced repeated conflict. Mental health professionals should take into account both trauma exposure and social isolation when assessing and treating survivors, so that care addresses both emotional distress and withdrawal from social life. In addition, community and religious leaders should support efforts that rebuild social connections and help survivors reintegrate into their communities, since being socially disconnected can worsen PTSD symptoms.

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