

BEYOND BIOMEDICAL INTERVENTION: COMMUNITY-PREFERRED INTERVENTION MODELS FOR TRAUMATIC DISTRESS AMONG THE KANURI OF NORTH-EASTERN NIGERIA

Ali HARUNA¹, Mayanja M. KAJUMBA², Grace M. KIBANJA³

^{2&3}Department of Mental Health and Community Psychology, School of Psychology, College of Humanities and Social Sciences, Makerere University, Kampala, Uganda

***Corresponding Author:** Ali Haruna, ¹Department of Sociology and Anthropology, Yobe State University Damaturu, Nigeria.

ORCID Ali Haruna ID <https://orcid.org/0000-0002-2232-882X>

Email: aliharunaktz15@gmail.com

DOI: <https://doi.org/10.64450/njsh.v4i2.012>

ABSTRACT

Mental health interventions for trauma-affected populations in non-Western settings are typically developed in Western contexts and exported globally without systematic adaptation. This practice assumes that what works in one cultural context will work in another, an assumption increasingly challenged by cross-cultural research. This study investigated the desirable intervention models for traumatic distress as articulated by the Kanuri people of North-Eastern Nigeria. A qualitative design guided by social constructivist, behaviour settings, and social-ecological frameworks was employed. Thirty-two Kanuri participants (aged 30-60 years; 50% female) in Damaturu, Yobe State, Nigeria, participated in in-depth interviews (n=20) and focus group discussions (n=12). Data were analysed using inductive thematic analysis. Two themes emerged. First, participants expressed a strong preference for spiritually and culturally grounded interventions, including spiritual intervention, religious healing, religious-based counselling, and community-based counselling. Hospital medication and individual psychotherapy were viewed as last resorts, addressing symptoms rather than causes. Second, participants identified specific legitimate intervention channels; sheikhs (imams), family members, community elders, and traditional herbalists. Western-trained mental health professionals were not recognised as a preferred channel. The Kanuri possess a coherent framework for desirable PTSD intervention that centres spirituality, religiosity, and cultural practices. A culturally adapted stepped-care model is proposed: Level 1 (mild distress) → family support + personal prayer; Level 2 (moderate distress) → sheikh counselling + congregational prayer; Level 3 (severe distress) → traditional healer + hospital referral if needed; Level 4 (life-threatening) → immediate hospital care with family and religious involvement. This model respects community preferences while ensuring biomedical care for severe cases.

Keywords: Cultural adaptation; Kanuri; stepped-care; global mental health; spirituality

INTRODUCTION

The global dissemination of Western-developed mental health interventions for trauma-affected populations has accelerated dramatically over the past two decades. Evidence-based treatments such as Cognitive Behavioural Therapy (CBT), Eye Movement Desensitisation and Reprocessing (EMDR), and Narrative Exposure Therapy (NET) have been implemented in diverse cultural contexts, from refugee camps in the Middle East to post-conflict communities in sub-Saharan Africa (Schnyder & Cloitre, 2015). Although, Recent systematic reviews and meta-analysis confirm that these interventions produce significant reduction in PTSD, depression, and anxiety symptoms among forcibly displaced adults and children, unfortunately no single treatment type has emerged as consistently superior (Molendijk et al., 2024). However, Group-based NET has also shown promise for internally displaced women in sub-Saharan Africa, with significant pre-to-post reductions in posttraumatic stress symptoms (Zelege et al., 2025). Nonetheless, the field continues to face challenges related to inconsistent cultural adaptation reporting, and overreliance on research conducted in high-income western context (Genc, 2022, Khan & Madihie, 2024)

This exportation continues from an assumption of universal applicability; if an intervention is effective in a Western, individualistic context, it should be effective elsewhere. However, as Gearing et al. (2013) argued, psychosocial evidence-based interventions routinely fail when borrowed from one culture to another. International translation requires a deep understanding of local culture, nuances and ambivalence within a culture, recognised service practices, and knowledge of obstacles to treatment implementation.

The role of Religiosity and Spirituality in trauma response

Haruna, Kajumba, and Kibanja (2021) demonstrated that among the Kanuri people of North-Eastern Nigeria, religiosity and spirituality play a central role in responding to traumatic experiences. Their study found that the Kanuri define PTSD symptoms as destiny, believing them to have been ordained by God. Prayers brought about a sense of protection and determined functional adjustment to traumatic experiences. The Kanuri people employ religiosity and spirituality as survival mechanisms to overcome unwanted thoughts, anxieties, and worries (Haruna et al., 2021).

This finding has direct implications for intervention design. If the Kanuri's primary coping resources are religious and spiritual, then desirable interventions should engage these resources rather than replace them. As Fuller (1972) found in an anthropological study of healers across different cultures, a shared worldview is an essential ingredient in a productive helping relationship. People are more likely to prioritise local values, beliefs, and rituals of healing.

The case for cultural adaptation

The failure of un-adapted Western interventions in non-Western contexts has prompted calls for systematic cultural adaptation. Fortuna, Porche, and Alegría (2009) argued that it is better to develop non-Western diagnostic instruments that incorporate cultural contexts and meanings. They listed five components for formulating diagnosis and treatment for trauma victims in non-Western contexts; cultural identity, cultural explanations of the illness, cultural factors related to the psychosocial environment and levels of functioning, cultural elements of the trauma specialist and victims, and the overall impact of culture on diagnosis and care.

Cultural adaptation is not merely translation. It is not adding a few culturally relevant examples to a manualised protocol. It is a systematic process of engaging with the community's explanatory models, help-seeking preferences, healing resources, and values. It requires identifying barriers and obstacles related to acceptability of the intervention within the cultural context (Gearing et al., 2013).

Traditional and religious healing as primary care

In many non-Western cultures, traditional and religious healing are not alternatives to biomedical care; they are the primary care. Moodley, Sutherland, and Oulanova (2008) reported that culture provides many alternative healing pathways. Communities access cultural healings provided by shamans, medicine men and women, traditional healers, culture-specific rituals, conventional medical practices, and community-based practices. These offer different forms of social and emotional support for the person suffering from the adverse, maladaptive aspects of trauma.

Dyregrov, Gupta, Gjestad, and Raundalen (2002) reported that culture could buffer its members from the impact of stressful experiences. Cultural practice creates meaningful procedures that explain the causes of trauma, provide rituals and healing strategies to people within a given community. The person expresses meaning and healing in response and at the same time reconnects with the group.

The Kanuri Context

The Kanuri people of North-Eastern Nigeria have a well-established system of traditional and religious healing that predates the arrival of Western medicine by centuries. Predominantly Muslim since the eleventh century, the Kanuri's

Islamic faith provides a comprehensive framework for understanding illness, suffering, and healing.

Traditional medicine is regarded as the most effective among the Kanuri people. Traditional healers are believed to have supernatural powers enabling them to communicate with spirits. The majority of Kanuri first visit traditional healers before considering hospitals, as most illnesses are believed to result from destiny, misfortune, evil spirits, or witchcraft. The Kanuri believe that only traditional healers and messages from the Qur'an can heal disease completely, while hospitals only cure the illness but do nothing to address the cause.

The Imams (sheikhs) are highly respected, even seen as divinely selected and sinless individuals. Their views on anything in the community are much respected and persuaded after. Apart from religious teachings, the imams offer religious healing to the community for any illness, including trauma-related distress.

Haruna et al. (2021) established that the Kanuri employ religiosity and spirituality as survival mechanisms to overcome unwanted thoughts, anxieties, and worries. Prayers bring about a sense of protection and determine functional adjustment to traumatic experiences. This finding provides the foundation for understanding what interventions the Kanuri themselves desire.

Damaturu, the capital of Yobe State, has been severely affected by the Boko Haram insurgency since 2012. International non-governmental organisations have implemented trauma care programmes in the region. However, no research has systematically asked the Kanuri what interventions they themselves desire, a gap this study addresses. Hence, the main objective of this study is to understanding the desirable intervention of traumatic distress among the Kanuri Community of Damaturu, Yobe State, Nigeria. The specific objectives are:

- a) To explain the desirable intervention suitable to PTSD maladaptiveness in

Kanuri context. b) To provide a suitable information on community preference for PTSD intervention in Kanuri community. c) To bring out the direct implication for programme design and intervention that do not align with the Kanuri preference.

Research question and study rationale

The research question addressed a distinct phenomenon; the desirable intervention models for PTSD maladaptiveness as articulated by the Kanuri community. Specifically, this study asked; What are the desirable intervention models suitable for PTSD maladaptiveness in the Kanuri context? The research question focuses on prescription (what should be done) rather than description (what is). Second, it centres community preferences rather than researcher assumptions. Third, it has direct implications for programme design; interventions that do not align with community preferences are unlikely to be accessed or adhered to.

Theoretical Framework

Three complementary theoretical frameworks, each addressing a different level of analysis relevant to intervention design, guided this study.

Social-Ecological Theory

Bronfenbrenner's (1974) social-ecological theory posits that human behaviour is shaped by multiple interdependent systems. The microsystem includes the individual and immediate family. The mesosystem includes interactions between microsystems. The ecosystem includes community institutions. The macro system includes cultural and religious beliefs. Therefore, an intervention that targets only the individual (microsystem) will miss resources at the family (microsystem), community (mesosystem), institutional (ecosystem), and cultural

(macro system) levels. Desirable interventions should work across ecological levels.

Behaviour Settings Theory

Barker's (1968) behaviour settings theory argues that different settings produce predictable patterns of behaviour. Settings are not backdrops but active organisers of behaviour. The physical, social, and temporal structures of a setting cue specific behaviours and not others. By implication an intervention delivered in a hospital setting will cue different expectations and behaviours than an intervention delivered in a mosque or family compound. Desirable interventions should be delivered in settings that cue trust and healing expectations.

Social Constructivism

Social constructivism (Galbin, 2014; Gergen, 1994) argues that reality, knowledge, and meaning are socially and culturally constructed through human activity and interaction. Individual judgment is not an attribute of individual thinking but the result of cultural principles (Gergen, 1994). Hence, the legitimacy of healers (sheikhs, traditional healers) is socially constructed through community consensus. An intervention delivered by a healer whom the community does not recognise as legitimate is unlikely to be accepted. Desirable interventions should work with, not against, socially constructed legitimacy.

METHODS

Research paradigm and design

The study adopted a social constructivist paradigm with a Husserlian transcendental (descriptive) phenomenological approach (Husserl, 1931). A qualitative case study design was employed, triangulating in-depth interviews

and focus group discussions. This approach was chosen because it enables exploration of participants' own preferences and recommendations, rather than imposing pre-defined intervention categories.

Setting

The study was conducted in Damaturu, Yobe State, North-Eastern Nigeria. Damaturu is the state capital, of Yobe State a multi-ethnic and homogeneous population, with the Kanuri as the dominant ethnic group. According to the National Population Commission projection (2026), the population of Damaturu was estimated at 154,418. The town has been severely affected by the Boko Haram insurgency since 2012 consequently, resulting to symptoms of traumatic distress.

Participants and sampling

A total of 32 Kanuri participants aged 30-60 years were purposively selected after reaching saturation point. The sample comprised 20 participants for in-depth interviews (10 male, 10 female) and 12 participants for focus group discussions (two groups of six, one male, one female). Purposive and snowball sampling strategies were used. Inclusion criteria were; Kanuri ethnicity, exposure to primary or secondary trauma, English proficiency, and meeting PTSD-8 diagnostic criteria (endorsing ≥ 1 item from each of three clusters, intrusion, avoidance, hypervigilance, with score ≥ 3). Children were excluded due to limited verbal expression of traumatic experiences.

Data collection instruments

Data were collected using a semi-structured interview guide. Participants were asked specific probes about desirable interventions; "What do you think needs to be done to help someone who is experiencing these symptoms?" "What is done to help a person deal with these symptoms?" "Who provides the help?"

"How does he/she help?" "What will be the desirable intervention in your community/culture?" The PTSD-8 (Hansen, Andersen, & Armour, 2010) was keyed into the protocol to establish symptom presence.

Data collection procedure

Data were collected over three month's period. In-depth interviews were conducted at locations agreed upon with participants. Focus group discussions were held in a theatre hall at Yobe State University after obtaining institutional permission. All interviews and discussions were audio-recorded, transcribed verbatim, and supplemented with field notes and observations of non-verbal cues. Gender-separate focus groups were conducted to facilitate female participants' expression.

DATA ANALYSIS

Data were analysed using inductive, data-driven thematic analysis (Braun & Clarke, 2006) with Atlas.ti 7.5 software. Analysis focused specifically on data relevant to desirable interventions, including participants' preferences, recommendations, and evaluations of different intervention approaches. Open, axial, and selective coding were used concurrently. Descriptive frequencies were calculated to indicate pattern prevalence but not for statistical inference.

Trustworthiness and Rigour

Trustworthiness was established using Guba and Lincoln's criteria (cited in Kumar, 2011), credibility (participant validation of transcripts, bracketing of researcher assumptions), transferability (independent volunteer review of findings), dependability (comprehensive documentation of study processes), and confirmability (detailed description of methods for replication).

Ethical Considerations

Ethical clearance was obtained from the Centre for Research, Innovation and Linkages of Yobe State University. All participants provided written informed consent. Confidentiality and anonymity were maintained using code numbers. Participants were informed of their right to withdraw at any time. Debriefing and referral to mental health services were arranged if needed.

Positionality Statement

The first author is a male researcher of Kanuri ethnicity, born and raised in Yobe State, and a Muslim. This insider status facilitated trust and access to participants' genuine preferences. However, as a clinical psychologist trained in Western models, he may have biases toward biomedical interventions. To mitigate bias, he engaged in systematic bracketing (Husserl, 1931), maintained a reflexive journal documenting his reactions to traditional healing practices, and sought participant validation of interpretations.

FINDINGS

Two themes emerged from participants' narratives regarding desirable intervention models for PTSD maladaptiveness; desired PTSD intervention, and PTSD intervention channels.

Theme one, Desired PTSD intervention

Participants were asked to explain the desirable intervention for PTSD in their community. The majority of participants expressed strong beliefs in spiritual intervention, religious healing, and religious-based counselling. A minority mentioned community-based counselling, hospital medication, and traditional healing.

Table 1: Desired PTSD intervention preferences among the Kanuri (N=32)

Intervention Modality	Participants Expressing Preference	Percentage (%)	Representative Quote
Spiritual intervention	28	87.5	"Prayer to God for healing; our community is purely Islamic. So whatever happened to us, we returned to God for help." (P-3)
Religious healing	26	81.3	"They will take the person to the mosque or the Ulama's house. The sheikh will take his holy Qur'an and recite some of the verses from the Holy Qur'an for healing." (P-4)
Religious-based counselling	24	75.0	"The Sheikhs often pray, counsel, and advise people. They are regarded and respected by all community members because of their role in helping people." (P-18)
Community-based counselling	18	56.3	"Well, for the intervention to traumatic experiences. First, the family has to come in for moral support." (Male FGD)
Traditional healing (herbal)	15	46.9	"Well, they used to give them some herbs sometimes and ask them to bathe with it or to robe their body with it." (P-9)
Hospital medication	6	18.8	"Yes, going to the herbalist, and the Ulamas. However, in the end, only in the hospital, one will be given the correct medication." (P-12)

Note: Participants could express preference for multiple modalities; percentages sum to >100%.

Participants explained that cultural and religious beliefs strengthen the Kanuri with local approaches to PTSD intervention that enhance coping and resilience. The Kanuri culture supplies members with a diversity of therapeutic processes for dealing with lived PTSD experiences in a particular way to achieve healing.

"Prayer to God for healing; our community is purely Islamic. So whatever happened to us, we returned to God for help." (P-3, in-depth interview)

"They will take the person to the mosque or the Ulama's house. The sheikh will take his holy Qur'an and recite some of the verses from the Holy Qur'an for healing. Some verses in the Holy Qur'an which provide a section for healing someone who experiences such symptoms." (P-4, in-depth interview)

"Well, they used to give them some herbs sometimes and ask them to bathe with it or to robe their body with it. There are some performative charms they use to give them to be using it." (P-9, in-depth interview)

"As for the Imams is through prayer, whereas the traditional healers do give some herbs to the person for drinking and bathing." (P-11, in-depth interview)

The belief in spirituality, religious healing and religious-based counselling among the Kanuri substantially decreases the psychological and physiological reactions to traumatic experiences. The local psycho-cultural beliefs provide the Kanuri people with knowledge about religious and cultural healing and rituals to escape the consequences of their lived PTSD experiences.

This finding is consistent with Haruna et al. (2021), who found that the Kanuri employ religiosity and spirituality as survival mechanisms to overcome unwanted thoughts, anxieties, and worries, and that prayers bring about a sense of protection and determine functional adjustment to traumatic experiences.

Participants also noted that differences exist in the choice of intervention, reflecting individual variation within the community.

"Sometimes not even the Sheikhs because most of the people in our culture practice Islam. We are 100% Muslims, so apart from the Imam, any other person can give these kinds of spiritual healing." (P-11, in-depth interview)

"However, differences exist in the choice of help (intervention). Others believe with Islamic scholars. In deviant, others prefer to reach out to traditional healers. Also, others believe in themselves. As such, they resort to prayer to get themselves healed. Basically, through the reading of some verses from the Holy Qur'an, which meant for the cure in case of such incidence." (Female focus group participant)

Theme two, PTSD intervention channels

Participants were engaged in discussing the appropriate channel for PTSD healing in their community. Fundamental to the well-being of the Kanuri community is the construction of the meaning of illness and the healing process acceptable within the local systems.

Table 2: PTSD intervention channels among the Kanuri

Intervention Channel	Role in Healing	Setting	Legitimacy Basis
Sheikhs (Imams)	Qur'anic recitation, prayer, counselling, washed text (karwadi)	Mosque	Islamic authority, divine selection
Family members	Moral support, counselling, guidance, practical assistance	Family compound	Kinship, love, shared experience
Community elders	Wisdom, advice, dispute resolution, guidance	Community gathering	Age, experience, respect
Traditional herbalists	Herbal medicine, amulets (laya), rituals, spirit communication	Traditional healer's compound	Supernatural powers, generational knowledge
Hospital (rare)	Medication, physical treatment	Clinic/hospital	Biomedical care (but less trusted)

The community as a whole, plays a significant role in managing and healing members with traumatic experiences. Healing is not an individual process but a collective one.

"In many ways, some are helped by family members, elders in the community, the Islamic scholars, and sometimes even the traditional herbalist." (P-6, in-depth interview)

"Individuals or the community, sometimes we have the ward/community leaders, we also have elders who provide all sorts of help." (P-12, in-depth interview)

"Almighty God provided the help, through prayers by the Sheikhs in the congregation." (P-16, in-depth interview)

"The Sheikhs often pray, counsel, and advise people. They are regarded and respected by all community members because of their role in helping people." (P-18, in-depth interview)

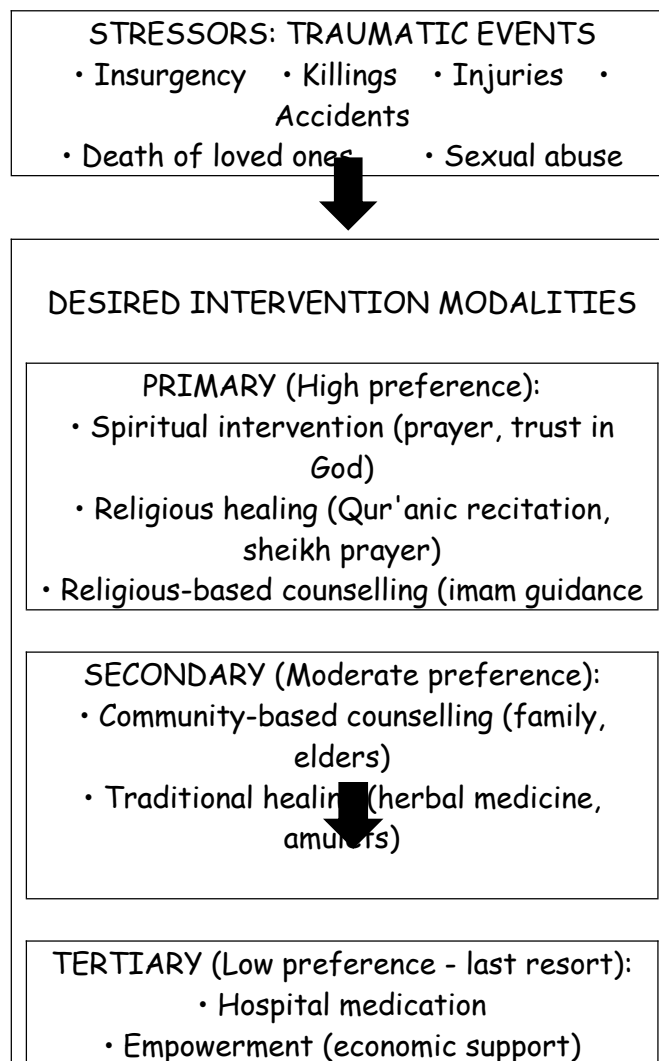
Participants explained that the local ontological beliefs define the Kanuri's healing pattern and the appropriate channel for achieving healthy and acceptable behaviour. The culture dictates and provides members with diverse healing practices for escaping traumatic stressors.

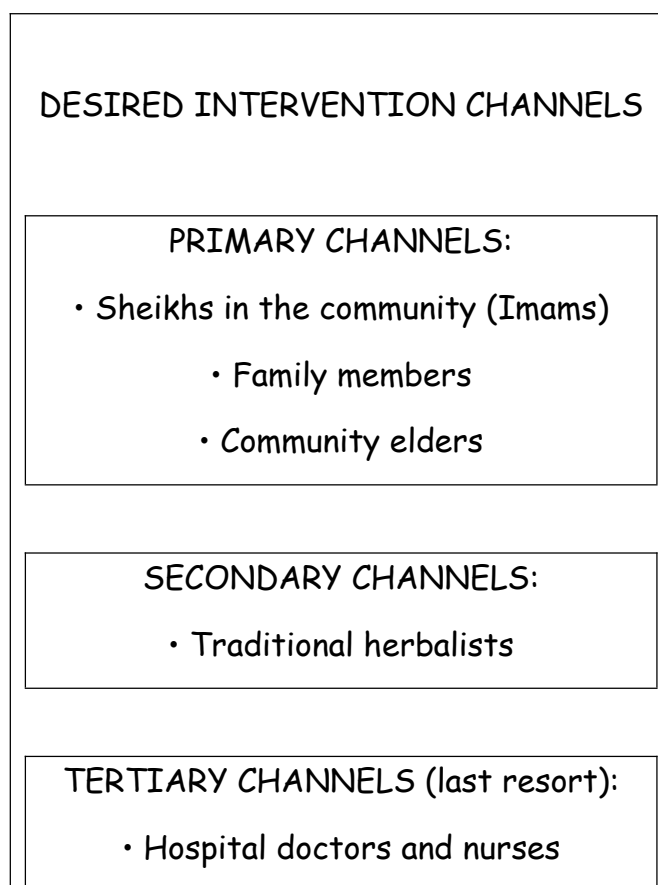
"Well, what we usually do, if the trauma persists, usually we refer ourselves to the religious book. Most importantly, the Qur'an, we usually take on our Qur'an and keep on reciting; through that, the trauma gradually goes down. However, still even with that, sometimes we also refer to the orthodox way of healing. Because the heart beats unnecessarily, there must be some medication (charms) that at least one will take to subside the tension." (Male focus group participant)

"Yes, we still have this situation where people go to the Sheikhs. People experiencing trauma usually collect washed-Arabic-text inside a bowl from the Sheikhs. After drinking, they forget about the terrible experiences." (Male focus group participant)

Summary of the desirable intervention pathways

Integrating theme one and theme two, a coherent picture of desirable intervention pathways emerges. The religious and spiritual framework adopted fundamentally shapes how the Kanuri define PTSD symptoms as destiny ordained by God, and they employ religiosity and spirituality as survival mechanisms to overcome unwanted thoughts, anxieties, and worries. Therefore, desirable interventions must work within this framework.

Figure 1: Desirable PTSD intervention pathways among the Kanuri



The desired PTSD intervention and channels to PTSD intervention in the Kanuri community centre on cultural realities shaped by spiritual and religious beliefs about the causation and recovery from traumatic experiences. Therefore, interventions that ignore or dismiss this framework will be rejected by the community.

DISCUSSION

Summary of principal findings

This study investigated the desirable intervention models for PTSD maladaptiveness as articulated by the Kanuri community of North-Eastern Nigeria. Two principal findings emerged. First, participants expressed a strong preference for spiritually and culturally grounded interventions; spiritual intervention, religious healing, religious-based counselling, and community-based

counselling. Hospital medication and individual psychotherapy were viewed as last resorts. Second, participants identified specific legitimate intervention channels: sheikhs (imams), family members, community elders, and traditional herbalists. Western-trained mental health professionals were not recognised as a preferred channel.

These findings directly align with and extend Haruna et al. (2021), who found that the Kanuri employ religiosity and spirituality as survival mechanisms to overcome unwanted thoughts, anxieties, and worries, and that prayers bring about a sense of protection and determine functional adjustment to traumatic experiences.

The primacy of spiritual and religious intervention

The finding that 87.5% of Kanuri participants prefer spiritual intervention and 81.3% prefer religious healing is consistent with research from other Muslim populations. Mölsä, Elmi, and Hjelde (2010) found that Somali refugees in Finland preferred seeking help from religious elders who shared their cultural background. Moreno and Cardemil (2013) reported similar preferences among Latino populations.

From a social constructivist perspective (Galbin, 2014; Gergen, 1994), the preference for spiritual and religious interventions is not "resistance to evidence-based treatment" but a coherent expression of the Kanuri's constructed reality about the nature of illness and healing. If illness is understood as originating from spiritual causes (destiny, evil spirits, witchcraft), then healing must address spiritual causes. Hospital medication, which addresses only physical symptoms, is seen as incomplete. The Kanuri's preference for religious healing is logically consistent within their constructed worldview.

From a social-ecological perspective (Bronfenbrenner, 1974), spiritual and religious resources operate at multiple levels. At the microsystem level, individual prayer provides immediate regulation of distress. At the mesosystem level, congregational prayer connects the individual to a community of others engaged in the same practice. At the ecosystem level, the mosque as an institution organises prayer times, provides leadership (imams), and maintains the physical space. At the macro system level, Islamic theology provides the belief system that gives prayer its meaning and efficacy.

Haruna et al. (2021) established that the Kanuri define PTSD symptoms as destiny ordained by God. This theological framework-qadr-is not merely a belief but an active coping resource. When a Kanuri person prays, they are not engaging in passive resignation but active trust in divine providence. This is precisely the mechanism that makes spiritual intervention effective for this population. Therefore, by implication any intervention imposed from outside, even if evidence-based in Western contexts, will likely fail if it does not align with local constructions of causality and healing. The desired intervention is not the Western model of individual psychotherapy but a holistic approach integrating spiritual, religious, and physical dimensions.

The role of traditional healing

The finding that 46.9% of participants expressed preference for traditional healing (herbal medicine, amulets, and rituals) is consistent with Adefolaju's (2014) observation that in Nigeria, various societies have relied on the indigenous health system for long. Traditional medicine involves using locally available resources to prevent and cure illnesses, including trauma and other mental disorders.

From a behaviour settings perspective (Barker, 1968), the traditional healer's compound is a behaviour setting that has evolved over centuries to provide healing. The physical environment (herbs, amulets, ritual objects), social environment (healer, sometimes apprentices), and ritual structure (specific procedures for preparing and administering treatments) work together to cue healing expectations. An intervention that requires the Kanuri to attend an unfamiliar clinic with a stranger therapist will face significant barriers because the setting does not cue trust.

Fuller (1972) found that a shared worldview was an essential ingredient in a productive helping relationship. The traditional healer shares the Kanuri's worldview about spiritual causation, evil spirits, and the need for ritual healing. This shared worldview may enhance the therapeutic alliance and improve outcomes. Therefore, interventions should not dismiss or replace traditional healing. Rather, they should collaborate with traditional healers, providing training in recognition of severe conditions (e.g., suicidality) requiring referral, while respecting the healer's expertise in spiritual and herbal treatments.

The hierarchy of intervention channels

The identification of legitimate intervention channels-sheikhs, family members, community elders, traditional herbalists-with Western professionals at the bottom has profound implications for programme design. The community as a whole plays a significant role in managing and healing members with traumatic experiences. This collectivist approach to healing differs fundamentally from the individualistic approach of Western psychotherapy. A Kanuri person who attended individual therapy without family involvement would be seen as strange; a therapy that did not involve the family would be seen as incomplete.

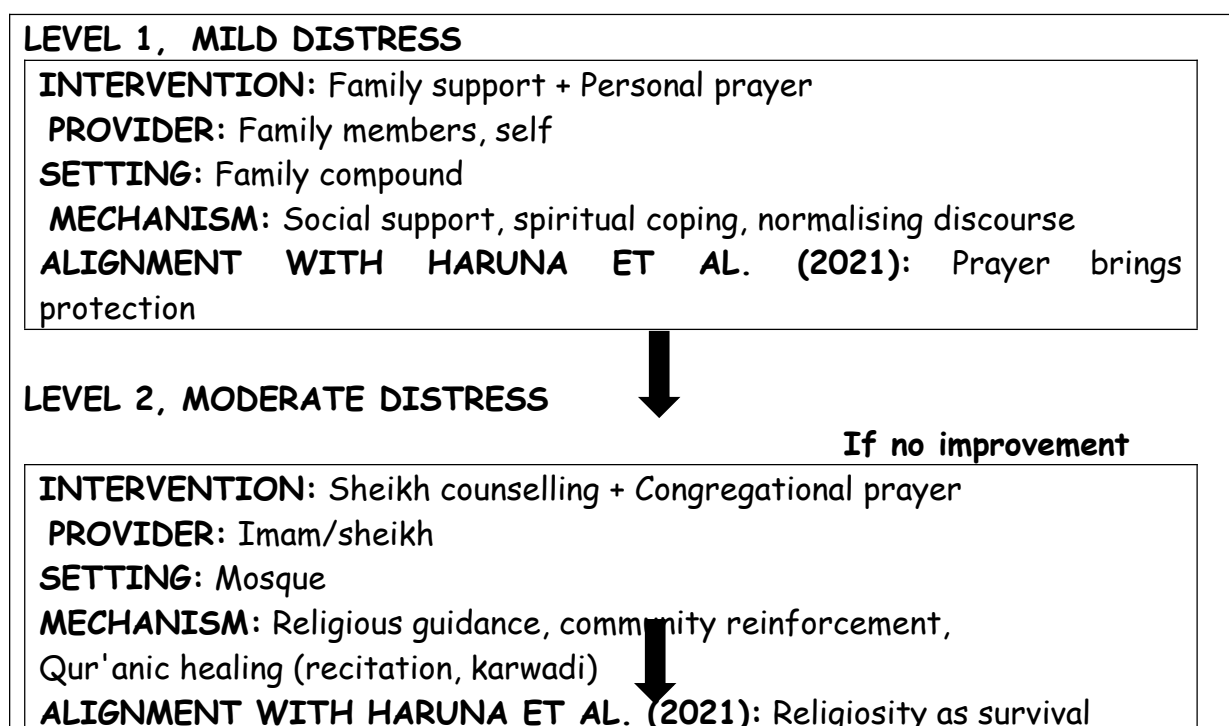
Dyregrov et al. (2002) reported that culture could buffer its members from the impact of stressful experiences. Cultural practice creates meaningful procedures that explain the causes of trauma, provide rituals and healing strategies to people within a given community. The Kanuri's healing channels represent precisely such culturally meaningful procedures.

It is therefore, important to ensure interventions work with existing channels, not create parallel systems. Training sheikhs in trauma-informed religious counselling may be more effective than training psychologists in Kanuri culture. Training family members in basic psychological first aid may be more effective than establishing community mental health clinics.

Towards a culturally adapted stepped-care model

Based on the findings of this study, we propose a culturally adapted stepped-care model that respects community preferences while ensuring biomedical care for severe cases.

Figure 2: Proposed culturally adapted stepped-care model for Kanuri communities



If no improvement

LEVEL 3, SEVERE DISTRESS

INTERVENTION: Traditional healing + Hospital referral (if needed)

PROVIDER: Traditional herbalist + Family

SETTING: Traditional healer compound + Primary health centre

MECHANISM: Herbal medicine, rituals, biomedical assessment, combined spiritual-biomedical explanation

If

no improvement

LEVEL 4, LIFE-THREATENING (Suicidality, psychosis, severe impairment)

INTERVENTION: Immediate hospital care + Family involvement + Religious support

PROVIDER: Mental health professionals + Family + Sheikh

SETTING: Hospital + Mosque collaboration

MECHANISM: Biomedical intervention, family presence, spiritual framing of treatment

Key principles of the Model

- Respects the community's preferred help-seeking hierarchy
- Works WITH existing healing channels, not against them
- Integrates spiritual, traditional, and biomedical approaches
- Ensures severe cases receive biomedical attention
- Family is involved at ALL levels
- Culturally acceptable at every step
- Aligned with Haruna et al. (2021) findings on religiosity and spirituality

This model differs from existing stepped-care models in five key respects. First, it is based on the community's preferred help-seeking hierarchy, not just symptom severity. Second, the first step is family support and personal prayer, not professional care at all. Third, it progresses to sheikh counselling and traditional healing before reaching hospital care. Fourth, interventions are delivered in culturally appropriate settings (family compound, mosque, traditional healer's compound). Fifth, the model is family- and community-focused at every level. Critically, this model is not an imposition from the researchers. It is a formalisation of what the Kanuri community already practices. This model simply provides a structured framework that integrates their existing practices with biomedical care for severe cases.

Implications for practice

First, mental health providers working in north-eastern Nigeria should not assume that hospital-based, individual psychotherapy is the desired or acceptable intervention. They should ask patients about their preferred intervention channels and work within them. Second, training should be provided to sheikhs and traditional healers in recognising severe mental disorders (e.g., suicidality, psychosis) and referring to biomedical care when needed. This task-sharing approach is more culturally appropriate than training psychologists. Sheikhs already provide counselling; they simply need additional skills for recognising when referral is necessary.

Third, family members should be involved in intervention whenever possible. Individual therapy without family involvement is culturally incongruent. The family is not just a support system; it is the primary unit of healing. Fourth, interventions should be framed within Islamic concepts. Therefore, interventions should incorporate prayer, trust in God (tawakkul), and patience (sabr). For example, cognitive restructuring can incorporate tawakkul-trusting

God's plan rather than catastrophizing. Exposure therapy can be framed within qadr-the event happened, it was destined; now we move forward.

Implications for Research

Future research should pilot the proposed stepped-care model with a small sample to assess feasibility, acceptability, and preliminary outcomes. Randomised controlled trials should compare the culturally adapted model to unadapted Western interventions (e.g., CBT) and to treatment as usual. Implementation research should identify barriers and facilitators to training sheikhs and traditional healers. Economic evaluations should assess whether the stepped-care model is cost-effective compared to clinic-based care. Additionally, research should explore whether the religious and spiritual coping documented by Haruna et al. (2021) is unique to the Kanuri or shared across other Muslim populations in Nigeria. Comparative studies with Hausa, Fulani, and other groups would identify shared and distinct intervention preferences

Theoretical Integration

The three theoretical frameworks together explain why the Kanuri's desired interventions take the form they do. Social constructivism explains why spiritual and religious interventions are preferred. The Kanuri's constructed reality, documented by Haruna et al. (2021) as defining PTSD symptoms as destiny ordained by God, locates the cause of illness in spiritual forces; therefore, healing must address spiritual forces. Hospital care, which ignores spiritual causes, is logically incomplete within this constructed reality. Behaviour settings theory explains why specific channels (mosque, family compound, traditional healer's compound) are preferred. These settings have evolved over centuries to cue healing expectations. The hospital setting, in contrast, is unfamiliar and does not cue trust. Social-ecological theory explains why interventions must

work across multiple levels. The individual (microsystem) is embedded in family (microsystem), community (mesosystem), institutional (ecosystem), and cultural (macro system) contexts. An intervention that targets only the individual will miss essential resources at other levels.

LIMITATIONS

This study has several limitations. The qualitative scope means findings are not statistically generalizable. Data were collected only in Damaturu; rural Kanuri communities may have different intervention preferences. English as the medium of communication may have lost some nuances. The age range (30-60 years) excludes youth and elderly populations, whose intervention preferences may differ. The first author's insider positionality as a Kanuri male may have influenced data collection, though bracketing and reflexive journaling were employed to mitigate bias. Most importantly, this study did not test the proposed stepped-care model; it provides the formative research necessary for such testing.

CONCLUSION

This study investigated the desirable intervention models for PTSD maladaptiveness as articulated by the Kanuri community of North-Eastern Nigeria. Two principal findings emerged. First, participants expressed a strong preference for spiritually and culturally grounded interventions: spiritual intervention, religious healing, religious-based counselling, and community-based counselling. Hospital medication and individual psychotherapy were viewed as last resorts. Second, participants identified specific legitimate intervention

channels: sheikhs (imams), family members, community elders, and traditional herbalists.

These findings directly align with and extend Haruna et al. (2021), who established that the Kanuri define PTSD symptoms as destiny ordained by God and employ religiosity and spirituality as survival mechanisms to overcome unwanted thoughts, anxieties, and worries. The Kanuri believe that prayers bring about a sense of protection and determine functional adjustment to traumatic experiences. Therefore, desirable interventions must work within this religious and spiritual framework.

The Kanuri possess a coherent framework for desirable PTSD intervention that centres spirituality, religiosity, and cultural practices. An intervention imposed from outside, even if evidence-based in Western contexts, will likely fail if it does not align with this framework. The proposed stepped-care model, Level 1; family support + personal prayer; Level 2; sheikh counselling + congregational prayer; Level 3; traditional healer + hospital referral; Level 4; immediate hospital care with family and religious involvement, respects community preferences while ensuring biomedical care for severe cases.

This study contributes to the growing literature on cultural adaptation of mental health interventions. It demonstrates that community preferences are not irrational barriers to evidence-based care but coherent expressions of culturally constructed realities. The task of global mental health is not to replace local healing systems but to collaborate with them, respecting their legitimacy while ensuring that severe cases receive biomedical attention. The Kanuri's voice on desirable intervention is clear: start with family and prayer, involve sheikhs and traditional healers, and only then consider the hospital. It is time for mental health professionals to listen.

Conflict of Interest Statement

The authors declare no conflicts of interest.

Funding

This research was supported by the Tertiary Education Trust Fund (TETFund) Academic Staff Training and Development Programme via Yobe State University, Damaturu, Yobe State, Nigeria.

Acknowledgements

The authors thank the 32 Kanuri participants who shared their lived experiences of trauma and the Centre for Research, Innovation and Linkages of Yobe State University for ethical approval.

REFERENCES

- Adefolaju, T. (2014). Traditional and orthodox medical systems in Nigeria: The imperative of a synthesis. *American Journal of Health Research*, 2(4), 118-124.
- Barker, R. G. (1968). *Ecological psychology: Concepts and methods for studying the environment of human behavior*. Stanford University Press.
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77-101.
- Bronfenbrenner, U. (1974). Developmental research, public policy, and the ecology of childhood. *Child Development*, 45(1), 1-5.
- Dyregrov, A., Gupta, L., Gjestad, R., & Raundalen, M. (2002). Is the culture always right? *Traumatology*, 8(3), 135-145.
- Fortuna, L. R., Porche, M. V., & Alegría, M. (2009). A qualitative study of clinicians' use of the cultural formulation model in assessing posttraumatic stress disorder. *Transcultural Psychiatry*, 46(3), 429-450.
- Fuller, T. E. (1972). What Western psychotherapists can learn from witchdoctors. *American Journal of Orthopsychiatry*, 42(1), 69-76.

Galbin, A. (2014). An introduction to social constructionism. *Social Research Reports*, 26, 82-92.

Gearing, R. E., Schwalbe, C. S., Mackenzie, M. J., Brewer, K. B., Ibrahim, R. W., Olimat, H. S., Al-Makhamreh, S. S., Mian, I., & Al-Krenawi, A. (2013). Adaptation and translation of mental health interventions in Middle Eastern Arab countries: A systematic review of barriers to and strategies for effective treatment implementation. *International Journal of Social Psychiatry*, 59(7), 671-681.

Gergen, K. J. (1994). *Realities and relationships: Soundings in social constructionism*. Harvard University Press.

Genc, E. (2022), The effectiveness of Trauma treatment approaches in refugee children and adolescents: *A systematic review*, *Children and Youth Service Review*, 141, 106602. <https://doi.org/10.1016/j.childyouth.2022.106602>

Hansen, M., Andersen, T. E., & Armour, C. (2010). PTSD-8: A short PTSD inventory. *European Journal of Psychotraumatology*, 1, Article 5622.

Haruna, A., Kajumba, M. M., & Kibanja, G. M. (2021). Cultural response to PTSD functional adjustment: Impact of religiosity and spirituality among the Kanuri community of Damaturu Nigeria. *Spirituality in Clinical Practice*. Advance online publication. <https://doi.org/10.1037/scp0000264>

Husserl, E. (1931). *Ideas: General introduction to pure phenomenology*. George Allen & Unwin.

Khan, A., & Madihie, A. bt. (2024). Cultural and methodological adaptations in eye movement desensitisation and reprocessing therapy across diverse cultural contexts: A narrative review, *Counselling and Psychotherapy Research*, 26, e70120. <https://doi.org/10.1002/capr.70120>

Kumar, R. (2011). *Research methodology: A step-by-step guide for beginners* (3rd ed.). Sage Publications.

Molendijk, M., Baart, C., Schaffeld, J., Akcakaya, Z., Ronnau, C., Kooistra, M., de Kleine, R., Strater, C., & Mooshammer, L., (2024). Psychological interventions for PTSD, depression, and anxiety in child, adolescent and adult forced migrants: A systematic review and frequentist and Bayesian meta-analysis. *Clinical Psychology & Psychotherapy*, 31(4), e3042, <https://doi.org/10.1002/cpp.3042>

Mölsä, M., Elmi, M., & Hjelde, K. H. (2010). Changing conceptions of mental distress among Somalis in Finland. *Transcultural Psychiatry*, 47(2), 276-300.

Moodley, R., Sutherland, P., & Oulanova, O. (2008). Traditional healing, the body and mind in psychotherapy. *Counselling Psychology Quarterly*, 21(2), 153-165.

Moreno, O., & Cardemil, E. (2013). Religiosity and mental health services: An exploratory study of help seeking among Latinos. *Journal of Latina/o Psychology*, 1(1), 53-67.

National Population Commission. (2010). Population census figures. NPC.

Schnyder, U., & Cloitre, M. (Eds.). (2015). Evidence based treatments for trauma-related psychological disorders: A practical guide for clinicians. Springer.

Zelege, W. A., Hailu, T., Mekonen, M, M., & Yehualashet, Y, W, (2025). Narrative exposure group therapy for posttraumatic stress symptoms among a small group of internally displaced women in Ethiopia; An uncontrolled pre-postintervention study. *Psychological Trauma: Theory, Research, Practice, and Policy*, Advance online publication. <https://doi.org/10.1037/tra0001993>