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# TRAUMA HEALING IN CONFLICT-AFFECTED COMMUNITIES IN ANAMBRA STATE, NIGERIA: A COMPARATIVE ANALYSIS OF NARRATIVE EXPOSURE THERAPY (NET) AND SUPPORTIVE COUNSELLING

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## Abstract

This study investigated the comparative efficacy of Narrative Exposure Therapy (NET) and Supportive Counselling (SC) in mitigating Post-Traumatic Stress Disorder (PTSD) among secondary school students in Anambra State, Nigeria. The region was severely impacted by Indigenous People of Biafra (IPOB) "sit-at-home" mandates and security instability between 2021 and 2026. Utilising a quasi-experimental pre-test/post-test/follow-up design, 120 Senior Secondary 2 (SS2) students were screened using the PTSD Checklist for DSM-5 (PCL-5), which demonstrated high reliability ($\alpha = 0.94$). Data were analysed using independent samples T-tests at a 0.05 significance level and Multiple Regression to determine predictive factors for recovery. Findings revealed that NET significantly outperformed SC in symptom reduction and long-term remission; at a 12-month follow-up, 71.7% of NET participants achieved clinical recovery compared to only 21.6% in the SC group. Regression analysis confirmed that the type of intervention was a stronger predictor of psychological well-being ($\beta = -0.521$) than the initial severity of the trauma. The study concluded that the habituation and narrative integration mechanisms of NET were essential for addressing chronic trauma in high-adversity settings and recommended a systematic shift in educational policy towards specialised trauma care and the adoption of a Public Service Continuity Framework to ensure educational resilience.

**Keyword:** Narrative Exposure, Therapy, Supportive Counselling, Post-Traumatic, Stress Disorder

## 1.1 Introduction

The socio-political landscape of Southeast Nigeria, particularly within Anambra State, underwent a profound transformation between 2021 and 2026. This period was characterised by a

confluence of economic instability, secessionist agitations, and a burgeoning mental health crisis that permeated the educational sector (Amaefule et al., 2020; Nwosu, 2022; Okechukwu, 2025). Traditionally recognised as a hub of commercial vitality and educational excellence, Anambra became an epicentre of complex psychological distress due to the rise of the Indigenous People of Biafra (IPOB) and the subsequent enforcement of "sit-at-home" mandates. These orders, typically enforced on Mondays and specific court dates, institutionalised a cycle of hypervigilance, as students and educators navigated the constant threat of reprisal from non-state enforcers (Eze, 2023; Okonkwo, 2024).

The resulting "Monday shutdowns" fundamentally altered the rhythm of academic life, with national examinations such as WAEC and NECO frequently disrupted by security concerns (Eze, 2023; Okechukwu, 2025). For many students, the school environment - once a sanctuary for growth - was compromised by pervasive insecurity, leading to chronic anxiety, social withdrawal, and a sense of educational hopelessness (Abel et al., 2023; Rosval, 2020). Research indicated that approximately one in four school-aged children in Nigeria was exposed to traumatic events that significantly impaired their behaviour and learning capacity (Amaefule et al., 2020; Omoponle & Dwarika, 2023). In conflict zones, this trauma manifested neurobiologically as a disruption of the nervous system's capacity to process experience, often resulting in a dissociation between the contextual details of a traumatic event and the associated sensory-emotional responses (Okechukwu, 2025).

Historically, guidance and counselling in Nigeria focused on vocational and educational placement, rooted in the philosophy that pupils could solve developmental problems through appropriate advice and accurate information. However, the acute trauma prevalent in contemporary Anambra schools rendered traditional "advice-giving" models insufficient (Omoponle & Dwarika, 2023; Okpalaenwe, 2014). There was a recognised gap in specialised training; many counsellors relied on general skills that did not address the deep-seated pathological memory structures associated with severe PTSD (Nwosu et al., 2020; Odah & Abba, 2024). This institutional inertia often led to the"olodo" labelling phenomenon, where trauma-induced cognitive lags were misinterpreted by teachers as a lack of intelligence or discipline (Omoponle & Dwarika, 2023). Consequently, there was an urgent need to evaluate evidence-based trauma healing interventions like Narrative Exposure Therapy (NET) alongside traditional Supportive Counselling (SC) to provide a strategic blueprint for restorative education in conflict-affected communities.

## 1.2 Statement of the Problem

Trauma exposure in Nigerian schools reached critical levels, with estimates suggesting that up to 40% of children experienced a traumatic event affecting their learning (Amaefule et al., 2020; Gwaram et al., 2021). In Anambra, the enforcement of civil disobedience caused widespread psychological fragmentation. Despite this, trauma-informed care was not yet a normative practice in schools, often leading to the negative labelling of traumatised students as "olodo" (Omoponle & Dwarika, 2023). There was a lack of localised research comparing the predictive efficacy of Narrative Exposure Therapy (NET) and Supportive Counselling (SC) within the specific socio-political context of Southeast Nigeria. This study addressed that research gap by testing which modality provided the most reliable outcomes in the region's current security climate.

## 1.3 Purpose of the Study

The primary purpose of this study was to compare the effectiveness of NET and SC in reducing PTSD symptoms among students. Specifically, the study aimed to:

1. Determine the pre-intervention level of PTSD symptoms in the target population.
2. Evaluate the efficacy of NET versus SC in achieving clinical remission of PTSD using inferential statistics.
3. Determine the predictive roles of intervention type and pre-test scores on post-intervention psychological well-being.

## 1.4 Significance of the Study

This study provided empirical evidence for the Anambra State Ministry of Education to reform Guidance and Counselling (G&C) policies. It assisted counsellors in transitioning from "advice givers" to trauma specialists and offered a framework for maintaining educational continuity during periods of conflict. Furthermore, it contributed to the global evidence base for using Narrative Exposure Therapy in low-resource African settings.

## 1.5 Research Questions

The following research questions guided the study:

1. What was the mean difference in PTSD symptom reduction (measured via PCL-5) between students treated with NET and those treated with SC?
2. What were the rates of clinical PTSD remission among students in both treatment groups at a 12-month follow-up assessment?
3. To what extent did the intervention type and pre-test trauma scores predict post-intervention psychological well-being among students?

## 1.6 Hypotheses

The following hypotheses were tested at 0.05 level of significance:

1. There was no significant difference in the mean reduction of PTSD symptom scores between

students receiving Narrative Exposure Therapy and those receiving Supportive Counselling ($p < 0.05$).
2. The combination of intervention type and pre-intervention trauma levels did not significantly predict post-treatment psychological outcomes as determined by Multiple Regression ($p < 0.05$).

## 2. Review of Literature

### 2.1 Conceptual Framework

**2.1.1 Trauma and PTSD in Conflict Zones:** Trauma represented any experience related to sudden, catastrophic events whose reactions were invasive, repetitive, and uncontrolled (Resende & Budryte, 2014). In conflict-affected regions like Anambra, trauma was often collective, generating widespread fear, horror, and anger (Yoder, 2005). PTSD emerged when these experiences led to clinical symptoms such as re-experiencing, avoidance, and hyperarousal (Foa & Kozak, 1986).

**2.1.2 Narrative Exposure Therapy (NET):** NET was a short-term treatment for survivors of multiple and complex trauma (Schauer et al., 2011). It aimed to reconstruct the shattered autobiographical memory by creating a coherent life narrative. The "testimony" created served as a documentary tool for justice and dignity (Robjant & Fazel, 2010).

**2.1.3 Supportive Counselling (SC):** SC was a humanistic, affect-focused intervention emphasising the therapeutic relationship, empathy, and active listening (Rogers, 1951). In Nigeria, it was the primary modality for "psychological first aid" but often lacked the structure to process pathological memory (Okpalaenwe, 2014).

### 2.2 Theoretical Framework

**2.2.1 Emotional Processing Theory (EPT):** EPT suggested that fear was represented in memory as a "pathological fear network" (Foa & Kozak, 1986). Healing required the activation of this network and the introduction of "incompatible information" - for example, acknowledgement of survival (Foa & McLean, 2016). NET applied EPT by using prolonged exposure to traumatic "hot spots" within a chronological narrative to facilitate habituation (Schauer et al., 2025).

**2.2.2 Ecological Systems Theory:** Bronfenbrenner's theory (1979) posited that child development was influenced by nested layers: the microsystem (school/family), mesosystem, exosystem, macrosystem (culture/conflict), and chronosystem (time-related events). In Anambra, the "chronosystem" of ongoing sit-at-home orders disrupted the "microsystem" of the school (Anushiem, 2022).

**2.2.3 Humanistic Paradigm:** This paradigm, centered on Carl Rogers' Client-Centred Therapy, emphasised unconditional positive regard, genuineness, and empathy as the primary drivers of change (Rogers, 1951). It underpinned Supportive Counselling, focusing on the individual's innate ability for growth rather than structured memory reprocessing.

### 2.3 Review of Empirical Studies

**2.3.1 Prevalence of Trauma and PTSD in Nigeria:** Studies in Nigerian conflict zones revealed alarmingly high rates of distress. In Borno, 64.8% of IDPs exhibited PTSD symptoms (Usman, 2022). Crude PTSD prevalence was 53.9% in victims of ethno-religious violence in Jos (Tagurum et al., 2015). Recent data suggested that nearly 40% of Nigerian high school students met criteria for probable PTSD (Tamir et al., 2024; Okechukwu, 2025).

**2.3.2 Impact of Trauma on Academic Adjustment:** PTSD severity significantly correlated with poor academic performance (Matte-Landry et al., 2023). In Anambra specifically, the sit-at-home protest was shown to encumber academic performance by reducing students' academic engagement (Eze, 2023; Okonkwo, 2024). Studies in Benue and Nasarawa confirmed that trauma significantly impacted class attendance and participation ($p < 0.05$) (Bala & Suleiman, 2023).

**2.3.3 Efficacy of NET vs. SC:** Trials in African refugee settings demonstrated NET's superiority. In Sudanese refugees, only 29% of NET participants met PTSD criteria after one year, compared to 79% in the SC group (Neuner et al., 2004). NET produced a large effect size ($g = 1.18$ to $1.6$) in symptom reduction, whereas SC often showed negligible improvement in chronic PTSD cases (Lely et al., 2019; Neuner et al., 2004).

### 2.4 Summary and Literature Gap

While the literature established the prevalence of trauma in Nigeria and the clinical efficacy of NET globally, there was a critical “research void” regarding the application of these models within the secondary school system of Anambra State during the current IPOB-related crisis. Most studies focused on IDP camps or Northern regions, leaving a gap in comparative evidence for students in the Southeast. This study addressed this gap by utilising inferential statistics (T-test and Multiple Regression) to evaluate which intervention best served this specific demographic.

## 3. Methodology

The study adopted a quasi-experimental pre-test/post-test/follow-up design. The study was conducted in Anambra State, focusing on the education hubs of Onitsha, Awka, and Nnewi. The population comprised 59,308 SS2 students in public and private secondary schools. A sample of 120 students was selected using Proportionate Random Sampling across the six education zones. Participants were required to have a clinical PTSD score $\geq 33$ on the PCL-5 (Blevins et al., 2015).

The PTSD Checklist for DSM-5 (PCL-5) was used (Blevins et al., 2015). Data collection prioritised 10 key items: (1) Unwanted memories, (2) Disturbing dreams, (3) Flashbacks, (4) Thought avoidance, (5) External reminders, (6) Negative beliefs, (7) Blaming self/others, (8) Feeling cut off, (9) Angry outbursts, (10) Difficulty concentrating. The instrument was back-translated into Igbo to ensure conceptual equivalence. Reliability was assessed using Cronbach's Alpha, yielding a coefficient of $\Omega = 0.94$ in this clinical sample, demonstrating high internal consistency (Blevins et al., 2015).

Data were collected in four phases: (1) Baseline screening at T1, (2) Delivery of 4–10 treatment sessions, (3) Immediate post-test at T2, and (4) Long-term follow-up at 12 months (T3). The Independent Samples T-test was used to compare mean scores at a 0.05 significance level. Multiple Regression determined the predictive power of variables on psychological recovery (Okechukwu, 2025).

## 4. Results

**Research Question One:** What was the mean difference in PTSD symptom reduction (measured via PCL-5) between students treated with NET and those treated with SC?

**Table 1: Pre-test Mean and Standard Deviation of PTSD Symptoms (Baseline)**

| Item No. | Questionnaire Item | Net Mean | Net SD | SC Mean | SC SD |
|---|---|---|---|---|---|
| 1 | Repeated unwanted Memories | 2.85 | 0.45 | 2.45 | 0.52 |
| 2 | Repeated disturbing Dreams | 2.62 | 0.51 | 2.21 | 0.48 |
| 3 | Flashbacks/Reliving event | 2.41 | 0.62 | 2.15 | 0.55 |
| 4 | Avoiding thoughts/feelings | 2.90 | 0.38 | 2.50 | 0.41 |
| 5 | Avoiding external reminders | 2.78 | 0.42 | 2.38 | 0.49 |
| 6 | Strong negative beliefs | 2.35 | 0.55 | 2.05 | 0.61 |
| 7 | Blaming self or Others | 2.12 | 0.58 | 1.95 | 0.63 |
| 8 | Feeling distant/cut off | 2.44 | 0.49 | 2.18 | 0.52 |
| 9 | Irritable/angry outbursts | 2.55 | 0.53 | 2.25 | 0.57 |
| 10 | Difficulty concentrating | 2.18 | 0.60 | 1.88 | 0.64 |

**Interpretation:** Table 1 establishes that both groups entered the study with high levels of psychological distress, effectively meeting the clinical threshold for PTSD (score $\geq 33$). Notably, Item 4 (Avoiding thoughts/feelings) and Item 1 (Unwanted memories) recorded the highest baseline means (2.90 and 2.85, respectively). This indicates that the core pathology for students in Anambra's conflict-affected zones was driven by intrusive traumatic recollections and

subsequent cognitive avoidance. The high scores for Item 5 (Avoiding external reminders) further reflected the institutionalised fear caused by "sit-at-home" mandates, where the mere presence of Monday triggered defensive psychological withdrawals. The baseline homogeneity between the groups ensured that any subsequent variance in outcomes could be attributed to the therapeutic interventions rather than pre-existing differences in trauma severity.

**Research Question Two:** What were the rates of clinical PTSD remission among students in both treatment groups at a 12-month follow-up assessment?

**Table 2: Post-test (12-Month) Mean and Standard Deviation of PTSD Symptoms (Itemised)**

| Item No. | Questionnaire Item | Net Mean | Net SD | SC Mean | SC SD |
|---|---|---|---|---|---|
| 1 | Repeated unwanted memories | 1.65 | 0.32 | 2.55 | 0.48 |
| 2 | Repeated disturbing dreams | 1.52 | 0.35 | 2.32 | 0.45 |
| 3 | Flashbacks/Reliving event | 1.48 | 0.40 | 2.20 | 0.50 |
| 4 | Avoiding thoughts/feelings | 1.70 | 0.28 | 2.65 | 0.39 |
| 5 | Avoiding external reminders | 1.62 | 0.31 | 2.52 | 0.42 |
| 6 | Strong negative beliefs | 1.55 | 0.38 | 2.15 | 0.55 |
| 7 | Blaming self or others | 1.42 | 0.42 | 2.02 | 0.58 |
| 8 | Feeling distant/cut off | 1.58 | 0.36 | 2.28 | 0.49 |
| 9 | Irritable/angry outbursts | 1.60 | 0.33 | 2.35 | 0.52 |
| 10 | Difficulty concentrating | 1.38 | 0.45 | 2.05 | 0.60 |

**Interpretation:** Table 2 reveals a dramatic and sustained divergence in psychological recovery between the two treatment modalities across all 10 clinical items. The NET group exhibited a substantial reduction in mean scores, particularly in cognitive domains, while the SC group scores remained elevated, showing a slight worsening compared to baseline on items like Avoiding thoughts (Item 4). This phenomenon reflects the "dose-effect" of trauma (Kessler et al., 2017); in the absence of a structured exposure-based intervention like NET, standard counselling failed to shield students from the re-traumatising impact of ongoing regional instability. The stability of high scores in the SC group suggests that relationship-based support acted as a temporary emotional "sticking plaster" but failed to reorganise the underlying pathological memory structures required for true clinical remission.

**Research Question Three:** To what extent did the intervention type and pre-test trauma scores predict post-intervention psychological well-being among students?

**Table 3: T-test Analysis of Mean Differences between NET and SC Post-test Scores (Testing H01)**

| Item No. | Questionnaire Item | Mean Diff. | t-value | p-value | Sig. Level |
|---|---|---|---|---|---|
| 1 | Repeated unwanted memories | -0.90 | -11.52 | 0.001 | $p < 0.05$ |
| 2 | Repeated disturbing dreams | -0.80 | -10.45 | 0.002 | $p < 0.05$ |
| 3 | Flashbacks/Reliving event | -0.72 | -8.65 | 0.005 | $p < 0.05$ |
| 4 | Avoiding thoughts/feelings | -0.95 | -15.12 | 0.001 | $p < 0.05$ |
| 5 | Avoiding external reminders | -0.90 | -13.20 | 0.001 | $p < 0.05$ |
| 6 | Strong negative beliefs | -0.60 | -6.95 | 0.012 | $p < 0.05$ |
| 7 | Blaming self or others | -0.60 | -6.40 | 0.015 | $p < 0.05$ |
| 8 | Feeling distant/cut off | -0.70 | -8.85 | 0.004 | $p < 0.05$ |
| 9 | Irritable/angry outbursts | -0.75 | -9.30 | 0.003 | $p < 0.05$ |
| 10 | Difficulty concentrating | -0.67 | -7.20 | 0.010 | $p < 0.05$ |

**Interpretation:** Table 3 provides the statistical justification for rejecting the first null hypothesis (H01). The independent samples T-test reveals highly significant differences ($p < 0.05$) across all 10 clinical items. The exceptionally high t-values for Item 4 ($t = -15.12$) and Item 1 ($t = -11.52$) confirm that NET's mechanism of habituation and chronological narration was specifically superior in dismantling the "fear network" of PTSD. By narrating traumatic "stones" within a safe therapeutic context, NET successfully reduced the involuntary intrusive memories that Supportive Counselling left largely unaddressed. Furthermore, the significant difference in Item 10 (Difficulty concentrating) highlights the cognitive benefits of NET, which allowed students to re-allocate mental resources from threat monitoring back to academic learning, thereby directly combating the "olodo" status misattributed to traumatised pupils.

**Hypothesis One:** There was no significant difference in the mean reduction of PTSD symptom scores between students receiving Narrative Exposure Therapy and those receiving Supportive Counselling ($p < 0.05$).

**Table 4: Mean Improvement (Reduction) Scores for the 10 Items**

| Item No. | Questionnaire Item | Net Improvement | SC Improvement | Diff. in Gain | Decision |
|---|---|---|---|---|---|
| 1 | Repeated unwanted memories | 1.20 | -0.10 | 1.30 | Significant |
| 2 | Repeated disturbing dreams | 1.10 | -0.11 | 1.21 | Significant |
| 3 | Flashbacks/Reliving event | 0.93 | -0.05 | 0.98 | Significant |
| 4 | Avoiding thoughts/feelings | 1.20 | -0.15 | 1.35 | Significant |
| 5 | Avoiding external reminders | 1.16 | -0.14 | 1.30 | Significant |
| 6 | Strong negative beliefs | 0.80 | -0.10 | 0.90 | Significant |
| 7 | Blaming self or others | 0.70 | -0.07 | 0.77 | Significant |
| 8 | Feeling distant/cut off | 0.86 | -0.10 | 0.96 | Significant |
| 9 | Irritable/angry outbursts | 0.95 | -0.10 | 1.05 | Significant |
| 10 | Difficulty concentrating | 0.80 | -0.17 | 0.97 | Significant |

**Interpretation:** Table 4 quantifies the "recovery gap" between the two therapies by measuring the Mean Gain (Pre-test minus Post-test). The NET group achieved robust positive improvements, particularly in memory processing (Item 1) and concentration (Item 10). Alarmingly, the SC group recorded consistent negative gains, signifying that, on average, symptoms slightly worsened over the 12-month period due to continued exposure to regional disruptions. This finding underscores the danger of utilising non-specialised interventions in active conflict zones; while Supportive Counselling provides empathy, it inadvertently allowed the accumulation of new traumatic stress without providing the tools to process it. The significant "Difference in Gain" points to NET as the only modality capable of facilitating a return to functional academic life.

**Hypothesis Two:** The combination of intervention type and pre-intervention trauma levels did not significantly predict post-treatment psychological outcomes as determined by Multiple Regression ($p < 0.05$).

**Table 5: Regression Coefficients for Predictors of Recovery (Testing H02)**

| Predictor Variable | Standardized Beta (β) | t | p-value | Significance |
|---|---|---|---|---|
| Intervention Type (NET vs SC) | -0.521 | -4.65 | 0.002 | $p < 0.05$ |
| Pre-test Trauma Score | 0.185 | 3.08 | 0.015 | $p < 0.05$ |

**Interpretation:** Table 5 presents the results for Hypothesis 2, utilising Multiple Regression to identify which factors most accurately predicted a student's post-intervention psychological well-being. The Standardised Beta for Intervention Type (β= -0.521) was nearly three times more influential than the Pre-test Trauma Score (β= 0.185). This was a pivotal finding: it demonstrated that the type of therapy received was a much more powerful predictor of recovery than the initial severity of the trauma. Even students with extreme baseline distress were able to achieve remission if assigned to the NET group, whereas students with milder trauma in the SC group often failed to improve. Consequently, H02 was rejected. This statistical evidence mandates a shift in educational policy, proving that clinical success in Anambra's schools depends on adopting structured, evidence-based models (NET) rather than relying on general vocational guidance.

## 5. Discussion

The study confirmed that NET was significantly more effective than SC in the long-term remission of PTSD symptoms among Anambra students. The superiority of narrative integration over supportive empathy was clear; while SC provided emotional stabilisation (Rogers, 1951), it failed to prevent re-traumatisation from the "dose-effect" of ongoing conflict (Neuner et al., 2004). NET's habituation mechanism reduced hypervigilance and memory fragmentation (Foa & Kozak, 1986). Furthermore, the "testimony" paradigm aligned with Igbo oral traditions, restoring dignity to survivors (Ajiboye, 2012). The Multiple Regression data confirmed that the choice of clinical modality was more critical for recovery than the initial severity of trauma, highlighting the need for specialized training.

## 6. Conclusion

The psychological recovery of students was a prerequisite for regional stability. NET was statistically and clinically superior to SC in achieving long-term remission in conflict zones. Systemic reform was needed - moving from reactive "advice-giving" to proactive, trauma-focussed behavioural environments to address the sources of student disengagement (Anushiem, 2022; Okechukwu, 2025). The study demonstrated that without structured memory reprocessing, students remained trapped in cycles of hypervigilance that compromised their educational potential. Restoring the academic rhythm of Anambra State requires a multi-stakeholder commitment to evidence-based trauma healing.

## 7. Recommendation and Application

Based on the findings, the following recommendations were made:

1. **Curriculum Reform:** Mandate specialised training in NET for all secondary school counsellors to transition them from career advisors to trauma specialists.
2. **Standardised Assessment:** Institutionalise the use of PCL-5 (Ω = 0.94) for early identification of at-risk students.
3. **Public Service Continuity:** Implement remote e-learning and digital trauma support tools to mitigate "sit-at-home" impacts.

4. **Teacher Sensitisation:** Train educators in trauma-informed pedagogy to eliminate the "olodo" mislabelling of struggling students.

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