# Influence of Stigmatization on Mental Health Disorders among Children Associated with Armed Forces or Armed Groups in Borno State: How Important is Perceived Social Support?

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## ABSTRACT

This research examined the mediating role of perceived social support in the relationship between stigmatization and mental health disorders among Children Associated with Armed Forces or Armed Groups (CAAFAGs). The cross-sectional survey involved 169 CAAFAGs selected from 7 Local Government Areas in Borno State who were within the age range of 7 – 17 years with the mean age of 13.48 years (Std.=3.01). The multi-stage sampling involving stratified and purposive techniques was used in selecting the participants. Data were collected using the Stigma Scale, Interpersonal Support Evaluation List (ISEL)–12, and Depression, Anxiety and Stress Scale (DASS). Results from data analysis showed that stigmatization contributed a large percentage to the overall mental health disorders observed among Children Associated with Armed Forces or Armed Groups (CAAFAGs). Specifically, CAAFAGs who were discriminated against had difficulty disclosing their status, exhibited self-stigma and tended to suffer higher mental health disorders (i.e. depression, anxiety and stress). Furthermore, it was found that, although perceived social support could not completely eliminate the effect of stigmatization on mental health disorders, it has the potential to lower the effect of stigmatization (which indicates partial mediation). It was therefore recommended that apart from supporting the CAAFAGs with tangible items like food, water, clothing and shelter, the government and NGOs should further hold community reintegration workshops, dialogue, mediation on reintegration challenges and social cohesion activities that are capable of building the children's self-esteem and further enhancing their mental health.

**Key words:** Stigmatization, Perceived Social Support, Depression, Anxiety, Stress, Mental Health disorders

## INTRODUCTION

There has been escalating curiosity among health professionals, including psychologists, concerning mental health of children affected by armed groups. This curiosity stems from the widespread violence orchestrated by wars and activities of armed groups and criminal gangs globally. Like many developing countries around the world and particularly on the African continent, Nigeria is confronted with unabated and diverse forms of violence including abductions and forceful displacement caused by armed groups and criminal gangs.

The Northeastern region in Nigeria, since 2009, has remained the most affected part of the country with thousands of women and children exposed to and/ or affected by violence. Groups such as Boko Haram, Islamic State – West Africa Province (ISWAP), armed bandits and herdsmen have continued to perpetrate violence leading to death of thousands of people and leaving many others, including women and children, displaced [1]. Ukoji and Ukoji [2], in their analysis of 16-year trends and patterns of violence-related mortality in Nigeria, reported that Borno State is the most affected by violence due to insurgency. Consequently, the

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abduction, recruitment and use of children by armed groups have become widespread in the North Eastern part of Nigeria, particularly Borno State. These children are described by UNICEF [3] as Children Associated with Armed Forces or Armed Groups (CAAFAGs). They are young individuals below the age of 18 years who are/ or have been recruited and used by armed forces or armed groups in any capacity, including but not limited to being used as fighters, cooks, porters, spies or for sexual purposes [3].

Since 2009, over 8,000 boys and girls were believed to have been recruited and used by armed groups in Nigeria [4]. They assumed myriad of roles as child soldiers, porters, cooks, informants, servants, human shields, mine sweepers, suicide bombers and manning of checks points [5]. Many are forced to perpetrate violence, participating in village raids and mass atrocities [6]. The reality of the CAAFAGs is that they are often both victims and perpetrators of violence.

While some of the abducted children could not survive because they were being used as suicide bombers or in war fronts as shields, others were lucky to gain freedom and return to their communities but without homes and families, grossly affecting their mental health [3]. Mental health is a state of mental well-being that enables people to cope with the stresses of life, realize their abilities, learn well and work well, and contribute to their community [7]. It is an integral component of health and well-being that underpins our individual and collective abilities to make decisions, build relationships and shape the world we live in. Research has also shown that, due to their exposure to violence, the CAAFAGs are at high risk of exhibiting wide range of mental health disorders including depressive symptoms, anxiety, Posttraumatic Stress Disorder (PTSD) as well as self-harm [8] [9]. Specifically, Kohrt [10] reported that the affected children could display higher functional impairment and psychosocial problems such as aggression, depression, anxiety, and posttraumatic stress as compared to never-affected children. The affected children could be seen avoiding specific locations, sights, situations, and sounds that serve as reminders of the traumatic events. Others may become hyper-vigilant, aggressive, engage in reckless behaviour including self-harm, loss of interest in activities that were once considered enjoyable, over thinking, insomnia and memory challenge.

Although their exposure to violence has placed them at high risk of mental health disorders [11], not all of the CAAFAGs suffer the same degree of mental disorders. The differences in mental health of children exposed to violence could be attributed to certain psychosocial factors including stigmatization and social support which may predispose, precipitate or protect children from mental health challenges.

Stigmatization as a psychosocial concept is inherent in the normative structure of all societies and provides a system of evaluating members on the basis of key characteristics or features. It may be described as a label that associates a person to a set of unwanted characteristics that form a stereotype, usually caused by misconceptions and social disapproval based on different beliefs or perceptions. Subu et al. [12] defined stigmatization as the discrediting, devaluing, and shaming of a person because of characteristics or attributes that they possess. It is a collective system of negative reactions that are elicited by human attributes. It leads to negative stereotyping and labeling of an individual, and can be followed by social exclusion, unjust treatment and reluctance to seek care from relatives by the stigmatized person [13] [14]. Stigmatization may play an important role in the mental health of CAAFAGs, particularly when returning to civil society in the aftermath of organized violence. CAAFAGs are often stigmatized for their association with armed groups and their consequent mental health problems. Mittal et al. [15] reported that common stereotypes for stigmatization include labels such as "dangerous/violent," or "crazy."

Stigmatization has been associated with debilitating effect on the quality of lives of individuals. Research literature has consistently shown a direct correlation between perceived stigma and diminished quality of life as individuals experiencing stigma tend to report lower life satisfaction [16], increased psychological distress [17], and greater social isolation [18]. It has been reported to play significant role as a barrier to effective management of mental health disorders [19]. Furthermore, it could precipitate and maintain higher prevalence of current and long-term PTSD, a diminished probability of spontaneous remission and higher PTSD symptoms before and after trauma-focused psychotherapy, beyond the effect of trauma load [20]. According to Kim et al. [21], concerns about potential stigma is a strong reason why people with mental health challenges could not seek help because of its detrimental influences on an individual's reputation. Continuing stigmatization and discriminating actions have also been linked to low self-esteem, long-lasting negative

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psychological effects and prevention of a successful re-integration into society [22] [23]. It may ultimately contribute to less access to protective resources such as family and community support [22].

Also mentioned in the extant literature on mental health, especially in relation to victims of violence and trauma, is the concept of perceived social support defined as the assistance or comfort given to other people to help them cope with a variety of problems. It has also been defined as a network of family, friends, neighbors and community members who are available in times of need to give physical, psychological and financial help [24]. Research often conceptualized social support as perceived social support because it is the belief of the receiver about existence of the support [25]. Therefore, perceived social support is defined as belief of the CAAFAGs that care, value and guidance are provided by the family, peers and community members [26]. The functional dimension of social support involves emotional components such as love and empathy. It also includes instrumental or practical support such as giving gifts of money or assistance with care [27].

Perceived social support is believed to provide physical and psychological advantages for people faced with traumatized events such as CAAFAGs. It is considered as a protective factor which reduces psychological distress that could lead to mental health disorders [28]. Researchers have reported positive effect of social support on mental health of adolescents whereby those who perceive good social support develop higher self-esteem which in turn contribute to their Psychological Wellbeing (PWB) and posttraumatic growth (PTG) [29] [30]. In their investigation of the role of community and family support in former child soldiers, Betancourt et al. [31] revealed that members of the socially vulnerable group were about twice as likely as those in the socially protected group to have high levels of anxiety and depression. They are at higher risk of suicide and more likely to have been in trouble with the police. Victims of mental health disorders such as depression and anxiety who perceive poor social support experience worst treatment outcomes [32].

Several other researchers have perceived social support as a coping resource that lowers the effect of traumatic events. For example, Paardekooper [33] observed that refugee children who reported higher social support tended to have lower levels of depression and Post-Traumatic Stress Disorder (PTSD). Both parental and peer social support have also been reported in different studies as being closely associated with psychosocial adjustment among adolescents affected by war [34].

From the foregoing, it appears that perceived social support is very important because it provides buffering effect against life stressors including stigmatization, and also promote health and wellness [35]. Since Children Associated with Armed Forces and Armed Groups (CAAFAGs) are forcibly displaced, they may lose not only material resources like housing, education, access to food, water, and security, but also social activities and relationship with loved ones. Hence, availability of social support to them could be an important factor for enhancing their mental health. This study is therefore, designed to test the following hypothesis:

**$H_1$:** There will be a significant influence of stigmatization on mental health of CAAFAGs in Borno State, Nigeria.

**H1:** Perceived social support will significantly reduce the negative influence of stigmatization on mental health of CAAFAGs in Borno State, Nigeria.

## METHOD

**Design:** This study employed the cross-sectional survey design involving collection of data from Children Associated with Armed Forces or Armed Groups (CAAFAGs) at one point in time. The sample is regarded as a cross-section of the population, thereby making it possible to explore the relationship between related variables and to make inferences about the population of interest at that point in time.

**Sampling/participants:** The stratified sampling technique was first used to segregate the CAAFAGs by gender. Then, the sample of males and females was proportionately taken from each of the Local Government Areas to make up the total sample for the study. Thereafter, purposive sampling technique was used to sample CAAFAGs for inclusion in the study. Participants were 169 CAAFAGs taken from the population of 3,562 CAAFAGs in Borno State IDPs camps (Statistics from Grow Strong Foundation, GSF, 2020). They were those

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who have experienced significant violence, displacement and trauma between 2009 and 2020 and were at high risk of mental health disorders. They were 76(45%) males and 93(55%) females selected from seven Local Government Areas in Borno State which are: Bama, Gwoza, Monguno, Maiduguri Municipal Council (MMC), Damboa, Dikwa and Jere.

**Data collection:** Data were collected using standardized instruments; *Stigmatization* was measured using the Stigma Scale by King, et al. [36]. It is a 28-item scale that measures stigmatization in three dimensions: Discrimination, Disclosure and Positive aspects. The instrument is scored on a 5-point rating scale ranging from 1=Strongly Disagree to 5=Strongly Agree with higher scores on the scales indicating greater stigma, after reversing the subscale exploring positive aspects of mental illness. Authors reported Cronbach's alpha coefficient for responses to the 28 items of the final version as 0.87 with while the subscales had discrimination α= 0.87; disclosure α= 0.85, and positive aspects α= 0.64. *Perceived social support* was measured using the Interpersonal Support Evaluation List (ISEL)-12 [37]. The three subscales are: 1.) Appraisal Support; 2.) Belonging Support; and 3.) Tangible Support. All answers are given on a 4-point rating scale ranging from "Definitely False" =1 to "Definitely True"=4. All scores are kept continuous with high scores indicating high perceived social support and low scores indicating low perceived social support. *Mental health* was measured using Depression Anxiety Stress Scale (DASS) by Lovibond and Lovibond [38], a 42-item scale measuring negative emotional symptoms. It is scored on a 4-point severity/frequency scale ranging from: 0=Did not apply to me at all to 3=Applied to me very much, or most of the time. Scores are summed for depression, anxiety and stress scales separately and together as a measure of mental health status. Cronbach's Alpha coefficient for the DASS normative sample as established by the authors were: Depression 0.91; Anxiety 0.84; Stress 0.90. High scores on this scale indicate high mental health disorders while low scores indicate low mental health disorders.

**Procedure:** For ethical considerations, permission was first obtained from Grow Strong Foundation (the NGO covering the CAAFAGs in Borno State). The organisation's Child Safeguarding Policy was duly signed and carefully observed by the researcher. With help of research assistants who were familiar with the context in terms of language and geographical terrain, the researcher visited the camps and collected data from the CAAFAGs who either completed the questionnaire on their own or with the aid of a research assistant (who also served as interpreter).

**Data Analysis:** Data were analysed using multiple linear regression analysis and mediation analysis through Andrew Haye's PROCESS Macro.

## RESULTS

The results are presented in the tables below and followed by interpretations respectively.

Table 1: Multiple linear regression analysis showing influence of stigmatization on mental health among (CAAFAGs) in Borno State

| Dv | Predictors | R | $R^2$ | df | F | Sig. | β | t | Sig. |
|---|---|---|---|---|---|---|---|---|---|
| Mental health | Constant | | | | | | | 4.57 | .000 |
| | Discrimination | | | | | | .506 | 12.04 | .000 |
| | Disclosure | .867 | .752 | 3,165 | 166.82 | .000 | .351 | 5.03 | .000 |
| | Positive aspect | | | | | | .219 | 3.06 | .003 |
| | Constant | | | | | | | 4.83 | .000 |
| | Discrimination | | | | | | .570 | 9.61 | .000 |

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| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Depression | Disclosure | .711 | .505 | 3,165 | 56.18 | .000 | .274 | 2.78 | .006 |
| | Positive aspect | | | | | | .007 | .074 | .941 |
| | Constant | | | | | | | -.45 | .655 |
| | Discrimination | | | | | | .249 | 5.03 | .000 |
| Anxiety | Disclosure | .809 | .654 | 3,165 | 104.04 | .000 | .413 | 5.02 | .000 |
| | Positive aspect | | | | | | .302 | 3.56 | .00 |
| | Constant | | | | | | | 1.95 | .052 |
| | Discrimination | | | | | | .281 | 3.67 | .000 |
| Stress | Disclosure | | | | | | .090 | .706 | .481 |
| | Positive aspect | | | | | | .144 | 1.10 | .174 |

The results showed that there is a significant influence of stigmatization on overall mental health of the Children Associated with Armed Groups and Armed Forces (CAAFAGs) R=.867, $R^2$=.752, F(3,165)=166.82, p<.01. Stigmatization as a whole accounted for 75.2% of the total variance observed in overall mental health problems (depression, anxiety, stress) among the CAAFAGs, implying its negative impact on mental health. All the three dimensions of stigmatization contributed positively to mental health disorders (Discrimination: β=.506, p<.0; disclosure: β=.351, p<.0, and positive: β=.219, p<.01), indicating their negative influence on mental health of the CAAFAGs.

Specifically, the results revealed that there is a significant influence of stigmatization on depression among the CAAFAGs R=.711, $R^2$=.505, F(3,165)=56.18, p<.01, with stigmatization accounting for 50.5% of the total variance observed in depression among the CAAFAGs. The three dimensions of stigmatization (except positive aspect) all had positive contribution to depression (Discrimination: β=.570, p<.0; disclosure: β=.270, p<.0, and positive aspect: β=.007, p>.05), indicating their negative influence on mental health of the CAAFAGs. This means that CAAFAGs who are discriminated against exhibit higher depression, followed by those who have difficulty disclosing their status and experience as CAAFAGs, while the positive of stigma did not significantly lead to depression.

Furthermore, the results showed a significant influence of stigmatization on anxiety among the CAAFAGs R=.809, $R^2$=.654, F(3,165)=104.04, p<.01, with stigmatization accounting for 65.4% of the total variance observed in anxiety. The three dimensions of stigmatization all made significant positive contributions to anxiety (Discrimination: β=.249, p<.0; disclosure: β=.413, p<.0, and positive: β=.303, p<.01), indicating their negative impact on mental health. This means that CAAFAGs who have difficulty disclosing their status exhibit higher anxiety, followed by positive aspect of stigma and discrimination.

Finally, the results showed that there is a significant influence of stigmatization on stress among the CAAFAGs R=.420, $R^2$=.176, F(3,165)=11.753, p<.01, with stigmatization accounting for 17.6% of the total variance observed in stress among the CAAFAGs. However, only discrimination made a positive significant contribution to stress (β=.281, p<.0), while disclosure (β=.090, p>.05) and positive aspect of stigmatization (β=.144, p>.05) did not make any significant contribution to anxiety among the CAAFAGs. This means that the more CAAGs are discriminated against, the more stress they suffer while on the other hand, the lesser they are discriminated against, the lesser the stress they suffer. However, problem with disclosure and positive aspect of life do not contribute significantly to their level of stress.

In summary, the results on hypothesis two revealed that stigmatization and all its three dimensions (discrimination, disclosure, positive aspect) together contributed positively to mental health disorders

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(depression, anxiety, stress). Specifically, discrimination had significant positive influence on depression, anxiety and stress; disclosure had significant positive influence on depression, anxiety but not on stress; while positive aspect when reversed had significant positive influence only on anxiety but not on depression and stress. This means that the more the CAAFAGs are stigmatized, the more they experience depression, anxiety and stress.

Table 2: Mediation analysis showing direct and indirect effect of stigmatization on mental health through perceived social support

| **Type of Effect** | **β** | **SE** | **$R^2$** | **t** | **p** | **LLCI** | **ULCI** | **c_cs** |
|---|---|---|---|---|---|---|---|---|
| Total effect | .7699 | .0368 | .7237 | 20.9166 | .000 | .6971 | .8426 | .8507 |
| Direct effect | .6331 | .0464 | .7534 | 13.6419 | .000 | .5415 | .7247 | .6996 |
| Indirect effect | .1368 (.1512) | .0294 (.0319) | | | | .0905 | .2140 | |

The results presented in Table 2 showed that stigmatization has significant total effect on mental health disorders of the CAAFAGs, with the effect of perceived social support held constant (β =.7699, t=20.9166, p<.01). The $R^2$-value ($R^2$=.7237) indicates that the model explained 72.37% of the variance in mental health disorders among CAAFAGs in Borno State, Nigeria. When perceived social support was included in the second model, stigmatization still had a significant direct effect on mental health disorders among the CAAFAGs (β =.6331, t=13.6419, p<.01). This means that stigmatization on its own significantly influences idea generation among the bank employees. The result further showed that there is a significant indirect effect of stigmatization on mental health disorders through perceived social support (β=.1368, BootSE=.0294, 95%CI(.0905 to .2140). The result indicates a significant partial mediation effect which means that perceived social support reduces the negative effect of stigmatization thereby reducing mental health disorders.

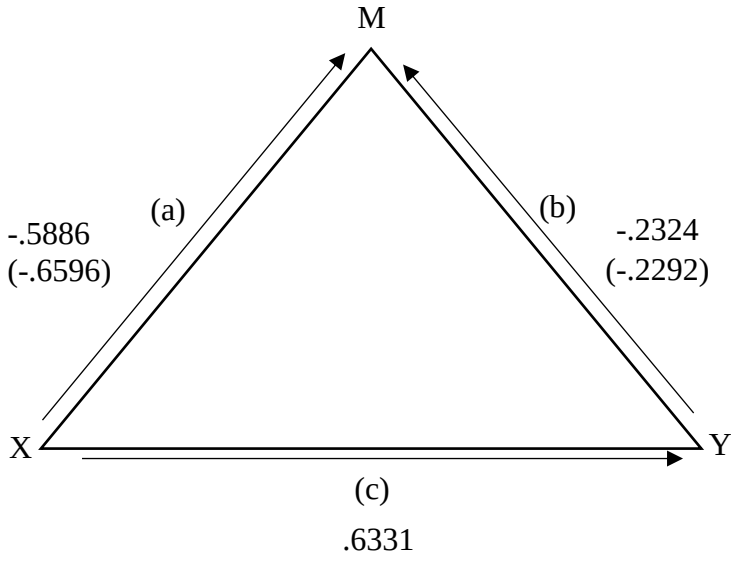


Fig. 1: The simple mediation model

Fig.1 showed the effect of stigmatization (X) on perceived social support(M) i.e. (path a); The effect of perceived social support (M) on mental health disorders (Y) i.e. (path b); and the direct effect of stigmatization (X) on mental health disorders (Y) after removing the contribution of perceived (M) social support i.e. (path c). The indirect effect is the effect of X on Y *through M*. This is equivalent to the product of path *a* and path *b*, sometimes known as the *ab* path. In the diagram, the indirect effect is the coefficient of path *a* multiplied by the coefficient of path *b* i.e. -.5886 x -.234 =.1368. The total effect is the sum of direct effect and the indirect effect, i.e. .1368 +.6331 = .7699.

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## DISCUSSION

From the results, stigmatization contributed a large percentage to the overall mental health disorders observed among Children Associated with Armed Forces and Armed Groups (CAAFAGs). The three dimensions of stigmatization all made significant positive contributions to overall mental health disorders with discrimination making highest positive contribution followed by disclosure while positive aspect of stigmatization (reversed) made the least positive contribution to overall mental health disorders among the CAAGs. This means that the more CAAGs are stigmatized, the more they suffer overall mental health disorders, indicating the negative impact that stigmatization has on metal health of the CAAFAGs. Specifically, CAAFAGs who are discriminated against, have difficulty disclosing their status, have self-stigma, tend to exhibit higher mental health disorders (i.e. depression, anxiety and stress). This finding has given credence to several other findings including that of Schneider, et al. [20] who found that stigmatization is strongly associated with a higher prevalence of lifetime and current PTSD, a diminished probability of spontaneous remission and higher PTSD symptoms before and after trauma-focused psychotherapy. The finding also tallies with Rizzo et al. [16] who reported that stigmatization is related to low life satisfaction and Siligato et al. [17] who reported it leads to increase psychological distress. Similarly, the findings agree with Betancourt et al. [31] who found that child soldiers who experienced stigmatization were about twice as likely as those who were protected from stigma to have high levels of anxiety and depression.

In the second hypothesis, the results showed that perceived social support has significant partial mediation effect in the relationship between stigmatization and mental health disorders of the CAAFAGs. This means that even though perceived social support could not completely eliminate the effect of stigmatization on mental health disorders, it has the potential to lower its effect. This implies that social support is an important psychosocial tool in cushioning the negative influence of stigmatization on mental health of CAAFAGs. The provision of emotional support in terms of giving the CAAFAGs sense of belonging as well as tangible support like good shelter, sporting facilities, educational facilities, hospitals and recreational activities would be very useful in helping the CAAFAGs recover from their traumatic experience of violence and consequent mental health disorders. This finding agrees with Poudel et al. [30] who found that Perceived Social Support (PSS) indirectly affects Psychological Well-Being (PWB) by boosting self-esteem which in turn contributes to PWB. Similarly, the finding agrees with Dar and Deb [29] who found that perceived social support significantly associates with increase in posttraumatic growth. It also tallies with Wang et al. [32] who found substantial evidence that people with depression who perceive their social support as poorer have worse outcomes in terms of symptoms, recovery and social functioning.

## CONCLUSION AND RECOMMENDATIONS

Based on the findings of this study, it is concluded that stigmatization increases mental health disorders and inflicts more psychological injuries to Children Associated with Armed Forces or Armed Groups (CAAFAGs) by increasing their feelings of guilt and lowering their self-worth. Nevertheless, the provision of social support (as perceived by the CAAFAGs) has the potency to buffer the effects of both exposure to violence and stigmatization, and to balance the state of mental health disorders of the CAAFAGs. It is therefore recommended that the government and Non-Governmental Organisations (NGOs) especially child protection actors in the North-East and other parts of the country should prioritize social reintegration of the CAAFAGs. Apart from supporting them with tangible items like food, water, clothing and shelter, the government and NGOs should further hold community reintegration workshops, dialogue, mediation on reintegration challenges and social cohesion activities that are capable of building the children's self-esteem and boost their mental health in turn.

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