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Cultural Categorisation of PTSD Symptomatologies, the Meaning of Symptoms, and Healing Practice in Kanuri Community of Damaturu, Nigeria

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ABSTRACT **Original Research Article**

The study explores the cultural categorization of PTSD symptoms, the meaning of the lived PTSD experience and healing practices in the Kanuri community of Damaturu Yobe State Nigeria. The study sample consisted of 32 participants (aged 30 to 60 years) who were purposively selected from the Kanuri community. Data was collected through in-depth interviews (N=20) and focus group discussions (N=12) in two groups, each comprising six participants. A qualitative data-driven thematic analysis technique was used to analyze data. The data analysis generated one broad theme; the cultural interpretation of PTSD experiences in Kanuri culture. This theme generated three subthemes—Cultural Categorisation of PTSD symptomatologies, the Meaning of PTSD symptoms, and PTSD healing practices. The most popular belief among the Kanuri people is that only traditional healers and messages from religious scriptures can completely heal an illness or disease; that hospitals only treat symptoms but do nothing to cure the illness. The Kanuri people also believe that religion is central in describing cultural and social behaviors and norms, particularly regarding illness beliefs. The social bonds in Kanuri culture explain their resilience and coping strategy that aids them to escape the consequences of the lived PTSD experiences. Similarly, the individual's understanding of the PTSD experiences and any symptom they experience is also informed by culture and contributes to the impact of these experiences on the individual level of functioning. Therefore, the implication of our findings demonstrates the need for mental health care providers, clinicians, researchers, and policymakers to consider integrating cultural/traditional and spiritual beliefs and/or practices with the western approaches to treating PTSD.

Keywords: Categorization of Symptoms, PTSD Healing, Interpretation, Kanuri Culture.

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Introduction

Although Posttraumatic Stress Disorder (PTSD) is presumed to be universal in manifestation, variation exists in the cultural categorization and interpretation of symptoms and the healing practices across different cultural groups. The development of somatic symptoms following PTSD-subthreshold experiences also varies across individuals and is informed by contextual factors, including culture. In many African cultures, the interaction between the individual, environment, and the broader community significantly determines how they experience and copes with a traumatic experience, which sets the phase for developing PTSD (Motsi & Masango, 2012). Globally, scholars have extensively contributed to cross-cultural studies of psychological trauma and PTSD, emphasizing the critical role that culture plays in influencing how individuals cope with traumatic experiences. In the African context, culture has always been the identity provider in the community. People from traditionally oriented African cultures often regard themselves as a community or societally belonging. Most African people live within the

networks of social relationships from which they derive their self-worth, self-control, sense of belonging, and sense of security (Motsi & Masango, 2012). The views, understanding, and perception of PTSD are externally caused and always linked to the larger society, which is the fabric from which African people derive resilience to a traumatizing event or experience. Thus, African culture provides the community with a system of values, lifestyle, and knowledge through which they handle traumatic experiences. The African culture also provides the context through which traumatic events and experiences are handled and managed. In countries like Nigeria, various societies rely on their traditional beliefs and indigenous health system to deal with PTSD and other mental disorders.

The DSM-V criteria describe the symptoms of the PTSD experiences in terms of sleep disturbances, a problem with concentration, being easily startled, irregular heartbeat, sweating, and anxiety, to mention just a few. The accompanying body reactions are headaches, stomach aches, and digestive complaints. The emotional reactions may include numbing, experiences of anxiety, or a horrible dream. Furthermore, intrusions (i.e., a flood of memories and images) and denial are also emotional responses unique to lived PTSD experiences. Thus, psychologically the individual's inability to control symptoms of a traumatic event exposure is a defining element of the PTSD experience. However, the same experiences and symptoms in the African context are interpreted differently, including responses or reactions to traumatic events. Consequently, the western psychological views assume that responses to traumatic events involve damage or threat to an individual's psychic integrity or sense of self (Carlson, Armstrong, 1997). Whereas in the African view, trauma experiences are beyond an individual; instead, the entire immediate family and the community share the experiences. By showing sympathy and concern to the traumatized survivor and sharing of pain.

Therefore, the responses and healing practice to PTSD experience in the African context is perceived, described, and understood by most people to mean a problem affecting the entire community and not just individuals. This is because, the understanding of PTSD symptoms and experiences is informed by culture and contributes to the impact of these experiences on the individual level of functioning. These shared senses of communal relationships or social bonds distinguish the African view or responses to PTSD experience from western psychology's assumptions, which are presumed to have failed in providing the desired community approach or traditional African PTSD healing practice. Similarly, African cultural practices provide the context through which potentially traumatizing experiences influence individual resilience and responses through the family and/or community social support. Therefore, imposing cross-culturally insensitive PTSD interventions based on the western psychological approach into an African context might not yield the desired results.

Previous studies on cultural sensitivity in psychology and medical anthropology had critiqued the concept of PTSD by projecting its cultural constitution as an idiom of illness (Breslau, 2004; McKinney, 2007; Young, 1995). However, trauma survivors in Africa interpret their PTSD experience and somatization as bounded by culture-specific idioms of distress, shaped by the experience of the individual or community members suffering from the illness (Kirmayer, 2003). Therefore, in most African communities, the making of meaning from distressing experiences of PTSD is interpreted using categorization of symptoms within one's cultural boundaries. These defining interpretations represent the culture-specific idiom of illness, shaping most communities' construction of phenomenological realities. In this regard incorporating the Kanuri communities approach to PTSD categorization of symptoms, understanding the meaning of the lived PTSD experiences, and the prevailing healing practice is imperative. This study's main goal was to ascertain the cultural categorization of PTSD symptoms, the meaning of the lived PTSD experience, and healing practices in the Kanuri community of Damaturu Yobe State, Nigeria. To achieve the study's purpose, we asked one broad question; How do the Kanuri people describe and culturally categorize the PTSD symptoms and their healing practice? Alongside specific questions raised, how do the Kanuri people: a) categorize; b) understand the meaning, and c) provide healing for PTSD symptoms?

Methods

Study Design

This study used a descriptive qualitative approach and phenomenological methodology to explore and hear the Kanuri people's silenced voices on issues related to PTSD-subthereshold experiences within their community. These approaches were used to question how social experience is created and giving meaning, particularly in Kanuri culture. Therefore, we describe the Kanuri people's experiences related to the cultural categorization of PTSD symptoms, the healing practices, and the meaning of PTSD-subthereshold experiences expressed by the sampled community members. We also examined the context in which the Kanuri people engage themselves in alleviating and addressing problems concerning their overall lived PTSD experiences. In this study, we enrolled and engaged the Kanuri people in their natural environment (settings) and explored their PTSD experiences based on their knowledge, opinion, and experiences.

Our study design utilizes a descriptive phenomenology and a qualitative paradigm with a triangulation of two data collection methods, in-depth interview and focus-group discussions throughout the process of data gathering, including observations on emotions, gestures, and sitting posture. We also used purposive and snowball sampling strategies to reach out to the participants' network with rich

information about the PTSD-subthereshold experiences. The triangulation also allows approaching the research questions from different opinions (Cohen, and Manion, 2000; Altrichter, Feldman, Posch, and Somekh, 2008).We also ensure that the purpose of the data gathering and analysis aimed at answering the research questions raised earlier in this study.

Location

This study was localized and conducted within the geographical context of Damaturu, a capital city of Yobe State, located in the Northeastern part of Nigeria. Damaturu is a home to multi-ethnic groups, with the Kanuri people as the dominant ethnic groups (Ireene Makura and Maureen Gallagher, 2011). The choice of Damaturu as a study location was based on the fact that the town is one of the areas most hardest-hit by traumatic events, mainly resulting from the Boko Haram war and insurgency attacks.

Study Population/Participants

In this study, we enrolled our participants from the Kanuri ethnic groups of Damaturu Yobe State, Nigeria. We ensured that only those who met the PTSD event exposure criteria participated in the study. Therefore, our study sampled only included participants that meet criteria for experiencing a trauma event with a corresponding presentation of PTSD-subthreshold symptoms. All the 32 participants were exposed to multiple primary and/or secondary traumatic events. Our participants age ranges between 30 and 60 years of age. Although for a phenomenological study, about 10 participants are recommended (Creswell, 2007), the richness of the data collected is essentially more important than the number of participants (Tuckett, 2004). Thus, this study's sample size was not determined in advance, and the enrolment of the 32 participants was informed by attainment of a saturation point during the data gathering process (Kumar, 2011);whereby the information given by the participants becomes repetitive with no more new findings.

Inclusion and Exclusion Criteria

Our pre-selection criteria for enrolment in this study involved using a PTSD event exposure scale for screening and PTSD-8 inventory for assessment and diagnoses. These tools helped us screen and enrolled those assessed or diagnosed to have shown a behavior diagnosable as PTSD-subthereshold. We ensure that only participants from the Kanuri ethnic group of Damaturu took part in the study and spoke English besides their local language. We also ensured that gender formed part of our inclusion criteria. Overall, we enrolled our participants because of their exposure to traumatic events and the ability to express their experience, knowledge, and opinion related to the experiences of a potentially traumatic event. Individuals not assessed or diagnosed with PTSD-subthereshold were excluded from the study. Other characteristics we found appropriate for exclusion include; belonging to other ethnic groups and not being able to communicate in English, which helped minimize the translation error.

Data Collection and Study Procedure

We collected data using a "direct data" method, which involved interviews using open-ended questions, and observations among the Kanuri people enrolled in this study. The use of "direct data" methods enabled us to gather data primarily through face-to-face and interpersonal contact. The process also involved the recording of their spoken words using a sensitive audio recorder in addition to observations of body language while noting their actions and behavior in response to questions asked. The data collection process uses semi-structured questions, which were intended to elicit responses while allowing for flexibility, probing for clarification, and elaborating responses.

As both subjects and objects of research, the authors have tried through Reflexibility to introspect, evaluate, and understand the influence of values and belief systems in the process of gathering and analyzing the data. Importantly, the lead author is a native of the Kanuri community in Damaturu yet shared a different language; thus, the English language was used throughout the interview sessions.

Data Management and Data Analysis

All the interviews conducted in this study were transcribed verbatim in English. The field notes and the transcribed data were reviewed and manually checked for data quality, rigor, and trustworthiness. However, to get immersed with the data, we first resort and engage ourselves with manual coding. The process helped us familiarise ourselves with the data before inputting the data into Atlas ti version 7.5, a software package for analysis. We used an inductive bottom-up-data-driven thematic analysis technique with an open-coding strategy to generate themes based on the research questions raised (Miles & Huberman 1994). The software helped us navigate easily and manipulate the data to identify and create sub-categories and categories from generated codes' networks. The related sub-categories and categories were later merged and collapsed into more related and much-defined categories that we later conceptualized to develop the themes. We further examined the concepts and themes for meaning. Finally, themes were identified and used extensively to explain and provide evidence for the emerging themes while writing the findings alongside the generated Quotations.

Ethical Consideration

To adhere strictly to the code of ethics, we first obtained an ethical clearance certificate from the Centre for Research, innovation, and linkages of the Yobe State University Damaturu (Review No: YSU/REC/00025-18/19). We ensure the privacy and comfort of the participants as recommended and prioritized by the research ethics committee. We appropriately obtained oral and written consent from our participants' before the commencement of each interview.

We used codes and numbers to anonymize any personal information that will expose our participants' identities. We reiterate to the participants' their right to withdraw at any stage of the study without prejudice. Participation in the study was voluntary, and there was no financial inducement or compensation to the participants. We ensured that the set of questions asked were not threatening, manipulative, unbalanced, coercive, or emotive throughout data gathering. In case, issues related to emotions arose during the interview process, an arrangement was made for referral to an expert for counseling at the specialist hospital Damaturu, Yobe State, Nigeria. However, no such issues arose throughout the data gathering process.

Results

Demographic Characteristics of the Participants

Thirty-two participants took part in this study. Eleven of the participant, 34.40% aged between 30-40 years. Thirteen 40.60% aged within the limit of 41 to 50 years, while 8 of the participants, 25.00%, aged between 51 to 60 years of age. The study enrolled an equal number of males and females, 50% of participants in each category, totaling thirty-two, constituting 100% of the total sampled Kanuri people. The distribution of the participants' education attainment has shown those with advanced level constituting 37.50%. The undergraduates constitute 28.10%, with the masters' holders constituting 31.30%, and one Ph.D. holder representing 3.10%. All the participants enrolled in this study were gainfully employed in different government agencies and organizations.

Table 3. Demographic characteristics of the study participants (n=32)

Variable	Frequency (%)
Age	
30-40	11(34.40)
41-50	13(40.60)
51-60	8 (25.00)
Sex	
Male	16 (50)
Female	16 (50)
Education	
Advance level	12 (37.50)
Undergraduate	9 (28.10)
Masters	10 (31.30)
PhD	1 (3.10)
Occupation	
All participants are working class	32 (100)

PTSD Event Exposure and PTSD-8 Inventory for Screening, Assessment, and Diagnoses (For Inclusion Criteria)

The PTSD event screening tools have shown that all our participants' were exposed to dual or multiple primary and/or secondary traumatic events for a period not less than 6 to 18 months and above. Exposure to insurgency attacks, suicide bombing, and witnessing killings and severe injuries top the participants' exposure lists. Fatal accidents that lead to the death of loved ones were also among the participants' traumatic events. There was also a reported case of sexual assault. The majority of the participants reported intrusive and avoidance symptoms, with few showing hyper vigilance symptoms. Therefore, the aim of using PTSD-8 was to established the relationship between the instrument and the manifestation of PTSD-subthereshold symptoms and their impact to individual level of functioning.

Overview of Findings

The study explores the cultural categorization of PTSD symptoms, the healing practices, and the meaning of lived PTSD experiences in the Kanuri community of Damaturu Yobe State Northeast Nigeria. Overall, the study found that the Kanuri people interpret PTSD-subthereshold experiences fundamentally different from the western individualistic cultures. The description and categorization of PTSD symptoms are expressed predominantly using linguistic metaphors as dictated by their culture. The most often used categorization found to describe PTSD-8 symptoms among the sampled Kanuri people are; karəgəkᾱm (Fear, Panicking), Angalzᾱ (Confusion), Yááta (frightened), Hâu (misfortune), Máshiwol (Worry), and Tájirwa (calamity).However, variations in categorizing the PTSD symptoms arise because the Kanuri language is a multi-dialect language. Some of these dialects include; Wuje, Gumati, Manga, Bodoi, Kanembu, Kwayam, Kuburi, Kaama, Njatko, Woloji, Fada, Karta, Zarara, Mobar, Dagira, and Yerwa dialect. The language also has the most significant number of speakers of the Central Saharan Language Family. (Bulakarima, S. U., Sheriff, B., Abba, 2003). Nevertheless, these descriptors mean the same thing and further explained the shared PTSD experience within the cultural beliefs and context of the Kanuri people.

This study also established healing practices and survival mechanism employed by the Kanuri people exposed to PTSD-subthereshold. Among these include; praying to God and recitation of the Qur'an for protection from the perceived misfortunes, fear, worry, calamity, and confusion. Which represents the actual practices in the community. In the Kanuri community, we also discover that the traditional healers are among the experts providing healing through rituals to appease the spirit, causing PTSD-subthereshold experiences. Simultaneously, the religious leaders (Imams) offer such services through counseling and other religious/community-based practices to heal PTSD experiences. In the Kanuri community, the sampled participants were asked to describe what PTSD-8 symptoms mean to them. The common descriptors established are disturbing, confusion, destiny, accident reminder, and remembering insurgency, which account for understanding the meaning of lived PTSD experiences in the community.

In this study, we engaged the participants in discussions centering on the cultural categorization of PTSD symptoms, the healing practices, and the meaning of lived PTSD experiences in the Kanuri community. Before the interview's commencement, thePTSD-8 inventory was presented as part of the interview protocol to steer and elicit responses to questions raised in the semi-structured questionnaire. The participants' responses bring out one broad theme; Cultural interpretation of PTSD experiences. Three subthemes inductively emerged from the data analysis: a) Cultural categorization of PTSD symptoms, b) the healing practice, and c) the meaning of PTSD symptoms in the Kanuri culture. These concepts or themes were extensively discussed verbatim alongside direct quotations from the participants' set of data.

Cultural Categorisation of PTSD Symptomatologies

In this study, we found that most of the sampled Kanuri people explained and described their PTSD-subthereshold experiences using linguistic metaphors. These categorizations and explanations were also found to represent a joint account in expressing the Kanuri people PTSD experiences. And, also exposed a pattern of shared experiences on the cultural categorization of PTSD symptoms and experiences among the sampled participants. These shared experiences also represent the cultural contexts upon which the Kanuri people understand and explain their PTSD symptoms. Another significant finding from this study is that Culture and Religion shape the shared values, morals, and code of conduct and construction of illness's meaning among the Kanuri people. We also found that religion profiles the Kanuri people's systems of values and beliefs, which influences the categorization and understanding of the meaning of PTSD symptoms and the healing practice. Therefore, in this study, we established that the Kanuri people use linguistic terms to categorized and interpret symptoms of PTSD-8 in their community and culture.

Quotations from some of the participants account during the in-depth interview corroborate the above assertion;

> *For anybody in our community to experience these kinds of symptoms, it means the person is befalling by a calamity (Tájirwa) (In-depth interview P7).*

> *In our culture, that is the Kanuri culture. These symptoms represent what we called karəgəkām (Fear, Panicking), or sometimes not only regarding these symptoms that we mentioned. Other things that make someone feel unsecured have also been referred to mean that. This is how people usually refer to these symptoms in our community (In-depth interview P-13).*

Participants in the focus group discussion further corroborated the assertions;

> *Well, in Kanuri culture, when someone says karəgəkām (Fear, Panicking) maybe it is a state of anxiety or Angalzā (Confusion). Trauma could also mean a state of being too incapacitated. Too demoralized or a state of being unable to comfort oneself resulting from an accident, robbery, or suicide bombing. (Female FGD voice).*

> *Trauma in Kanuri culture is described traditionally to mean Yááta,* (frightened), *an unnecessary, unstable, or abnormal condition experienced by someone (male FGD).*

PTSD Healing Practices

In this study, we also engaged participants in discussing the kind of help given to someone suffering from PTSD symptoms in their culture. One of the significant findings illuminated by our study is that the most popular belief among the Kanuri people is that only traditional healers and messages from the Qur'an can heal an illness or disease completely. We also found that most of the Kanuri people believe that hospitals only treat symptoms but do nothing to cure the illness. To heal from PTSD-subthereshold experiences, we found that the Kanuri people always engaged in; prayer to God and recitation of the Qur'an for protection from the perceived misfortunes, fear, worry, calamity, and confusion as part of their survival mechanisms to live a healthy life. Furthermore, community and religious counseling also form part of the healing practices and traditional practices, which include a form of rituals and the use of charms to appease the spirit. We also found that most Kanuri people believe that religion is central in describing cultural and social behaviors and norms, particularly regarding illness beliefs. In the Kanuri community, we also found that the Imams (Sheiks) are highly respected, even seen as divinely selected and sinless individuals. Their views on anything in the community are much respected and persuade after. Apart from religious teachings, the Imams offer

religious healing and counseling to the community members of any kind of illness or disease.

However, what we also discovered from this study is that the Kanuri people equally regarded traditional medicine as the other most effective approaches in healing various illnesses within their community. Traditional healers are among the foremost people in the Kanuri community. Therefore, as demonstrated by our findings, the traditional healers are believed to have supernatural powers that enable them to communicate with spirits. In this regard, we can report that most of the Kanuri people visit religious leaders or traditional healers for healing an illness or disease. After that, few among them go to the hospitals on rear occasions. Because the belief among the majority of the Kanuri people is that illnesses or diseases result from destiny, misfortunes, evil spirits, and/or witchcraft. Overall, we found that most participants prioritized seeking help from religious leaders (Shaikhs or Imams) and traditional healers because the Kanuri people believe in them as custodians of cure and healing. Therefore, we reported that the Kanuri people always sublime their world views based on these religious and traditional indoctrinations. Every aspect of their lives has been severely affected by those healing practices.

Segments of text from the participants' voices in an in-depth interview supported the above assertion;

> *The Kanuri culture is an Islamic based culture, so it is more of Islam as a way of life. So, whatever happened in society, mostly we just attributed it to God. We are attributing almost everything to God. So that is why whatever happened, we used to rush to Mallams for spiritual help (In-depth interview P-13).*

> *Actually, in our community or Culture as Kanuri's, we deal with these kinds of issues through Spiritual help. As a Muslim, in situations like this, one needs to recite some verses of the Holy Quran, soliciting God's protection. Protection from the reoccurrence of such kind of experience and events, let it not happen again (In-depth interview P-1).*

> *The only thing we do base on our tradition and culture is that we go to the herbalist. Who usually help with some traditional medicine to help one who is experiencing such symptoms (In-depth interview P-2)*

We confirmed these claims in focus group discussion.

> *Well, from a religious perspective, one can only be taken to Ulamas. Ulama's can give a kind of healing process. In terms of bringing someone closer to God. The most important thing is to bring someone close to God. They counseled the person, guiding him to believe that this happening is from God. So, as a religious person, the person is expected to accept it as destiny. So, if the person is believed to be a Muslim, he must believe in destiny (female FGD).*

> *What we usually do when the trauma persists, we usually refer ourselves to the religious book. Most importantly, in the Qur'an, we usually take on our Qur'an and keep on reciting; through that, the trauma gradually goes down. Nevertheless, 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 subsides the tension (male FGD).*

Understanding of Meaning of PTSD Symptoms

We also engaged our participants in discussing the meaning of PTSD symptoms in Kanuri culture. The majority of the Kanuri people interviewed describe their understanding of PTSD-8 symptoms to mean something that is; disturbing, confusing, a destiny, a tragedy, and an insurgency experience. These descriptions further explain the individual differences in understanding the meaning of PTSD-subthereshold symptoms among the sampled Kanuri people. Therefore, we found this understanding or visualization of PTSD symptoms providing insight into the meaning attached in explaining the meaning of lived PTSD experiences in Kanuri culture. Therefore, our findings confirm the impact of the prevailing socialization patterns and cultural values inherent among the Kanuri people as the reason behind their understanding and meaning-making from their PTSD-subthereshold experiences. These have been found to explain the cultural norms and range of meaning attached to lived PTSD experiences and the community's prevailing healing practice. Although we also found that the family members and the community always share the experience of adversities, this further explains strong evidence for a social bond in Kanuri culture. It further explains their resilience and coping strategy that aids them to escape the consequences of the lived PTSD experiences.

Reflection of ideas from some of the participants interviewed supports this explanation.

> *They remember the trauma that happened in 2018 when the accident happed where we lost our brother. We believe it is from God, soit is a destiny (in-depth interview P-6).*

> *In the Kanuri community, when something like this happens, it means something tragic. So, it is a tragedy to everyone (in-depth interview, P-12).*

> *Well, this is a life experience. This can happen to anybody, and it can happen to any community. So it is the experience from the Boko Haram insurgency that causes all these kinds of things (in-depth interview P-17).*

> *Well, this is a natural phenomenon. So there is nothing one can do, but we should keep praying to God that such events should not reoccur again (in-depth interview P-18).*

These positions were further supported during focus group discussions.

> *Well, we usually take it as a destiny. The trauma will be there because the heart will start beating unnecessarily, abnormal beating, palpitation, confusion, and other things. However, one only refers to it as an act of God. It is destiny, and there is nothing one can do since one cannot take an arm and confront them (insurgents) or whatever. One can only relate it to an act of God (male FGD).*

Although we can confirm the manifestation of intrusion, avoidance, and hyper vigilance symptoms among the sampled Kanuri people as evidenced by the PTSD-8 measure. However, as observed, those symptoms have not led to distressing or disorganized behavior among the sampled Kanuri people. They did not manifest negative psychological symptoms and other cognitive or emotional disturbances. Therefore, Kanuri people's behavior did not necessitate the need for psychological interventions outlined by the PTSD criterion in DSM-5. Overall, our study's findings established that the socialization patterns help the Kanuri people internalize their lived PTSD experiences to feel relaxed, hopeful and developed the desired self-esteem to go on with their life activities fig 1.

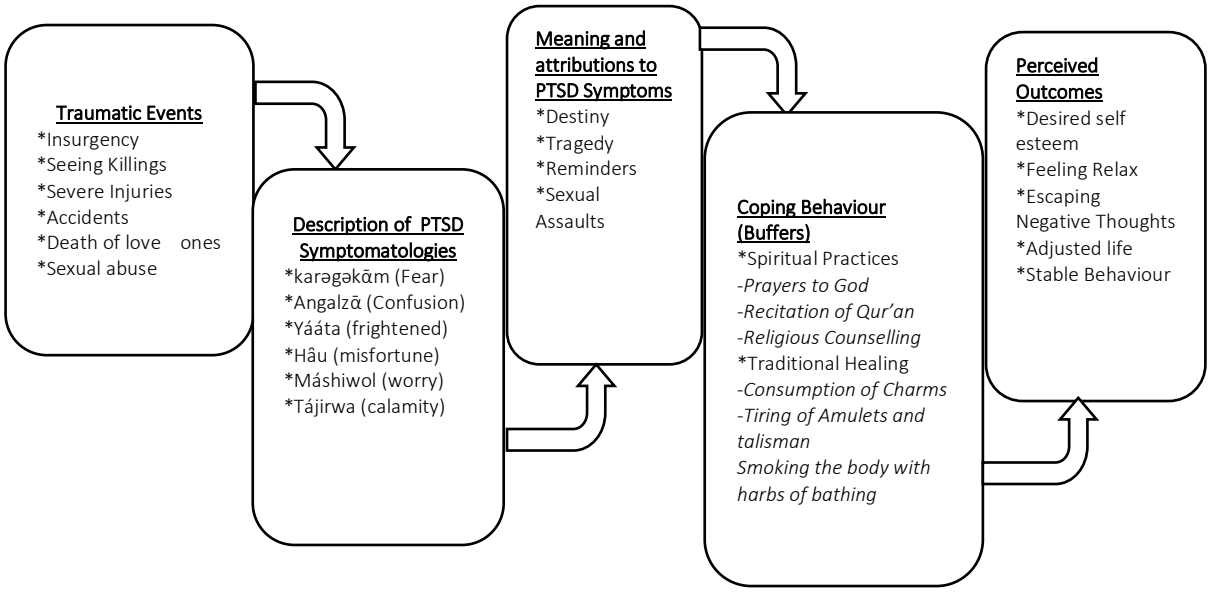

Fig. 1: The use of linguistic metaphors in describing and interpreting the symptoms of PTSD-8 inventory in Kanuri culture.

Figure 1: Illustrate how the sampled Kanuri people use linguistic metaphors in describing, perceiving, and interpreting the symptoms of PTSD-8 inventory. Therefore, the sampled Kanuri people's socialization patterns influenced their cultural categorization of PTSD symptoms, the perceived meaning of PTSD symptoms, the prevailing coping behavior, and the perceived outcome in response to their exposure to traumatic events. The linguistic Metaphors like karəgəkām (Fear, Panicking), Angalzā (Confusion), Yááta (frightened), Hâu (misfortune), Máshiwol (worry) and Tájirwa (calamity) were used to describe and interpret the symptoms of PTSD-8 inventory traumatic events. The Kanuri's misconceived the symptoms caused by their exposure to the traumatic events, and therefore, ascribed the meaning of fear, confusion, and frightening to either destiny or tragedy. Therefore, the Kanuri people employed help-seeking behaviors (remission) through adherence to spiritual practices and traditional healing as a cultural buffer. Therefore, the perceived outcomes tremendously help the Kanuri people maintain the desired self-esteem, feel relaxed, escape negative thoughts, live adjusted life, and have stable behavior.

Discussion

The study explores the cultural categorization of PTSD symptoms, the healing practices, and the meaning of lived PTSD experiences in Kanuri culture. The study was conducted and localized in the Kanuri community of Damaturu Yobe State, Northeast Nigeria. Findings from this study relatively agree with the viewpoints reported by researchers in the field of trauma and culture such as (Bracken, 2012; Bracken, Giller, &Summerfield, 1997; Summerfield, 2001; Terheggen et al., 2001; Herbert J. D. and Forman E. M., 2010; Marsella, Freidman, Gerrity, & Scurfield, 1996; and Marsella, 2007). These authors discussed the implications and/or inappropriateness of applying Western psychological views in the collectivist cultural set-up where the lived PTSD experiences are shared, particularly among family members or the community. These scholars stressed using individual assets, social support resources, and religious/traditional resources, including other cultural resources, to be more vigorous in making people cope and lessen their lived PTSD experiences. Hence, promoting resilience among African communities from any kind of adversity that can cause PTSD experiences.

Overall, our findings have illuminated that firmly held cultural issues can influence how individuals, families, and communities perceive, react, and interpret lived PTSD experiences. We found these perceptions and interpretations expressed in the way the Kanuri people categorized the PTSD symptoms. In addition to prevailing healing practices and their understanding of PTSD-8 symptoms. Although these categorizations and descriptions indicate a partial fit to PTSD criterion for DSM-IV and DSM-5, the word *Fear* expressed as a perceived emotional reaction to danger might fit (Criterion-D of the DSM-5) as well as the (Intrusion cluster of DSM-IV). Furthermore, the word *worry* expressed in terms of a distressing behavior may also fit (criterion B of the DSM-5). Unfortunately, our observations suggest that disorganized or maladaptive behavior did not accompany these diagnosable behaviors. This, therefore, did not qualify the sampled Kanuri people to be assessed or diagnosed as manifesting a clinically significant or maladaptive behavior diagnosed as PTSD. Therefore, we reported that the observed socialization patterns that help the Kanuri people internalize their lived PTSD experiences account for such differences in the manifestation of PTSD experiences between the Western psychological views and the Kanuri cultural expressions of the lived PTSD experiences. These could suggest that Kanuri people lack a clear explanation of some mental illness outlined in the Diagnostic and Statistical Manual of Mental Disorders editions, particularly PTSD.

Our findings supported the argument by some researchers who explore and document diversity in cultural variation to trauma response. The majority of the scholars argue on the need for promoting cultural sensitivity when assessing for trauma in a cross-cultural context. (Chhim, 2014; Kidron, 2012; Marsella, Freidman, Gerrity, & Scurfield, 1996; Shannon et al., 2015). Therefore, we can report that cultural beliefs, norms, and values, including linguistic and ethnic background, can contribute to and influence the categorization of symptoms, perception, and interpretation of the meaning of lived PTSD experiences and the healing practices. These are found to be more relevant and appropriate in the Kanuri culture as they represent the community-based practice for achieving the desired lived PTSD intervention approach. Kidron's suggestion that culture offers a background for individuals in understanding emotions and psychological pain while communicating their suffering to others has no doubt confirmed our findings (Kidron, 2012).

We discussed our study findings based on the interviews conducted with the Kanuri people exposed to lived PTSD experiences in Damaturu. The participants were presented with a list of PTSD-8 symptoms by way of eliciting responses for discussions during the interview process. We ask our participants to; a) describe or explain what those symptoms mean to someone in their community or culture, b) the kind of help given to someone/self when suffering from those symptoms in their community, c) What they understand or think to be the meaning or cause of such symptoms in their community. The three inductive themes that emerged from the analysis of data area) Cultural categorization of PTSD symptoms, b) the healing practice, and c) the meaning of PTSD symptoms in the Kanuri culture. These emerging themes were extensively discussed with supportive quotations from the participants' narratives.

We engaged our participants in discussions about describing or explaining what PTSD symptoms mean to someone in their community. The findings have shown that the Kanuri people use cultural metaphors to describe and interpret the symptoms of PTSD experiences. The most usual linguistic terms used in interpreting symptoms of trauma are; karəgəkᾱm (Fear, Panicking), Angalzᾱ (Confusion), Yááta (frightened), Hâu (misfortune), Máshiwol (Worry), and Tájirwa (calamity). These cultural interpretations and descriptions of PTSD symptoms are the functions of the cultural context. Therefore, we reported that culture and religion shape the shared values, morals, and code of conduct and construction of illness's meaning in the Kanuri community. Also, that religion profiles Kanuri people's values and beliefs, influencing how they expressed their lived PTSD experiences. We found that the Kanuri people respond to trauma following what it means to them. Therefore, meaning matters more than the diagnosis of the lived PTSD experiences because the diagnosis of PTSD was somewhat partial but not fully applicable to the Kanuri culture. We also established that the Kanuri community's interpretation of PTSD symptoms is expressed and described based on cultural, traditional, and religious worldviews.

Therefore, our study finding corresponds with other studies that concluded that the use of metaphor in the language is considered universal but shaped by cultural differences, which is also profoundly tied to the history and development of a culture and its language. The culturally specific metaphors entailed communal human experience, within one community or across cultures Martínez-hernáez, (2013). The present finding also supports studies conducted elsewhere that concluded that culture supplies people with behavioral patterns, ways of thinking, and feelings. It is an acquired "lens" through which individuals perceive and understand the world they inhabit and learn how to live within it. Cultural practices influence individuals through the socialization process. Thereby shaping individual responses to extreme and unpredictable events. Rolf, Charles (1995). However, scholars argued that research had provided evidence pointing to the universality of PTSD despite cultural differences. They argue that biological reactions to traumatic experiences are universal because the activation of specific endocrine and neurotransmitter pathways are found to regulate a specific brain region that regulates fear behavior in the event of exposure to trauma (Hinton et al., 2011). Nonetheless, we found this evidence as physiological rather than psychological in explaining traumatic experiences cross-culturally. Therefore, Kanuri people expressed their lived

PTSD experiences more significantly in cultural terms than physiological and/or psychological Sherin and Nemeroff (2011).

We also engaged our participants in discussions relating to the kind of help given to someone suffering from symptoms of PTSD-8 in their community. Findings from the study have shown that the Kanuri people's prevailing belief was that only the Sheikhs and traditional healers and message from the Qur'an could heal an illness or disease completely. These findings confirmed some qualitative studies that reported religious beliefs, and social support, among other things, as coping strategies among Sudanese refugees in Australia (Khawaja et al., 2008; Schweitzer et al., 2007). Also, found that the hospital only cures the illness but does nothing to address the cause.

Therefore, based on our observations and as demonstrated by our data, we found that the Imams (Sheiks) are highly respected, even seen as divinely selected and sinless individuals in Kanuri culture. Furthermore, we found that the views of these Sheikhs on anything are respected and persuaded by all community members. Apart from religious teachings, the Imams (Shaikhs) also offer religious healing to any community's illnesses or diseases. Studies with the Sudanese refugees in Brisbane and Australia supported these findings. Both studies suggested that religious beliefs and social support are critical factors that help Sudanese refugees cope with mental health issues, particularly traumatic experiences (Schweitzer et al., 2007; Khawaja et al., 2008). However, a quantitative study with Sudanese Christians and Muslims reported a significant association between higher psychological well-being with higher social support, particularly from family members and the Sudanese community even outside their country of origin (Schweitzer et al., 2006). Therefore, despite the nature and severity of the context-specific traumatic experiences even within the African ecology, our findings suggest Afri-ecology's importance on the collective experience, perception, interpretation, and understanding of trauma experience and response behavior. In this context, Afri-ecology means the African Worldview of an individual that is knotted with the culture, tribe, and the entire community, which cannot be understood in isolation.

Also, traditional healers are found to be among the foremost people in the Kanuri community. The traditional healers are believed to have supernatural powers that enable them to communicate with spirits in providing healing to members of the community. Therefore, we can report that most of the Kanuri people prepare to visit religious leaders and/or traditional healers before going to hospitals on rare occasions because most of the illnesses and even diseases are believed to be a result of destiny, misfortunes, evil spirits, and witchcraft. This finding is supported by Baron's claims that Southern Sudanese refugees in Uganda believed that psychosocial problems are caused by misfortune to do with spirits, unperformed rituals, or curses (Baron, 2002). Our findings also confirmed that most Kanuri people refer to traditional/cultural and religious healing to cope and adjust to their lived PTSD experience.

Our study agrees relatively well with Tseng, who argued that the bio-medical model on which western medical knowledge support believes that diseases are universal and independent of time and place. Therefore, the focus on healthcare is purely biological without attention to the alternative perception of signs and symptoms of culturally specific illnesses or diseases. Consequently, this model neglects the importance of cultural diversity in the manifestation of illness behavior and the interaction between the individual and the outside world in generating illness. It also, do away with the perception of illness, shaping, and the manifestation of symptoms and reaction patterns Tseng, (2011). Therefore, this study suggests that the western medical model should consider setting or context more important while implementing intervention approaches in non-western cultures. Hence, the present study emphasizes that those cultural realities are essential towards shaping and providing contextually relevant intervention and healing for trauma in a non-western culture. Therefore, our findings supported research findings that reported a help-seeking behavior pattern to conform with the professional and traditional approaches to the intervention in culturally sensitive communities. Certain cultural factors are considered significant as they affect the conception, manifestation, diagnosis, subjective experience prognosis of mental disorder, and family and community beliefs (Minas, & Silove, 2001).

The sampled Kanuri people were also engaged in discussing the meaning and understanding of trauma symptoms in their community and culture. Findings from the study provide evidence that understanding the meaning of PTSD and belief about traumatic experiences among the Kanuri people differ significantly from the western psychological world views. However, the western model assumed that trauma impacts the individual's body and mind. Therefore, therapeutic engagement requires one-to-one interaction between the client and the therapist. Nevertheless, this study's findings have shown that the perception of traumatic events, experiences, and therapeutic relationships among the Kanuri people is shared and communal. We also found that the causal attribution of lived PTSD experience does not represent the traumatic events. The Kanuri people are found to attribute the cause of their lived PTSD experiences to destiny, calamity, and tragedy. These findings suggested that Kanuri people believe that the body and mind are not relevant in expressing trauma symptoms or the lived PTSD experiences. Therefore, our findings relatively agree with (Goodman, 2004) studies in the USA, which reported that the unaccompanied Sudanese refugee youth maintained high resilience levels using suppression and distraction, focusing on the collective and communal self, thereby making meaning and retaining hope.

Whereas religious and traditional healing practices provide the desired PTSD intervention as understood by the majority of the Kanuri people, the western psychological worldviews provided that the mind and the body are always the targets for PTSD intervention. However, this study's findings suggest that the Kanuri people's causal attributions enable them to internalize their lived PTSD experiences by how the culture socialized them. Those socialization patterns have helped the Kanuri people feel relaxed, hopeful, and even developing the desired self-esteem to go on with their daily activities. Therefore, our study findings corroborated study findings, which confirmed that not only do symptoms vary across cultures, nevertheless, culture also affects how disorders are understood, explain, and cope with Kirmayer and Minas, (2000). Other studies found to be consistent with the present findings reported that the health belief of non-western cultures adheres mostly to a complete perception of health, which varies across cultural context is therefore contrary to the western division of mind and body. Therefore, mental illness in non-western cultures is interpreted or meant to be caused by supernatural means or spirit (Kuittinen Saija, Raija-Leena Punamäki, Mulki Mölsä, Samuli, Saarni & Honkasalo, 2014).

Accordingly, in this study, we found that local phenomenologies of the lived PTSD experiences in Kanuri culture influences how trauma affects community members' mental health experiences. In addition to a distinct and peculiar healing practice aimed at reducing the symptoms. As such, those found with diagnosable PTSD among the sample Kanuri people are significantly well-adjusted and living a healthy life. Therefore, our findings relatively agree with studies, which questioned the Western intervention model's universal application as a form of healing approach regarding different forms of psychological distress in other contexts. Those findings, therefore, recommend as essential for an intervention to be effective; it must be sensitive to the beliefs and practices of the people in a given culture (Bracken, Giller, & Summerfield, 1995). To further confirm and support the present study's assertions, studies from the literature also suggested that every culture has its psychological range of meaning attached to events and modes of seeking help. Since the effect of traumatic events depends on what they mean or come to mean to those affected. Hence, what these findings mean there are no universal post-traumatic responses Summerfield (1995a).

However, it is imperative to acknowledge that our study's findings have some limitations, which might hamper the study's generalization to other populations. Although Schwandt suggested that findings from a qualitative study are not meant for generalization from a sample to the population, it transfers what is learned about one group to other groups in a similar context (Schwandt, 2007). Thus, the study population's homogeneity limits the understanding and exploration of similar experiences from other ethnic groups within the community. Secondly, the expression of the lived PTSD experiences by the sample Kanuri people were mainly based on retrospective accounts. Therefore, individuals' subjective nature, coupled with the delay in the PTSD endorsement, may likely affect the experience' expressed during data gathering. Thirdly, we did not categorically explore the cultural descriptors of the PTSD symptoms to equate them with the PTSD criterion as outlined in DSM classification.

Despite the limitations of our study, it is glaringly evident that it advances the need for incorporating cross-cultural approaches to PTSD healing into clinical practice. Integrating the local categorization and healing practices will promote appropriate desired behavior to improve the Kanuri people's adaptive capacity to cope with and alleviate the lived PTSD experiences. Consequently, the lack of an integrative approach would result in a potential failure to identify the actual sufferers of PTSD experience with those who are not. Therefore, the implication of our findings demonstrates the need for mental health care providers, clinicians, researchers, and policymakers to consider integrating traditional and indigenous resources with the western psychological approach to PTSD intervention and healing in Kanuri culture.

Conclusions

Our study concludes that any PTSD approach that ignores the cultural descriptors and categorization of PTSD symptoms, understanding of meaning, and healing practices may not be appropriate in the Kanuri community. Although many authors have continued to argue that PTSD and its features are seen across cultures, others see PTSD and its symptoms as explicitly constructed in a European-American context and so not applicable to culturally diverse groups (Auxéméry, 2012; Kira and Tummala-Narra, 2015; Summerfield, 2001; Young, 1995). However, despite the argument, other Scholars reported that historically most cultures had a way of framing reactions to trauma within the context of religion, with priests and shamans offering an interpretation of the causes or meanings of traumatic events while also serving as healers (Herbert J. D. and Forman E. M., 2010). Similarly, our study found the use of linguistic metaphors in describing PTSD symptoms and the utilisations of Shaikhs (Mallams) and traditional healers to help the Kanuri people cope with and alleviate their suffering acquired through the lived PTSD experiences. Therefore, clinicians and researchers need to avoid accentuating the universalism of PTSD responses by focusing on the diversity of PTSD experiences across cultures. Therefore, we argue that ignoring the cultural diversity of PTSD responses could introduce inappropriate healing approaches or models in the Kanuri community. Therefore, it is essential to consider how cultures employ strategies to assist those suffering from lived PTSD experiences. Finally, we recommend that it is also important to note that understanding the expression of PTSD

experience, categorization of symptoms, and the Kanuri people's cultural healing practice has significant clinical implications.

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Competing interests

The author declare no competing interest.

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