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ENHANCING LOCAL AGENCY FOR HUMAN SECURITY THROUGH COMMUNITY-BASED TRAUMA INTERVENTION IN FRAGILE CONTEXTS: A CLINICAL PSYCHOLOGY PERSPECTIVE

Emmanuel Josiah Mahanan[1] & Gwet Daniel[2]
[1]Plateau State College of Health Technology, Pankshin, Plateau State, Nigeria.
[2]Gwet Mind Therapy Licensed Clinical Psychologist.
josiahemm1967@gmail.com[1]; Correspondence: danypeace4lifesaver@gmail.com[2]

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ABSTRACT
Fragile and conflict-affected settings face interconnected threats to safety, livelihoods, social relationships, and psychological wellbeing. Yet mental health and psychosocial support (MHPSS) is often delivered as a short-term humanitarian service rather than as part of locally owned recovery and human-security planning. This conceptual narrative review examines how community-based trauma intervention may strengthen local agency and contribute to human security, with particular attention to evidence from Nigeria. A targeted review of recent peer-reviewed studies and institutional reports was used to organize evidence around three questions: the developmental consequences of untreated trauma; the benefits and limitations of community-based approaches compared with externally led models; and practical measures for embedding psychosocial support in public services and peacebuilding. The evidence includes a multi-country cohort of community-level MHPSS recipients that included Nigeria, research on post-traumatic stress in conflict-affected Cross River communities, and a programme evaluation of integrated counselling and peacebuilding in north-east Nigeria. These sources indicate substantial unmet need and suggest that accessible, supervised psychosocial support can be associated with reduced distress and improved functioning. However, differences in study design, selection, setting, and follow-up mean that findings should not be interpreted as proof that all community programmes are effective or that observed improvements are caused by a single intervention. The review argues for a layered model combining community participation, culturally responsive support, trained non-specialist providers, professional supervision, clear referral pathways, and stable financing. It concludes that community-based trauma intervention can contribute to human security when local agency is meaningful and services are linked to health, protection, livelihood, and peacebuilding systems. Further Nigerian implementation research with transparent outcome measures and longer follow-up is required.

Keywords: community-based intervention, trauma, mental health and psychosocial support, human security, local agency, Nigeria, resilience

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Introduction

Human security is concerned with the protection and empowerment of people facing interconnected threats to survival, livelihood, and dignity. Unlike a narrow state-centred conception of security, it recognizes that physical safety, access to essential services, social relationships, and psychological wellbeing are interdependent (United Nations Human Security Unit, 2023). In fragile and conflict-affected settings, violence, displacement, bereavement, economic disruption, and the breakdown of trusted institutions can create conditions in which psychological distress and material insecurity reinforce one another.

Humanitarian responses necessarily prioritize urgent needs such as shelter, food, protection, and healthcare. Nevertheless, psychological distress can affect family relationships, school participation, livelihood activities, trust, and the ability of people to participate in collective recovery. The World Health Organization (WHO, 2022) emphasizes that mental health is integral to health and social functioning and that conflict-affected populations face substantial risks. Psychosocial support should therefore be considered part of recovery and development, not an optional addition after physical needs have been met.

The question is not simply whether psychological support is available, but who shapes it, how it is delivered, and whether it can continue after an external project ends. Community-based programmes may improve access by bringing support closer to affected people and working through existing social networks. However, local delivery is not automatically safe or effective. Community hierarchies, stigma, confidentiality concerns, gendered power relations, and limited referral capacity can create risks if they are not addressed. Local agency should mean more than asking community members to deliver a programme designed elsewhere; it includes meaningful participation in identifying needs, selecting approaches, monitoring quality, and determining priorities.

These issues are relevant to Nigeria, where insecurity and displacement have affected communities in the north-east and north-west and where communal and intercommunal violence has also affected other regions. Nigerian research has documented trauma-related distress in conflict-affected communities and described community-level psychosocial programmes. This paper brings that evidence into a human-security discussion while acknowledging that findings from one population or programme cannot automatically be generalized to all Nigerian settings.

Statement of the research problem

Despite increased recognition of mental health and psychosocial support in humanitarian policy, access to sustained and culturally acceptable services remains uneven in fragile contexts. The problem has three connected dimensions. First, exposure to violence and displacement can be accompanied by psychological distress and reduced daily functioning. Second, services may be geographically inaccessible, under-resourced, or poorly connected to primary healthcare, protection, and social recovery. Third, programmes that depend on external personnel or short funding cycles may struggle to build local ownership and continuity.

In Nigeria, the available evidence includes studies of trauma-related symptoms and programme-level psychosocial support, but the literature is heterogeneous. Some studies report outcomes among people who received services, while others estimate distress in a defined community. These designs answer different questions and should not be treated as equivalent evidence of intervention effectiveness. A careful synthesis is needed to distinguish evidence of need, evidence of change following support, and broader arguments about local ownership and human security.

Aim and research questions

The aim of this paper is to examine how community-based trauma intervention grounded in clinical psychology may strengthen local agency and contribute to human security in fragile contexts, drawing particular attention to available evidence from Nigeria.

The review addresses three questions:

1. How can untreated trauma undermine individual functioning, social relationships, and community recovery in fragile contexts?
2. What do recent studies indicate about the potential and limitations of community-based or community-led psychosocial interventions compared with externally led approaches?
3. What policy and practice measures can embed safe, culturally responsive psychological support within human-security and development programming?

Conceptual framework: Human security, trauma, and local agency

Human security and psychological wellbeing

Human security places people's lived experiences at the centre of analysis and connects protection from fear with protection from deprivation and the ability to live with dignity. Psychological wellbeing is relevant to each dimension. Persistent distress may complicate the restoration of routines and livelihoods; stigma may discourage help-seeking; and mistrust may reduce participation in public services or community initiatives. These pathways are plausible and supported by broader mental-health evidence, but they should not be read as a claim that every person exposed to trauma develops a disorder or that distress inevitably produces social instability.

Community-based trauma intervention

Community-based trauma intervention refers here to structured psychosocial or psychological support that is accessible within affected communities and connected to appropriate professional services. It may include psychological first aid, psychoeducation, facilitated peer or family support, brief evidence-informed interventions, and referral for specialist care. The term does not imply that every community member should provide therapy. Interventions should match the provider's competence, the participant's needs, and the severity of symptoms.

Local agency

Local agency is the capacity of affected people and their institutions to influence decisions, mobilize resources, define culturally meaningful forms of support, and sustain collective action. It is expressed through participation in programme design, transparent feedback mechanisms, shared governance, use of local languages, respect for diverse coping practices, and meaningful roles for local service providers. Local agency does not require accepting harmful practices or abandoning evidence-based care. Rather, it requires negotiating the relationship between clinical evidence, local knowledge, rights, safety, and community priorities.

Theoretical framework

Trauma-informed care

Trauma-informed care provides a service-delivery orientation that recognizes the prevalence and possible effects of trauma and seeks to avoid re-traumatization. Its commonly used principles include safety, trustworthiness, choice, collaboration, empowerment, and attention to cultural and historical context (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014). In fragile settings, these principles matter because affected people may have experienced coercion, discrimination, or betrayal by institutions. Applying a

trauma-informed approach means explaining confidentiality and its limits, obtaining informed consent, avoiding unnecessary retelling of traumatic events, and giving participants meaningful choices.

Cognitive behavioural approaches

Cognitive behavioural therapy (CBT) proposes that patterns of interpretation, emotion, and behaviour can interact to maintain distress and can be addressed through structured therapeutic techniques (Beck, 1976). CBT-informed approaches have been adapted for use in humanitarian settings, including brief interventions delivered by trained providers. Their use in community settings requires appropriate training, supervision, adaptation to language and culture, and referral arrangements for people with complex needs. Community delivery should not be interpreted as a substitute for specialist assessment when such assessment is indicated.

Resilience and community psychology

Resilience research emphasizes processes of adaptation under adversity rather than an assumption that people are unaffected by hardship. Masten (2001) describes resilience as an ordinary adaptive process supported by protective systems, relationships, and resources. Community psychology similarly emphasizes empowerment, participation, and the relationship between individuals and their social environments (Rappaport, 1981). Together, these perspectives suggest that psychosocial recovery depends not only on individual coping skills but also on supportive relationships, credible institutions, access to services, and opportunities to rebuild livelihoods. These theories guide interpretation in this paper; they are not presented as variables tested by the review.

Methodology

Design and scope

This paper is a targeted narrative review and conceptual synthesis, not a systematic review or primary empirical study. No participants were recruited and no new field data were collected. The purpose was to bring together relevant clinical, public-health, and humanitarian evidence to answer the stated research questions, with a deliberate effort to include Nigerian evidence. The review is therefore intended to clarify patterns and implications rather than estimate a pooled intervention effect.

Search approach and eligibility

A targeted search was undertaken for peer-reviewed articles and institutional material concerning trauma, mental health and psychosocial support, community-based intervention, human security, resilience, and conflict-affected populations. Search terms were combined in different ways, including "Nigeria" with "mental health and psychosocial support," "conflict-affected communities," "post-traumatic stress," "community-level support," "peacebuilding," and "task-sharing." Relevant records and reference lists were checked for further sources. Priority was given to peer-reviewed empirical studies, systematic or scoping reviews, and authoritative institutional reports published from 2022 onward. Earlier foundational publications were retained where necessary to explain the theoretical framework.

Sources were considered relevant when they addressed at least one of the following: trauma-related need in conflict-affected populations; community-level psychosocial intervention; local participation or task-sharing; or the relationship between psychological wellbeing, recovery, and human security. Sources that were solely clinical and had no meaningful connection to community, conflict, or recovery were not central to the synthesis. Because this was a targeted narrative search, it did not use a registered protocol, exhaustive database

coverage, duplicate independent screening, or a formal risk-of-bias tool. It should not be described as a systematic review.

Data extraction and synthesis

For each key source, the review noted its setting, design or evidence type, population where reported, and finding relevant to the research questions. Evidence was synthesized narratively under three themes: (a) trauma-related need and its implications for functioning; (b) the potential and limitations of community-based support; and (c) conditions required for local ownership and sustainable integration. Findings from prevalence studies, before-and-after programme monitoring, and policy reports were kept distinct. Reported programme outcomes are described as associations or observed changes unless the original design supports a stronger causal interpretation.

Ethics and limitations

The review uses published studies and public institutional documents and involved no direct contact with human participants. Formal participant ethics approval was therefore not applicable to this review. The method has important limitations: the search was targeted rather than exhaustive; the included sources differ in design and population; intervention monitoring may be affected by selection and follow-up limitations; and the Nigerian evidence base identified here is not representative of every fragile or conflict-affected community in the country. These limitations reduce the strength of general conclusions and are considered when interpreting the findings.

Findings and discussion

1. Trauma-related need and the developmental consequences of distress

The literature indicates that trauma-related distress is a relevant public-health concern in conflict-affected settings, but the scale and presentation of need vary by population and measurement method. WHO (2022) provides a global account of the mental-health burden and service gap. Nigerian evidence makes the issue more concrete. Awa et al. (2024) studied 486 adults in conflict-affected communities in Odukpani Local Government Area, Cross River State, and reported a high prevalence of post-traumatic stress disorder symptoms according to their assessment. The authors also identified associations between PTSD and several individual or social characteristics. Because the study was cross-sectional and conducted in a specific setting, its estimate should not be generalized to all conflict-affected people in Nigeria.

The Nigerian evidence also shows why service need should not be understood only through diagnosis. Psychological distress may affect everyday functioning, relationships, trust, and the ability to participate in recovery. At the same time, exposure to adversity does not determine a single outcome. Social support, material security, family relationships, cultural resources, and access to care can influence how people respond. A human-security approach therefore combines accessible mental-health support with attention to safety, livelihoods, protection, and social inclusion rather than treating distress as an isolated individual problem.

2. Evidence on community-level psychosocial support

Andersen et al. (2022) examined community-level MHPSS delivered through 32 projects in the Democratic Republic of the Congo, Mali, and Nigeria. The study included 6,413 recipients of support and assessed psychological distress and daily functioning before and after intervention. Across the programme data, many beneficiaries showed reductions in reported distress and improvements in functioning. The authors also found that social support and the duration or type of engagement were relevant to outcomes. These findings provide useful

evidence that community-level services can reach people affected by violence and may be associated with improved wellbeing.

However, the study should be interpreted carefully. It drew on programme monitoring data rather than a randomized controlled design, and the reported changes across multiple countries do not isolate a Nigeria-only effect. Before-and-after improvements may be influenced by who entered the programme, changes over time, missing follow-up data, or other forms of support. The evidence supports the practical value of accessible community-level MHPSS, but it does not prove that every delivery model is effective or that improvements will necessarily persist.

A related programme description by the NEEM Foundation, "Counselling on Wheels," examined an integrated approach to MHPSS and peacebuilding in Borno State, north-east Nigeria (Toward an integrated approach..., 2023). This work is important because it locates psychosocial support within a setting affected by prolonged conflict and considers the relationship between individual support and wider peacebuilding. Programme descriptions and preliminary outcome reports can illuminate implementation and feasibility, but they should be distinguished from controlled evaluations. The evidence base would be strengthened by transparent comparison groups where feasible, standardized outcome measures, reporting of attrition, and follow-up beyond the immediate intervention period.

International evidence similarly suggests that brief CBT-based interventions can reduce symptoms in some refugee populations, while the durability of gains and transferability across contexts require attention (Daniel et al., 2024). This supports the use of evidence-informed interventions, not the uncritical transfer of a single treatment package. Cultural and linguistic adaptation, appropriate supervision, participant choice, and realistic referral options are essential.

3. Limits of externally led and poorly integrated interventions

Externally supported programmes may bring specialist knowledge, resources, and rapid response capacity. The concern is not that external actors are inherently ineffective, but that programmes can become fragile when local people have little influence over design, when services are poorly adapted to context, or when funding ends without a handover plan. Chase (2023) highlights a central tension in community-based psychosocial care: local delivery can improve acceptability and reach, but it can also reproduce local power inequalities, stigma, or confidentiality risks. Community participation must therefore be paired with safeguarding, accountability, and options for confidential access outside a person's immediate social network.

Kornwachs et al. (2024), describing the handover of a psychotherapy and psychotraumatology programme in northern Iraq, emphasize cultural understanding and practical collaboration in the transition to local leadership. This reinforces the need to plan for local capacity from the beginning rather than treating sustainability as a final project activity. Local leaders and traditional or faith-based actors may be trusted sources of support, but they should not be assigned clinical responsibilities beyond their competence. Clear boundaries, referral procedures, and supervision protect both service users and community providers.

4. Local actors, task-sharing, and sustainable service design

Task-sharing can extend basic support where specialist mental-health workers are scarce. Appropriate roles may include community awareness, psychological first aid, supportive listening, psychoeducation, identification of warning signs, and referral. More complex assessment and treatment require appropriately qualified professionals. Evidence on task-sharing emphasizes the importance of clear roles, supervision, and referral pathways; task-sharing

without these safeguards can transfer responsibility to under-supported workers without ensuring quality.

In Nigeria, IOM's humanitarian planning describes community-based MHPSS delivered through multidisciplinary psychosocial mobile teams, local partners, safe spaces, counselling and support groups, and referral to specialized care in affected states, including Plateau and Benue as well as parts of northern Nigeria (International Organization for Migration [IOM], 2024). This institutional material documents a service model and programme priorities; it is not, by itself, evidence that the model has achieved a particular clinical effect. It nevertheless illustrates how psychosocial services can be linked with community capacity, protection, and recovery activities.

Sustainable local agency requires more than training a small number of volunteers. Programmes need continuing supervision, a referral directory that is actually functional, safe recordkeeping, culturally and linguistically appropriate materials, feedback and complaints mechanisms, predictable financing, and plans to prevent provider burnout. Participation should include women, young people, people with disabilities, displaced people, and groups whose voices may be marginalized in existing leadership structures. Local ownership is meaningful when affected people can influence decisions and hold providers accountable.

5. Direct answers to the research questions

Research question 1: Untreated trauma can contribute to distress and difficulties in daily functioning, relationships, livelihood activity, and participation in community recovery. The Nigerian studies reviewed demonstrate a substantial need for support in specific conflict-affected settings, but they do not justify assuming that every exposed person develops a mental disorder or that findings from one locality represent the entire country.

Research question 2: Community-based support can improve access and has been associated with reductions in distress and improvements in functioning in programme data. Nigerian and multi-country evidence is promising but heterogeneous. Community delivery is not automatically superior to externally led care: outcomes depend on intervention quality, safety, cultural fit, supervision, referral capacity, continuity, and the extent of genuine local participation. Causal and long-term claims remain limited where controlled comparisons and extended follow-up are absent.

Research question 3: The most defensible policy measures are to integrate MHPSS into primary healthcare and humanitarian coordination; train and supervise community providers within clearly defined roles; create accessible referral pathways; involve affected communities in governance and adaptation; protect confidentiality and prevent stigma; and provide stable financing and outcome monitoring. These measures should be linked with protection, livelihood recovery, education, and peacebuilding so that psychological support complements rather than replaces action on the structural causes of insecurity.

Policy and practice recommendations

1. Integrate MHPSS into routine public-health and humanitarian planning. Federal and state health authorities, humanitarian agencies, and local service providers should connect community-level support to primary healthcare and specialist referral systems, rather than relying exclusively on short-term stand-alone projects.
2. Establish supervised task-sharing arrangements. Define the competencies of community facilitators, provide initial and refresher training, offer regular professional supervision, and maintain clear referral protocols for severe distress, suicide risk, abuse, or other urgent concerns.

3. Co-design programmes with diverse community members. Include displaced and host communities, women, young people, people with disabilities, traditional and faith-based actors, and local health workers. Participation should influence programme decisions, not merely be used to recruit beneficiaries.
4. Protect safety, privacy, and informed choice. Explain confidentiality and its limits, provide discreet routes to care, monitor for stigma and power imbalances, and avoid pressuring participants to disclose traumatic experiences in public or group settings.
5. Link psychological support with wider human-security needs. Coordinate psychosocial services with protection, livelihood support, education, housing, and peacebuilding because psychological distress is shaped by continuing insecurity and deprivation.
6. Strengthen monitoring and research. Nigerian programmes should use clearly described measures of distress and functioning, report recruitment and attrition, document intervention dose and provider supervision, include community-defined outcomes, and conduct follow-up where feasible. Evaluations should distinguish service reach, acceptability, observed change, and causal effectiveness.

Conclusion

Community-based trauma intervention offers a practical route for bringing psychological support closer to people affected by conflict and displacement. The evidence reviewed, including Nigerian studies, indicates considerable need and suggests that community-level MHPSS can be associated with reduced distress and improved daily functioning. Yet the available evidence does not support blanket claims that all community interventions are effective, that local delivery is inherently better than external delivery, or that short-term gains are necessarily sustained.

The contribution of community-based intervention to human security depends on the quality of care and the degree to which local agency is real. Community participation must be supported by trauma-informed practice, culturally responsive and evidence-informed interventions, competent supervision, confidentiality, referral pathways, and reliable financing. Psychological support should also be integrated with action on livelihoods, protection, healthcare, and social cohesion. Future research in Nigeria should assess implementation and longer-term outcomes across different contexts, using transparent methods and measures that matter to affected communities.

References

American Psychological Association. (2020). Publication manual of the American Psychological Association (7th ed.). American Psychological Association.

Andersen, I. A., Rossi, R., & Hubloue, I. (2022). Community-level mental health and psychosocial support during armed conflict: A cohort study from the Democratic Republic of the Congo, Mali, and Nigeria. Frontiers in Public Health, 10, Article 815222. https://doi.org/10.3389/fpubh.2022.815222

Awa, T. M., Ugbe, U. M.-J., Onwusaka, O. C., Abua, E. E., & Esu, E. B. (2024). Correlates of post-traumatic stress disorder among adult residents of conflict-affected communities in Cross River State, Nigeria: A cross-sectional study. BMJ Open, 14(3), e078851. https://doi.org/10.1136/bmjopen-2023-078851

Beck, A. T. (1976). Cognitive therapy and the emotional disorders. International Universities Press.

Chase, L. (2023). The double-edged sword of 'community' in community-based psychosocial care: Reflections on task-shifting in rural Nepal. Anthropology & Medicine, 30(3), 294–309. https://doi.org/10.1080/13648470.2022.2161765

Daniel, N. A., Liu, X., Thomas, E. T., Eraneva-Dibb, E., Ahmad, A.-M., & Heneghan, C. (2024). Brief CBT-based psychological interventions to improve mental health outcomes in refugee populations: A systematic review and meta-analysis. European Journal of Psychotraumatology, 15(1), Article 2389702. https://doi.org/10.1080/20008066.2024.2389702

International Organization for Migration. (2024). Nigeria crisis response plan 2024–2025. https://crisisresponse.iom.int/response/nigeria-crisis-response-plan-2024-2025

Kornwachs, G., Hautzinger, M., & Kizilhan, J. (2024). The importance of cultural understanding and practical solutions during the handover of a psychotherapy and psychotraumatology program in Northern Iraq into local hands. Frontiers in Psychiatry, 15, Article 1434670. https://doi.org/10.3389/fpsyt.2024.1434670

Masten, A. S. (2001). Ordinary magic: Resilience processes in development. American Psychologist, 56(3), 227–238. https://doi.org/10.1037/0003-066X.56.3.227

Rappaport, J. (1981). In praise of paradox: A social policy of empowerment over prevention. American Journal of Community Psychology, 9, 1–25. https://doi.org/10.1007/BF00896357

Substance Abuse and Mental Health Services Administration. (2014). SAMHSA's concept of trauma and guidance for a trauma-informed approach (HHS Publication No. SMA 14-4884). U.S. Department of Health and Human Services.

Toward an integrated approach for mental health and psychosocial support and peacebuilding in North-East Nigeria: Programme description and preliminary outcomes from 'Counselling on Wheels'. (2023). BJPsych International, 20(4), e190. https://doi.org/10.1192/bjo.2023.575

Thobane, K. F., Mulaudzi, F. M., Lavhelani, N. R., & Gundo, R. (2024). Enablers and barriers for task sharing of mental health care from nurses to community health workers: A scoping review. International Journal of Africa Nursing Sciences, 20, Article 100761. https://doi.org/10.1016/j.ijans.2024.100761

United Nations Human Security Unit. (2023, March 7). Operationalizing the triple nexus approach in conflict and fragile settings: Reinforcing national actors to advance collective outcomes that reduce risks and vulnerabilities. United Nations.

https://www.un.org/humansecurity/wp-content/uploads/2023/04/FINAL_MM_Statement_LDC5_March_2023.pdf

World Health Organization. (2022). World mental health report: Transforming mental health for all. https://www.who.int/publications/i/item/9789240049338