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The Efficacy of Psychoeducation on Psychological Trauma Victims of Violent Communal Attack and Internally Displaced Persons (IDP) in Bassa Local Government Area of Plateau State, Nigeria

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Abstract. Nigerian communities have experienced a succession of relentless and unending invasions stemming from banditry, communal violence, abduction and other types of insurgencies, leaving citizens in pain, devastation and despair. Undoubtedly, the readily accessible interventions mostly consisted of material support, which does not seem to focus on the mental and emotional aspects of the trauma. It is on this premise that this study investigated the interplay of community trauma incidents, psychoeducation and coping resources, together with the variability in the severity of traumatic experiences during the period of residence in internally displaced persons camps. An experimentation-based strategy was employed, with a total of $N = 120$ internally displaced individuals between the ages of 18 and 70 (mean age ≈ 44.00, SD = 15.01). A baseline test was administered to measure the severity of trauma among the participants; those with high scores were then randomly assigned to the control or intervention group. The result of an independent t-test for the difference in psychological trauma between the control and experimental groups at post-test showed a significant difference in mean scores of psychological trauma between the treatment and control groups: $t(88) = 4.70$, $p < .001$ ($p < .05$), with mean scores of 66.80 (control) and 60.71 (intervention). This implies that psychoeducation reduced psychological trauma for the victims of violent communal attacks. Also, a mediation analysis using Hayes' PROCESS indicated lower levels of psychological trauma, suggesting that psychoeducation independently predicts reductions in psychological trauma, regardless of participants' ages. In sum, psychoeducation intervention is a coping skill for managing psychological distress in a crisis-based situation. Therefore, employing a holistic approach that includes psychoeducation to manage traumatic conditions in Nigeria will help victims heal and recover from traumatic experiences.

1. Introduction

Psychoeducation is a strategy to navigate everyday challenges and build coping mechanisms for a balanced life. It is understood as systematic, structured and didactic information about an illness and its treatment options to enable patients and family members to cope with it (Bauml, 2006). This strategy entails boosting knowledge and awareness among individuals and their families through guidance, resources and skills that foster understanding and the development of coping strategies that promote self-management and ameliorate mental health issues and life challenges (Gang, 2024). It is typically provided in a variety of contexts, such as healthcare settings, community outreach programmes, educational institutions and virtual platforms. It incorporates all-inclusive treatment programmes for a range of social, physical and mental health challenges (Gang, 2024).

Plateau State has experienced a series of relentless assaults that have caused suffering and distress among its populace. For years, human lives and property have been lost. Communities have been terribly ravaged, resulting in people experiencing anxiety, trauma and profound fear of potential future occurrences. The Plateau State Peace Building Agency (2025) revealed that over 31,000 households have been displaced in Barkin Ladi, Bassa, Bokkos, Mangu and Riyom Local Government Areas (LGAs) of Plateau State, while armed groups continue to occupy several ancestral areas, and the inhabitants remain in displaced camps. Also, in 2025, the International Organisation for Migration (IOM) reported that a series of attacks by armed bandits in Bassa and Riyom LGAs affected

1,203 individuals from 373 households, with 672 children and 345 women living in different displacement camps

As reported by the Plateau Peace Building Agency in 2025, violent attacks have become increasingly pervasive and lethal, affecting local administrations, notably Bassa, in cycles of reprisal, communal disaster and targeted killings. Despite security measures, unrest grew worse between 2020 and 2025, culminating in attacks in Zikke, Kimakpa, Maiyanga, Kishsha, Kpachudu, Nche-tahu, Zarama, Ancha, etc., which resulted in the killing of many people, destruction of homes and property, and burning of agricultural products. This has resulted in internally displaced persons (IDPs) in various camps as a result of loss of homes, leading to pain and other traumatic experiences. With these IDPs having disjointed and unpleasant experiences in multiple camps, it is critical to support them in building resilience and developing psychological interventions for adjustment and coping mechanisms. Trauma is an experience that shocks all systems of wellness (emotional, cognitive, physical, spiritual and social) and fragments a survivor's self-regulation and internal narrative of the past, present and future (Phipps et al., 2007).

The United Nations Secretary General defined IDPs as "persons or groups of persons who have been forced or obliged to flee or to leave their homes or places of habitual residence, in particular as a result of or to avoid the effects of armed conflict, situations of generalized violence, violations of human rights, or natural or human-made disasters, and who have not crossed an internationally recognized state border" (United Nations UN, 1998, p. 1). In Nigeria, fleeing conflict and ethnic/religious crises is the most frequent cause of internal displacement. Over a million Nigerians have fled their homes due to Boko Haram's ongoing insurgent activities and the ongoing attacks by herdsmen, creating a massive humanitarian crisis, particularly in the country's northeast (Internally Displaced by Conflict and Violence, 2015). People are typically exposed to a wide range of horrifying experiences during forced displacement, including the destruction of individual belongings, shortage of food, separation from family members, disappearance of loved ones and death of close family members. These traumatic occurrences can be life-threatening, particularly when they overwhelm an individual's stress response system (Brewin & Holmes, 2003).

Owoaje et al. (2017) identify various risk factors, including large population movement and resettlement in temporary sites, overcrowding, poor economic and environmental hygiene, poverty and a lack of safe drinking water, all of which contribute to disease spread. Specifically, in Bassa's IDP camps, victims of communal violence are supported through medical care, limited psychosocial intervention and material relief. However, there is a significant gap in the availability of psychological interventions due to severe shortage of mental health resources (Stopping Nigeria's Spiralling Farmer-Herder Violence, 2018; Volatile Plateau State in Nigeria's Middle Belt, 2023).

Incidences of Violent Communal Attacks in Nigeria

Over 1.25 million IDPs were identified in Nigeria in the assessed displacement sites covering 216,288 households as of March 2025, according to the IOM Displacement Tracking Matrix. In this report, there were about 65,000 IDPs in Plateau State in the middle of 2025 as a result of continuous conflict and violence; many of them lived in IDP camps or concentrated settlements in Bokkos, Barkin Ladi, Mangu LGAs and other areas. The Plateau State Emergency Management Agency reported that a total of 38,051 IDPs are taking refuge in 31 camps in the state owing to violence. Armed banditry and kidnapping accounted for 45 per cent of the displacements, while communal clashes were the main reason for displacement in 27 per cent of the IDP locations. Increasing tensions between nomadic herders and sedentary farmers accounted for 19 per cent of the displacement in the region. Six per cent of displacements resulted from natural disasters, while 4 per cent were generated by the spillover of the insurgency in northeast Nigeria (IDP Atlas, 2024).

Nextier, a non-governmental organisation, in its 2025 annual report, claimed that the Violent Conflicts Database indicated that Nigeria experienced 43 incidents of terrorism and 1,306 bandit attacks in 2024. The North Central region led the statistics with 416 casualties, or 89.1 per cent of the total, and 42 violent occurrences, representing 68.9 per cent of those involving farmers and herders. The harm was mostly caused by insurgency, kidnapping, rural banditry, land conflict, and counter-operations of government security forces. In 2023, Borno State ranked as the most dangerous state in Nigeria, registering 29.03 fatalities per 100,000 inhabitants, primarily due to the Boko Haram conflict. Following closely were Plateau (14.29) and Benue (12.68) States (*Thirteenth Report on Violence in Nigeria,* 2023).

Self-efficacy Model in Psychoeducation

Self-efficacy is a conviction-based construct that argues that an individual can effectively perform the actions required to achieve the intended results

(Bandura, 1977). Within the realm of health, self-efficacy pertains to an individual's level of assurance in their capacity to engage in behaviours that promote well-being, such as sticking to implementing essential lifestyle adjustments. The concept of self-efficacy is a crucial factor in comprehending and promoting adjustment among the target population.

The level of self-efficacy is believed to substantially impact the degree to which employees with health challenges adhere to treatment recommendations. In the view of Lorig et al. (2021), individuals with greater self-efficacy are more inclined to owning to their confidence in their abilities to manage their health issues effectively. This implies that psychoeducation is aimed at enhancing self-efficacy. Intervention solutions grounded in the self-efficacy paradigm frequently include several behaviour-change techniques, particularly goal formulation, problem-solving and mastery of experiences.

1.1 Study's Aim

Given all of the aforementioned outcomes, psychoeducation becomes important in identifying traumatic experiences and coping resources, as well as developing a framework to support those who are or will be in such situations. Therefore, the purpose of this study is to investigate the relationship between community trauma attacks, psychoeducation and coping resources, as well as the variations in the intensity of traumatic events over the course of time spent in IDP camps.

1.2 Hypotheses

H1: Internally displaced adults residing in camps who receive psychoeducation would show enhanced life coping skills compared to those who do not receive the intervention.
H2: Participants exposed to psychoeducation will report lower levels of psychological trauma, and this relationship will be direct, with no mediation effect of age.

2. Research Methodology

2.1 Participants and Setting

The experimental design was employed, involving a total of $N = 120$ internally displaced persons selected from Bassa Local Government. All the participants were between the ages of 18 and 70 ($M\ age \approx 44.00$ and $SD \approx 15.01$). The few camps visited were created in an ad hoc way and remain informal (WHO, 2024). However, 98% of the IDPs live in host communities (IOM, 2023).

Table 1: Distribution of the Participants across Displacement Locations in Bassa Local Government Area

Location / Displacement Site	n
Government Primary School, Zikke	60
Makeshift Church Sites, Miango	35
Kwall Community Centres	25
Total	120

The participants were selected from government primary school facilities, temporary church locations and community centres for internally displaced persons in the Bassa Local Government Area of Plateau State using the multistage cluster sampling method. It is a practical and robust strategy for increasing representativeness and feasibility while studying difficult-to-reach populations, such as IDPs (Cochran, 1977). In order to assign the participants to intervention and control groups, they were allocated unique identification numbers drawn from random number tables. This technique enhanced, validated and represented numerous camps inside the local government area.

2.2 Measures

Impact of Event Scale–Revised (IES–R)

Weiss and Marmar (1997) designed the Impact of Event Scale-Revised (IES–R). It is a concise, specific and individualised assessment of current distress, especially that which is associated with a recognised traumatic experience (violent attack, death, sexual abuse, property loss, etc.). The response is given on a 5-point Likert scale:
0 = Not at all
1 = A little bit
2 = Moderately
3 = Quite a bit
4 = Extremely

The IES–R is scored by summing responses (0-4) across its 22 items, with a total score of 33 or higher indicating a clinically significant level of post-traumatic distress. It has an excellent internal consistency, meaning the Cronbach's alpha coefficients are consistently high ($\alpha > .90$ (often .94-.96)). Consequently, the test-retest reliability over the short periods (one to two weeks) yielded correlations (r) ranging from .89 to .94 for the total score.

Attitudes Toward Seeking Professional Psychological Help Scale – Short Form (ATSPPH-SF)

The Attitudes Toward Seeking Professional Psychological Help Scale–Short Form was modified and shortened based on the previously established self-report measure on attitudes toward seeking professional psychological help by Fischer and Farina (1995). This scale evaluates attitudes toward the pursuit of professional psychological assistance. The value of this tool lies in its robust psychometric foundation and its applicability in both research and practical contexts to pinpoint persons who may possess negative or stigmatised beliefs that might impede access to mental health services.
The items are statements answered on a 4-point Likert scale from 0 to 3:
0 = Disagree
1 = Partly Disagree
2 = Partly Agree
3 = Agree
Scoring: Items 2, 4, 8, 9, and 10 are reverse-scored. After reverse scoring, all scores are summed.
The ATSPPH-SF is generally considered reliable for research purposes, revealing a good internal consistency (Cronbach's alpha .84).

2.3 Study Procedure

This study was approved by the respective chairpersons of the Bassa IDP camps, with verbal authorisation from the respective community leaders at Kimapa, Zikke, and makeshift camps in Miango. Written permission was also obtained from the university ethics board (Ref. PSY-PLASU: IDPs-2025). The selection of potential participants conformed to the study's eligibility criteria, specifically adults aged 18 to 70 years, as stipulated by the World Health Organisation (1989), and those with higher baseline scores on the Impact of Event Scale-Revised (IES-R), indicating the experience of traumatic stress following violent communal attacks and residing in the aforementioned IDP camps. All individuals residing outside the camps and minors within these camps were excluded from the research.

The mentioned scales and psychoeducation instruction were administered and returned immediately. All individuals with difficulties in understanding the questionnaire text and the instructions were supported by members of the research team by reading and explaining the questions and scenarios.

2.4 Psychoeducation Intervention

The psychoeducational facilitator led teaching in the IDP camps in Miango and Kwall, adopting a structured approach that provided practical coping strategies through instructional worksheets and simulated situations for skill development (Barrett et al., 2006; Uysal et al., 2024). During the session, the participants were asked to talk about experiences. This was followed by development of practical skills and application of the evidence-based knowledge acquired to actual-world trauma coping scenarios. Focus was then placed on skills-based support (breathing, problem-solving and MHGAP first-line psychosocial interventions, 2016). This toolkit is designed for trained facilitators, teachers and community workers, consistent with mhGAP task-shifting principles (mhGAP stepped-care models, 2016). The framework mapping—WHO mhGAP Toolkit (2016)—was employed to identify prevalent responses to violence and displacement, recover psychological stability, and enhance coping mechanisms and trust.

In the psychoeducation sessions, the facilitator employed language that was easily understood to better understand and express emotions such as anger, sadness, regret, fear, traumatic experiences, exhaustion, headaches, physical discomfort, withdrawal, agitation and concentration difficulties within the fundamental psychoeducational content. The objective of the session was to lower the fear and disorientation associated with trauma reactions, enhance emotional regulation and coping strategies, and restore a sense of security, resilience and community support.

Each segment of the psychoeducation session, lasting between 20 and 40 minutes, started with a 5-minute introduction aimed at establishing ground rules for secrecy, privacy, respect and voluntary withdrawal when they feel uncomfortable. Subsequently, the participants engaged in a 10-minute discussion on "What Changed after the Attack", describing changes in their physical experiences, mental and physical processes, or moods, while the facilitator recorded prevalent themes, such as fear, trouble sleeping and anxiousness. The session ended with a 20-minute educational component that communicated a message of hope, reminding the participants of the possibility of recovery and presenting coping strategies to control their reactions, thoughts and emotions. During the activity, strict precautions were adhered to: the participants were not required to disclose specifics of the traumatic incident; the facilitator carefully observed for evidence of distress and provided support; and severe cases were transmitted in accordance with the existing mhGAP protocols.

2.5 Ethical Concerns

The internally displaced adults who were 18 years and above who indicated their interest were given the information sheet about the research or had it read out

to them, and subsequently filled out and signed the consent forms before the administration of the intervention. All participants were duly informed about their freedom to withdraw from participation at any time they felt uncomfortable.

2.6 Data Analysis

Independent Variable: Psychoeducation programme (before vs. after and intervention vs. control).
Dependent Variables (Outcomes): traumatic experience scores (fear, sleeplessness, and depression), knowledge or awareness scores, coping self-efficacy and well-being.

Based on the description above, bootstrapped mediation analysis using the PROCESS model was employed to examine psychoeducation and violent trauma attacks. Subsequently, since it was health and psychoeducation research, a regression-based moderation analysis using an interaction term (i.e. Hayes' PROCESS Model 1) was conducted, as the predictor was categorical (i.e. intervention vs. control), the moderator was continuous (i.e. trauma exposure/severity, age and resilience), and the outcome was continuous, focusing on trauma symptoms and knowledge score.

Finally, the baseline and post-test scores were compared using a Paired t-test to compare the mean scores before vs. after for the same group, i.e. trauma experience scores pre- vs. post-psychoeducation.

3. Results

The results are organised in line with the study hypotheses and supported with statistical procedures. The descriptive results begin with the baseline analysis to establish the study groups (pre-test and post-test) among the participants prior to the implementation of the intervention. This provided a basis for assessing initial group equivalence and comparing subsequent changes in trauma-related outcomes following the psychoeducation programme.

Table 1: Socio-demographic characteristics at baseline (N= 120)

	Frequency	Percentage %
Age (Mean±SD)	52.7±15.4	
Gender		
Female	82	68.3
Male	38	31.7
Marital Status		
Married	85	70.8
Single	20	16.7
Widowed	15	12.5
Occupation		
Farmer	58	48.3
Trader	62	51.7
Educational Level		
Degree	5	4.2
Diploma	5	4.2
No education	80	66.7
Primary	15	12.5
Secondary	15	12.5

Table 1 presents the baseline sociodemographic characteristics of the participants (N = 120). The mean age of the respondents was 52.7 years (SD = 15.4), indicating a predominantly middle-aged to older adult population. In terms of gender distribution, females constituted the majority (68.3%), while males accounted for 31.7%. Most of the participants were married (70.8%), with smaller proportions being single (16.7%) or widowed (12.5%). Regarding occupation, the sample was fairly balanced between traders (51.7%) and farmers (48.3%). Educational attainment was generally low, with a substantial majority of the participants (66.7%) having no formal education, while only a small fraction had attained primary (12.5%), secondary (12.5%), diploma (4.2%), or degree-level education (4.2%). Overall, the findings suggest that the study population was largely composed of older, married females engaged in informal occupations, with limited educational background.

Pretest

The pre-test assessment of psychological trauma among the randomised participants was conducted to determine baseline equivalence between the control and intervention groups prior to the intervention (Table 2).

Table 2: Mean scores of psychological trauma across study groups at pre-test

Group	N	Mean Psy. Trauma	SD	t	df	*P*
Control	45	66.47	6.11	-.086	88	.932
Intervention	45	66.58	6.14			

Table 2 captures the pre-test mean scores of psychological trauma for the control and intervention groups. The results indicated that the control group (M = 66.47, SD = 6.11) and the intervention group (M = 66.58, SD = 6.14) had very similar levels of psychological trauma at baseline. An independent samples t-test showed no statistically significant difference between the two groups, t(88) = -0.086, p = .932 (p > .05). This suggests that both groups were equivalent in terms of psychological trauma symptoms prior to the intervention, thereby establishing baseline comparability and supporting the internal validity of subsequent outcome comparisons.

Posttest

The post-test data were analysed following the implementation of the psychoeducation intervention to assess changes in psychological trauma among the participants. This facilitated the evaluation of the effectiveness of the intervention by comparing post-intervention outcomes.

Table 3: Independent t-test mean difference in psychological trauma between the control and experimental groups at post-test

Study Group	N	Mean scores	Standard deviation	t	df	p-value	Cohen's d
Control	45	66.80	6.13	4.696	88	<.001	0.99
Experimental	45	60.71	6.17				

Table 3 shows the independent t-test for the difference in psychological trauma between the control and experimental groups at post-test. The result indicated that there was a significant difference in mean scores of psychological trauma between the treatment and control groups, t(88) = 4.70, p < .001 (p < .05), with mean scores of 66.80 (Control) and 60.71 (Intervention). The experimental group had a significantly lower mean score on psychological trauma than the control group. The hypothesis was supported. This implies that psychoeducation significantly reduced the psychological trauma of victims of violent communal attack. The effect size was large, Cohen's d = 0.99 (≈ 33%), indicating a substantial practical effect.

Table 4: Direct, indirect and total effects of psychoeducation on psychological trauma

Effect Type	β	SE	t	*p*	95% CI Lower	
					Lower	Upper
Total Effect	-6.09	1.30	-4.70	< .001	-8.67	-3.51
Direct Effect	-6.13	1.29	-4.76	< .001	-8.69	-3.57
Indirect Effect	0.04	0.21			-0.39	0.55

A mediation analysis using Hayes PROCESS Model 4 was conducted to examine the direct, indirect and total effects of psychoeducation on psychological trauma, with age as a potential mediator (Table 4). The total effect of psychoeducation on psychological trauma was statistically significant, β = -6.09, SE = 1.30, t = -4.70, $p < .001$, indicating that the participants exposed to psychoeducation reported significantly lower levels of psychological trauma than those in the control group. When age was included in the model, the direct effect of psychoeducation on psychological trauma remained statistically significant, β = -6.13, SE = 1.29, t = -4.76, $p < .001$. This suggests that psychoeducation independently predicts reductions in psychological trauma, regardless of participant's age.

The indirect effect of psychoeducation on psychological trauma through age was not statistically significant, β = 0.04, BootSE = 0.21, 95% CI [-0.39, 0.55], as the confidence interval included zero. Additionally, psychoeducation did not significantly predict age, β = -1.82, SE = 3.16, t = -0.58, $p > .05$, nor did age significantly predict psychological trauma, β = -0.23, SE = 0.14, t = -1.61, $p > .05$. Furthermore, the interaction between age and psychoeducation was not significant, β = 0.10, SE = 0.09, t = 1.18, $p > .05$, indicating that the effect of psychoeducation on psychological trauma does not vary across different age levels. The findings indicate that age does not mediate the relationship between psychoeducation and psychological trauma. The effect of psychoeducation on reducing psychological trauma among victims of violent communal attacks is primarily direct.

4. Discussion

In this study, the pre-test scores of psychological trauma for both the control and intervention groups showed comparable levels at baseline, indicating that

both groups were equivalent in terms of psychological trauma symptoms before the intervention. This establishes baseline comparability and reinforces the internal validity of subsequent outcome comparisons. Subsequently, the post-test data were collected to evaluate changes in psychological trauma following the implementation of the psychoeducational intervention.

The intervention proved effective when comparing outcomes. Above all, the psychoeducation protocol resulted in significantly lower levels of psychological trauma in the intervention group than the control group. When age was included in the model, psychoeducation's direct effect on psychological trauma remained statistically significant. This shows that psychoeducation predicts decreases in psychological trauma independent of participant age.

Importantly, the outcome of this study revealed that exposure to psychoeducation is essential for identifying coping strategies and formulating an action plan that will benefit those presently or possibly facing traumatic situations. This study examined the interplay of community trauma incidents, psychoeducation and coping strategies, along with the variability in the severity of traumatic events during a period of living IDP camps.
In this study, the victims of violent communal attacks who received psychoeducation at the intervention stage reported significantly lower levels of psychological trauma symptoms compared to those who did not receive psychoeducation. Consequently, it may be deduced that offering help to persons affected by communal violence should include psychoeducation to provide coping skills in IDP camps. Interventions in IDP camps have mostly consisted of palliative, pastoral and medical care, relegating trauma coping to a secondary mode of intervention, which would further complicate the coping processes.

Long-term displacement is noted to have negative consequences, such as higher rates of illness, food insecurity and mental health problems (De Bruijn, 2009; Siriwardhana et al., 2015; Mubarak et al., 2016; Food & Agriculture Organisation of the United Nations (FAO), 2022). According to Salama et al. (2001) and Roberts et al. (2009), all IDPs are susceptible to long-term challenges that may persist for many years after the crisis.

The various aspects of traumatic events encountered by individuals in IDP camps will inevitably influence their physical and psychological health, necessitating the use of psychoeducation to build resilience. This therapeutic approach integrates educational and therapeutic components to empower individuals and their families, reduce unpleasant experiences (trauma), improve insight into illness, and reduce relapse through knowledge and skill development (Colom et al., 2006). It has been argued that psychoeducation could instead focus on cognitive and behavioural approaches, such as motivating discourses and coping strategies for managing general life stressors, to encourage behavioural change to enhance overall individual well-being.

The study also analysed the direct, indirect and overall impacts of psychoeducation on psychological trauma, taking into account age as a possible mediator among victims of the communal attack. The research suggests that psychoeducation independently predicts reductions in psychological trauma, irrespective of the participant's age. Better mental health treatment increases life expectancy, resulting in a growing elderly population. As noted by World Health Organisation (2021), psychoeducation promotes healthy ageing and lowers the prevalence of mental disorders in older persons. Psychoeducation programmes increase knowledge and encourage behavioural adjustments related to decreased cognitive decline (Livingston et al., 2020).

5. Limitation of the Study

The study is limited in several ways. First of all, the sample size was clearly limited, which might affect how broadly this result can be generalised. Secondly, the fact that the intervention only used a limited sample size over a short period of time raises serious concerns about methodological limitations. The study's reliability would have been further reinforced if all the population, that is adults and adolescents of all ages affected by this recurrent communal attack, had participated. Lastly, the research was restricted to Bassa Local Government Area and did not cover the entire of Plateau State and areas in Nigeria impacted by communal attack. However, the findings sufficiently capture the usefulness of psychoeducation to the well-being of IDPs.

6. Implication of the Study

Frequent communal assaults, including banditry, kidnapping and other insurgencies, have devastated numerous Nigerian communities, subjecting individuals and families to distressing experiences that adversely affect their physical and psychological well-being, resulting in their relocation to various internally displaced persons (IDP) camps. Various interventions have been implemented in this region as humanitarian

gestures, like donations of food items, financial assistance, provision of building materials, and physical or medical support. To be able to treat the emotional component of trauma among the affected individuals in Plateau communities, psychological interventions such as psychoeducation ought to be given top priority since it is believed to empower people with life coping capacity.

Based on the findings of the study, employing a holistic approach that incorporates psychoeducation to manage trauma in individuals exposed to unpleasant life conditions in this region of the country will help the victims heal and recover without experiencing a substantial relapse of their traumatic conditions. Additionally, the study recommends that policymakers, the government, religious institutions, enthusiastic individuals and international organisations need to put into effect comprehensive measures that will involve employing highly qualified psychologists to support individuals whose traumatic experiences have caused them greater distress.
Lastly, funding for the establishment of specialised psychological facilities with qualified experts at crisis flashpoints is essential. This is good for empowering and training victims of communal attacks to develop life coping skills.

7. Conclusion of the Study

Psychoeducation, which is a systematic, organised and didactic transfer of knowledge about a specific mental health condition, treatment and coping strategies, has progressed from a peripheral adjunct to a key component of evidence-based mental healthcare (Lukens & McFarlane, 2004). This study revealed that psychological services have not been investigated as an option in mediating traumatic experiences and the coping resources of victims of communal violence in Nigeria. Finally, the study showed that individuals who have experienced a number of communal attacks and currently reside in various IDP camps are more likely to develop coping skills that are essential to managing psychological distress when psychoeducation intervention is employed.

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