

Cultural Meanings of Trauma, Resilience, and Help-Seeking Among Internally Displaced Persons in Nigeria: Implications for Cross-Cultural Mental Health Practice.

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ABSTRACT:

This conceptual paper examines the cultural meanings of trauma, resilience, and help-seeking among internally displaced persons in Nigeria, with particular attention to their implications for cross-cultural psychiatry, psychology, and mental health practice. Although forced displacement is often discussed through clinical categories such as post-traumatic stress, depression, anxiety, and grief, these categories do not always fully capture how displaced persons interpret suffering, survival, and recovery within their own cultural worlds. Adopting a qualitative orientation, the paper engages interpretively with the ways psychological distress may be understood through religious belief, communal loss, family disruption, social stigma, moral endurance, and spiritual explanations of adversity. Drawing conceptually on Harmony Restoration Therapy, an African indigenous therapeutic perspective that understands wellbeing in terms of balance and harmony within the self, relationships, community, and wider existential world, the paper argues that displacement-related trauma should be understood not only as an individual clinical condition but also as a culturally mediated experience shaped by social dislocation and disrupted belonging. This perspective does not reject psychiatric diagnosis; rather, it questions its adequacy when detached from cultural context and lived experience. The paper contributes to global mental health discourse by arguing for culturally grounded assessment, community-sensitive trauma care, and more ethically responsive interventions for displaced populations in African settings.

Keywords: Cross-Cultural Mental Health; Harmony Restoration Therapy; Help-Seeking; Internally Displaced Persons; Nigeria; Trauma

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I. INTRODUCTION

Trauma is never experienced outside culture. For internally displaced persons, violence, loss and insecurity are interpreted through religious beliefs, communal values, family roles, social identity and

local meanings of suffering. Internal displacement is therefore not only a humanitarian crisis, but also a disruption of belonging, livelihood, dignity and social order. Globally, displacement remains a major concern in conflict-affected and fragile settings

(Internal Displacement Monitoring Centre [IDMC], 2025). In Nigeria, the north-east continues to record large populations of internally displaced persons living in camps, camp-like settlements and host communities (International Organization for Migration [IOM], 2025).

Although displacement-related distress is often discussed through clinical categories such as post-traumatic stress, depression, anxiety and grief, these terms may not fully capture how displaced persons understand and communicate suffering. The World Health Organization (2022) notes that mental health is shaped by social conditions, which means trauma must also be read through poverty, uncertainty, stigma, family separation, food insecurity and limited access to care. Bovey et al. (2025) similarly show that trauma-related distress across parts of Africa and the Middle East is often shaped by cultural, psychosocial, structural and spiritual meanings.

This article maintains that trauma among internally displaced persons in Nigeria is both clinical and culturally mediated. Harmony Restoration Therapy (HRT) offers a useful African lens here, as Igboke (2022) presents it as an indigenous psychotherapy model concerned with harmony within the person, relationships, community and wider existential environment. Applied to displacement, HRT frames trauma as a disturbance of harmony involving home, belonging, kinship, identity and meaning. This conceptual paper therefore adopts a qualitative orientation to support the need for mental health care that is clinically informed, culturally grounded and ethically responsive to displaced populations in Nigeria.

II. CONCEPTUALISING TRAUMA BEYOND SYMPTOM-BASED DIAGNOSIS

Trauma is often approached through diagnostic categories that identify symptoms such as intrusive memories, avoidance, negative mood, hyperarousal, anxiety, depression and functional impairment. These categories are clinically useful because they provide a shared language for assessment, research and intervention. The DSM-5-TR, for instance, remains important in helping clinicians classify trauma- and stressor-related disorders with a degree of consistency (American Psychiatric Association,

2022). Yet diagnostic classification should not be mistaken for a complete account of suffering. A person may meet clinical criteria for trauma-related distress, but the meaning of that distress is still shaped by culture, belief, social position and lived experience.

This distinction is particularly important in contexts of forced displacement. For internally displaced persons, trauma is rarely confined to the violent event that caused movement. It may continue through the loss of home, separation from family, damaged social identity, poverty, insecurity, stigma and uncertainty about return. The World Health Organization (2022) rightly locates mental health within social environments, which suggests that distress should not be separated from the conditions that sustain it. A symptom-based approach may identify anxiety or post-traumatic stress, but it may not fully explain why distress is expressed through silence, bodily pain, spiritual fear, shame, anger, withdrawal or moral endurance.

A culturally attentive understanding of trauma therefore asks not only what symptoms are present, but how suffering is interpreted and communicated. Bovey et al. (2025) show that trauma-related distress across parts of sub-Saharan Africa, the Middle East and North Africa is often expressed through cultural concepts and idioms that include psychosocial, structural and spiritual explanations. This does not make such distress less real or less clinically serious. Rather, it shows that mental suffering may be organised through meanings that extend beyond biomedical language. For Nigerian internally displaced persons, distress may be understood through disrupted belonging, spiritual vulnerability, family loss, communal humiliation or the sense that life has fallen out of balance.

The argument, therefore, is not that psychiatric diagnosis should be rejected. Such a position would be clinically weak and unnecessarily oppositional. The more careful position is that diagnosis must be interpreted alongside culture. Without this, mental health practice risks treating trauma as if it were only an individual disorder, while overlooking the social and cultural worlds in which suffering is produced and managed. This is also why culturally adapted interventions have become increasingly significant

in work with forcibly displaced populations. McDermott et al. (2024) note that intervention acceptability depends partly on whether psychological care is adapted to the cultural experiences and expectations of those receiving it.

For this article, conceptualising trauma beyond symptom-based diagnosis means recognising trauma as both clinical and cultural. Symptoms matter, but so do meanings. In the Nigerian displacement context, cross-cultural mental health care must therefore attend to the language, beliefs, relationships, spiritual interpretations and community structures through which displaced persons understand suffering and seek recovery.

III. INTERNALLY DISPLACED PERSONS IN NIGERIA: SOCIAL DISLOCATION AND PSYCHOLOGICAL VULNERABILITY

Internal displacement in Nigeria is shaped by overlapping conditions of insurgency, communal violence, banditry, farmer-herder conflict, poverty, food insecurity and weak protection systems. Although the north-east remains the most visible site of displacement, the experience itself is not only geographical movement. It involves the loss of home, livelihood, social identity, kinship networks and the ordinary cultural spaces through which people make sense of safety and belonging. The International Organization for Migration (2025) reported over 2.2 million internally displaced persons in north-east Nigeria, spread across camps, camp-like settlements, host communities and durable-solution pathways. Behind these figures are people whose psychological distress is tied not only to violence, but also to the breakdown of familiar social worlds.

This social dislocation is important because trauma is often intensified by what follows displacement. A person may survive an attack, yet continue to live with hunger, uncertainty, overcrowding, dependency, loss of dignity and fear of the future. George and Adelaja (2022) show that forced displacement in Nigeria has implications for food security in host communities, indicating that displacement affects both those who move and those who receive them. Such material pressures are not separate from mental health. They shape how suffering is experienced, interpreted and endured.

The camp environment can also become psychologically burdensome. Salihu et al. (2022), in a comparative study of internally displaced persons and host communities in Maiduguri, found higher vulnerability to anxiety, depression and stress among displaced persons. Their findings suggest that displacement-related distress is not only a response to past violence; it is also sustained by present living conditions. Camps may provide safety from immediate threat, but they may also reproduce loss through restricted mobility, weakened privacy, uncertain routines and prolonged dependence on humanitarian assistance.

This matters for the cultural meaning of trauma. For many displaced persons, suffering may not be described simply as anxiety, depression or post-traumatic stress. It may be understood as the loss of dignity, the shame of dependency, the weakening of family authority, the disruption of religious and communal life, or the painful feeling of no longer belonging anywhere. Duke et al. (2025) reported anxiety and depression among internally displaced persons in North Central Nigeria, but their call for culturally tailored assessment is especially important. It suggests that mental health care must listen not only for symptoms, but also for the meanings attached to displacement.

For cross-cultural mental health practice, Nigerian IDPs should therefore not be approached as isolated traumatised individuals detached from their social worlds. Their distress is shaped by disrupted kinship, lost livelihood, weakened community support, uncertain belonging and culturally mediated interpretations of suffering. A meaningful response must address psychological symptoms while also recognising the social and cultural dislocations that give those symptoms their deeper meaning.

IV. CULTURAL MEANINGS OF TRAUMA AMONG DISPLACED PERSONS

The meaning of trauma is not fixed across cultures. While clinical psychology often describes trauma through symptoms such as intrusive memories, fear, avoidance, sleep disturbance and emotional dysregulation, displaced persons may interpret these experiences through different cultural and social vocabularies. This is particularly important in

contexts where suffering is not always separated into “mental”, “physical”, “spiritual” and “social” categories. Among internally displaced persons in Nigeria, trauma may therefore be understood not only as psychological injury, but also as loss of home, broken belonging, spiritual vulnerability, family disruption, shame and the collapse of social order.

Cohen (2023) shows that displaced populations often communicate distress through cultural idioms that include somatic complaints, social isolation, fear of others, spiritual explanations and a shared sense of injustice. This is useful for the present article because it moves the discussion beyond diagnosis alone. If distress is expressed through the body, silence, dreams, spiritual fear or withdrawal from communal life, then a purely symptom-based assessment may miss the deeper meanings through which suffering is organised. In such contexts, trauma is not simply what happened to the individual; it is also what the event has done to the person’s place in family, community and moral life.

This cultural dimension is equally visible in African understandings of distress. Naidoo and Shaik (2024) argue that trauma narratives are shaped by cultural concepts and contexts, and that Western diagnostic frameworks may overlook spiritual and cultural elements embedded in non-Western experiences of suffering. Their argument does not mean that clinical models are irrelevant. Rather, it suggests that clinical language must be placed in conversation with local meanings. For Nigerian IDPs, this may include understanding distress as fear caused by insecurity, grief over lost relatives, shame associated with dependency, spiritual disturbance, or the pain of being cut off from land, livelihood and ancestral or communal spaces.

The Nigerian mental health context further complicates this issue. Ogunwale et al. (2023) note that indigenous mental healthcare in Nigeria is often shaped by cultural preference for spiritual or mystical explanations of mental disorder, although such settings may also raise concerns about stigma and harmful practices. This complexity is important. Culture should not be romanticised, but it also should not be dismissed. Some cultural interpretations may provide comfort, belonging and

meaning, while others may deepen stigma or delay formal care.

For this reason, cultural meanings of trauma must be approached critically. The task is not to replace psychiatry with culture, or culture with psychiatry. It is to recognise that displaced persons may live within both worlds at once. Their suffering may require clinical attention, yet their recovery may also depend on dignity, communal recognition, spiritual reassurance, family reconnection and restored belonging. Cross-cultural mental health practice must therefore listen to how trauma is named, narrated and morally understood before deciding how best to respond.

V. RESILIENCE AS CULTURAL, COMMUNAL AND SPIRITUAL SURVIVAL

Resilience among internally displaced persons should not be reduced to a simple idea of “coping well” after trauma. In contexts of forced displacement, resilience is often less about individual strength alone and more about the ability to survive through relationships, faith, communal solidarity and the reconstruction of meaning. This distinction is important because displaced persons may continue to experience fear, grief, uncertainty and material hardship even while showing remarkable forms of endurance. To describe them as resilient without recognising their suffering would risk romanticising survival.

Ekezie (2022) provides a useful Nigerian example by showing how internally displaced persons in northern Nigeria developed camp leadership structures, social cohesion, advocacy practices and alternative means of managing health and daily survival. This suggests that resilience among IDPs is not passive endurance. It may involve collective organisation, negotiation with humanitarian actors, informal care systems and the effort to create order within unstable environments. Such practices are especially meaningful in African communal contexts, where wellbeing is often tied to relational support and shared responsibility.

At the same time, resilience should not be treated as a substitute for protection, justice or adequate services. Lane et al. (2025), in their systematic review and meta-analyses of forcibly displaced populations, found that resilience was associated with lower

symptoms of post-traumatic stress, depression, anxiety and psychological distress. However, they also noted considerable variation across studies, suggesting that resilience is shaped by context rather than operating as a universal shield against suffering. Grupp et al. (2026) make a similar point in their study of forcibly displaced people in Germany, where resilience showed a general protective effect but did not remove the psychological burden of traumatic exposure, discrimination and post-migration stress.

For Nigerian IDPs, resilience may also be spiritual and moral. Faith, prayer, religious community, hope and the belief that suffering has meaning may help some displaced persons endure loss without collapsing psychologically. Abu-Ras et al. (2026), in their study of widowed Syrian refugee women in Türkiye, found that resilience and spirituality were linked with lower distress and depression, while also stressing that structural conditions such as safety, support and living environment remained important. This balance is useful for the present article. Spiritual coping may protect wellbeing, but it should not be used to excuse poor humanitarian conditions or inadequate mental health services.

Resilience, then, must be understood as culturally embedded survival. Among displaced persons, it may appear in prayer, shared stories, communal labour, caregiving, moral endurance, humour, silence, religious interpretation or the determination to rebuild family life. Cross-cultural mental health practice should recognise these resources without overstating them. The aim is not to celebrate suffering, but to understand how displaced persons continue to create meaning, maintain dignity and seek continuity in the middle of profound disruption.

VI. HELP-SEEKING, STIGMA AND LOCAL PATHWAYS OF CARE

Help-seeking among internally displaced persons is rarely a simple matter of recognising distress and attending a clinic. It is shaped by how suffering is understood, who is trusted, what services are available, and whether formal mental health care is seen as meaningful or threatening. In many displaced communities, psychological distress may first be taken to family members, religious leaders,

camp elders, humanitarian workers or informal support networks before it reaches a mental health professional. This does not necessarily indicate ignorance. It reflects the fact that care is often sought through the relationships and institutions that people already trust.

Stigma remains one of the strongest barriers. Where mental illness is associated with shame, spiritual weakness, madness or family disgrace, displaced persons may avoid disclosing distress even when symptoms are severe. Thiel et al. (2026), in a systematic review of qualitative studies on refugees and asylum seekers, found that access barriers included stigma, misinformation, language difficulties, fear of discrimination and doubts about the usefulness of therapy. Although refugees and IDPs are not the same legal category, the finding is relevant because both groups often navigate trauma, disrupted belonging, marginalisation and unfamiliar care systems. In Nigerian IDP settings, stigma may be intensified by overcrowded living conditions, limited privacy and fear that disclosure could affect family reputation or social acceptance.

Local pathways of care can therefore be protective and limiting at the same time. Religious support, prayer, communal encouragement and family advice may provide emotional containment, hope and belonging. At the same time, distress that is explained only as spiritual attack or moral failure may delay access to psychological care. Olufadewa et al. (2022), in their work with young internally displaced persons in northern Nigeria, showed that IDPs described severe emotional suffering and a need for mental health support. Their study is important because it suggests that displaced persons are not necessarily unwilling to receive help; rather, support must be accessible, trusted and responsive to their realities.

This is where community-based and task-shifted approaches become relevant. Adesina et al. (2024) evaluated the Brave Heart intervention among young IDPs in northern Nigeria and found that a task-shifting model delivered by trained community members helped reduce depressive symptoms. The value of such an approach is not only practical. It also shows that mental health care may become more acceptable when delivered through familiar

social channels rather than distant clinical systems alone.

For cross-cultural mental health practice, help-seeking should therefore be understood as a social and cultural process. Effective care must reduce stigma, protect confidentiality, respect religious and communal coping, and build bridges between formal mental health services and trusted local support systems. The goal is not to replace professional care with informal care, but to create pathways where displaced persons can move between both without shame, fear or cultural misunderstanding.

VII. HARMONY RESTORATION THERAPY (HRT) AS AN AFRICAN CONCEPTUAL LENS

Harmony Restoration Therapy offers a culturally relevant way of interpreting displacement-related trauma without reducing it to symptoms alone. Igbokwe (2022) explains HRT as an African indigenous psychotherapy model that understands wellbeing through harmony within the person, relationships, community and wider existential world. This is important for the present paper because internal displacement does not only affect the mind. It unsettles the person's connection to home, family, livelihood, land, faith, identity and communal recognition.

From an HRT perspective, trauma may be understood as a disturbance of harmony. The displaced person is not merely an individual carrying psychological distress; he or she is also a person whose social world has been fractured. Home is lost, kinship systems may be weakened, familiar community structures are disrupted, and the moral meaning of life may become uncertain. This interpretation aligns with the broader argument that trauma-related distress can be shaped by cultural, spiritual, psychosocial and structural meanings (Bovey et al., 2025). HRT therefore helps to explain why healing should not be limited to the reduction of anxiety, depression or post-traumatic symptoms.

The value of HRT lies in its attention to relational and communal restoration. For many internally displaced persons, recovery may involve more than clinical treatment. It may require dignity, safety, family reconnection, religious reassurance, communal acceptance and renewed hope. Ekezie

(2022) shows that displaced persons in northern Nigeria often develop collective strategies of survival, including leadership structures, advocacy and social cohesion within camp-like settings. Such practices support the view that resilience is not only internal strength; it may also be organised through community, shared meaning and collective survival.

However, HRT should not be applied uncritically. Cultural models can deepen mental health care, but they should not replace evidence-based clinical assessment or excuse inadequate humanitarian support. Its strongest contribution is conceptual: it reminds cross-cultural practitioners that displaced persons may experience trauma as disharmony across psychological, relational, communal and spiritual domains. In this sense, HRT strengthens the paper's central argument that culturally responsive care must address both symptoms and the wider meanings through which suffering and recovery are understood.

VIII. IMPLICATIONS FOR CROSS-CULTURAL PSYCHIATRY, PSYCHOLOGY AND MENTAL HEALTH PRACTICE

The central implication of this article is that mental health care for internally displaced persons should be culturally responsive without losing clinical seriousness. Cross-cultural psychiatry and psychology must recognise symptoms of trauma, depression and anxiety, but they must also ask how displaced persons understand those symptoms within their own social, spiritual and communal worlds. A displaced person who describes fear, bodily pain, silence, spiritual disturbance or loss of dignity may be communicating distress in ways that do not fit neatly into Western diagnostic language.

This requires a broader form of assessment. Clinicians and humanitarian mental health workers should explore not only symptom severity, but also family separation, shame, religious interpretation, disrupted belonging, loss of livelihood and the meaning attached to displacement. The World Health Organization (2022) makes clear that mental health is shaped by social conditions, and this is particularly relevant for IDPs whose distress is sustained by insecurity, poverty and unstable living environments. For such populations, diagnosis is

useful, but it should not become the only lens through which suffering is interpreted.

Intervention should also be community-sensitive. McDermott et al. (2024) show that culturally adapted psychological interventions are important for displaced populations because acceptability depends partly on whether care fits people's cultural experiences and expectations. In Nigeria, this may require collaboration with trusted local actors, including community leaders, religious figures, trained lay counsellors and humanitarian workers. Adesina et al. (2024) demonstrate the usefulness of task-shifting through a mental health intervention delivered among young internally displaced persons in northern Nigeria, suggesting that care can become more accessible when brought closer to the community.

However, culturally responsive care must remain critical. Religious and communal support may provide hope, belonging and emotional containment, but some cultural explanations may also deepen stigma or delay formal care. Thiel et al. (2026) show that stigma, misinformation and distrust remain important barriers to mental health access among displaced populations. Cross-cultural practice must therefore build bridges between informal and formal systems of care without romanticising either.

Harmony Restoration Therapy (HRT) strengthens this implication by framing healing as more than symptom reduction. Igbokwe (2022) describes HRT as concerned with harmony within the person, relationships, community and wider existential environment. Applied to internal displacement, this suggests that mental health intervention should also support dignity, relational safety, communal reintegration and restored meaning. The goal is not to replace psychiatric care with cultural interpretation, but to ensure that clinical support is grounded in the lived realities of displaced persons.

IX. CRITICAL REFLECTIONS AND LIMITATIONS

This paper has maintained that trauma among internally displaced persons in Nigeria should be understood through both clinical and cultural lenses. Its strength lies in bringing together cross-cultural mental health, displacement-related distress and Harmony Restoration Therapy to show that

suffering is not only a matter of symptoms, but also of meaning, belonging, dignity and disrupted social life. This position is useful because it challenges a narrow reading of trauma while still recognising the value of psychiatric diagnosis and psychological intervention.

However, the article is conceptual rather than empirical. It does not present primary interview data from internally displaced persons, and therefore does not claim to represent the full diversity of IDP experiences across Nigeria. Displacement differs across region, religion, gender, age, ethnicity, camp structure and exposure to violence. The cultural meanings discussed here should therefore be read as interpretive possibilities grounded in literature, not as fixed explanations that apply to all displaced persons.

There is also a need for caution in using cultural frameworks. Culture can provide meaning, social support and pathways of recovery, but it can also deepen stigma, silence distress or delay formal care when suffering is explained only through spiritual or moral failure. Bovey et al. (2025) rightly show that trauma-related distress may be shaped by cultural, spiritual and structural meanings, but these meanings must be examined critically rather than romanticised. Similarly, Harmony Restoration Therapy offers a valuable African lens for understanding trauma as disharmony, yet it should complement, not replace, evidence-based assessment and intervention (Igbokwe, 2022).

Future research should therefore include qualitative interviews with internally displaced persons, caregivers, community leaders, religious figures and mental health practitioners. Such work would help clarify how trauma, resilience and help-seeking are actually narrated in specific Nigerian IDP settings. It would also strengthen culturally responsive interventions by grounding them more directly in lived experience.

X. CONCLUSION

This article has stated that trauma among internally displaced persons in Nigeria cannot be understood adequately through clinical symptoms alone. While post-traumatic stress, depression, anxiety and grief remain important for assessment and intervention, they do not fully explain how displaced persons

interpret suffering within their cultural, religious, social and communal worlds. Trauma in this context is not only an individual psychological wound; it is also a disruption of home, belonging, dignity, kinship, livelihood and meaning.

By adopting a conceptual approach with qualitative orientation, the article has shown that displaced persons may communicate distress through silence, bodily complaints, spiritual explanations, moral endurance, communal shame or a sense that life has fallen out of harmony. This makes cultural interpretation central to cross-cultural mental health practice. Harmony Restoration Therapy strengthens this argument by conceptualising wellbeing in relation to harmony within the person, relationships, community and wider existential environment

(Igbokwe, 2022). Applied to displacement, this lens suggests that recovery should involve more than symptom reduction. It should also support dignity, relational safety, communal connection and restored meaning.

The article does not reject psychiatric diagnosis or evidence-based psychological care. Rather, it contends that such care becomes more ethically and clinically meaningful when grounded in the lived realities of displaced populations. For Nigerian IDPs, culturally responsive mental health practice must therefore listen for symptoms and meanings together. This is the basis for a more humane, context-sensitive and internationally relevant approach to trauma care in African displacement settings.

REFERENCES

- Abu-Ras, W., Al-Quraini, M., Amin, S., Al-Qaisi, S. T., & Idris, L. B. (2026). Widowed and displaced: Spiritual and religious coping in mental health recovery among Syrian refugee women in Türkiye. *Women's Health*, 22, Article 17455057261416249. <https://doi.org/10.1177/17455057261416249>
- Adesina, M., Olufadewa, T., Olufadewa, I., & Oladele, R. (2024). Impact of the Brave Heart mental health intervention on the prevalence and severity of depression among young internally displaced persons in Northern Nigeria. *Journal of Medicine, Surgery, and Public Health*, 2, Article 100053. <https://doi.org/10.1016/j.glmedi.2024.100053>
- American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text rev.). American Psychiatric Association Publishing. <https://doi.org/10.1176/appi.books.9780890425787>
- Bovey, M., Hosny, N., Dutray, F., & Heim, E. (2025). Trauma-related cultural concepts of distress: A systematic review of qualitative literature from the Middle East and North Africa, and Sub-Saharan Africa. *SSM – Mental Health*, 7, Article 100402. <https://doi.org/10.1016/j.ssmmh.2025.100402>
- Cohen, F. (2023). Cultural idioms of distress among displaced populations: A scoping review. *International Journal of Social Psychiatry*, 69(1), 5–13. <https://doi.org/10.1177/00207640221114742>
- Duke, A. E. E., Harri, B. I., Iyamu, I., Obi-Jeff, C., Dahiru, A. M. C., Ojo, T. M., Musami, U. B., Said, J., Agyapong, V. I. O., Orji, R., Yaya, S., & Eboreime, E. (2025). Anxiety and depression among internally displaced persons in North Central Nigeria: Prevalence, correlates, and policy implications. *Journal of Primary Care & Community Health*, 16, Article 21501319251406840. <https://doi.org/10.1177/21501319251406840>
- Ekezie, W. (2022). Resilience actions of internally displaced persons (IDPs) living in camp-like settings: A Northern Nigeria case study. *Journal of Migration and Health*, 6, Article 100115. <https://doi.org/10.1016/j.jmh.2022.100115>
- George, J., & Adelaja, A. (2022). Armed conflicts, forced displacement and food security in host communities. *World Development*, 158, Article 105991. <https://doi.org/10.1016/j.worlddev.2022.105991>
- Grupp, F., Mewes, R., & Tudorache, A.-C. (2026). Trauma, post-migration stress, and mental health among forcibly displaced people in Germany: Does resilience have a protective effect? *International Journal of Social Psychiatry*, 72(2). <https://doi.org/10.1177/00207640251358094>
- Igbokwe, D. O. (2022). Reflective perspective on the development of the cosmoeses in the indigenous psychotherapy model, Harmony Restoration Therapy. *Covenant International Journal of Psychology*, 7(1). <https://journals.covenantuniversity.edu.ng/index.php/cijp/article/view/3079>
- International Organization for Migration. (2025). Nigeria — North-east — Mobility Tracking Round 50 IDP and returnee atlas: July 2025. Displacement Tracking Matrix.
- Lane, R., Taylor, H., Ellis, F., Rushworth, I., & Chiu, K. (2025). Resilience and its association with mental health among forcibly displaced populations: A systematic review and meta-analyses. *Journal of Affective Disorders*, 379, 387–400. <https://doi.org/10.1016/j.jad.2025.03.015>
- McDermott, L., Hameed, I., & Lau-Zhu, A. (2024). Cultural adaptations, efficacy, and acceptability of psychological interventions for mental health in adults with refugees and asylum-seeker status: A systematic review. *Trauma, Violence, & Abuse*, 25(5), 3758–3776. <https://doi.org/10.1177/15248380241262262>

- Naidoo, R., & Shaik, S. (2024). "I think too much": Culture, trauma, and expressions of distress. *Teaching Anthropology*, 13(2), 87–99.
- Ogunwale, A. O. A., Fadipe, B. F., & Bifarin, O. B. (2023). Indigenous mental healthcare and human rights abuses in Nigeria: The role of cultural syntonicity and stigmatization. *Frontiers in Public Health*, 11, Article 1122396. <https://doi.org/10.3389/fpubh.2023.1122396>
- Olufadewa, I. I., Adesina, M. A., Oladele, R. I., & Ayorinde, T. A. (2022). "Watching my family being killed by terrorists made me really depressed": Mental health experiences, challenges and needed support of young internally displaced persons in northern Nigeria. *Journal of Migration and Health*, 6, Article 100121. <https://doi.org/10.1016/j.jmh.2022.100121>
- Salihu, D., Wong, E. M. L., Kwan, R. Y. C., Ho, G. W. K., Chutiyami, M., Surajo, K. S., Bello, U. M., Ibrahim, A. A., Ali, M. U., Wang, S., Bashir, K., Jalo, H. A., Haddad, M. M., Suleiman, A. D., Ajio, D. K., Ali, G. M., & Leung, D. Y. P. (2022). Anxiety, depression and stress among internally displaced persons and host community in an armed conflict region: A comparative study. *Psychiatry Research*, 315, Article 114700. <https://doi.org/10.1016/j.psychres.2022.114700>
- Thiel, R., Kreis, L. G., Schneider, S., König, H.-H., & Brettschneider, C. (2026). Perceived barriers to access mental health services for refugees and asylum seekers: A systematic review of qualitative studies. *BMC Psychiatry*, 26, Article 86. <https://doi.org/10.1186/s1298-306-07802-x>
- World Health Organization. (2022). World mental health report: Transforming mental health for all. World Health Organization.