

## The Invisible Wounds of War: Somatic Manifestations of Psychosocial Trauma Among Women in Communal Land Conflict Areas in South Western Nigeria

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### **Abstract:**

Globally, the health impacts of communal conflict are often measured in mortality and physical injury, while the pervasive, non-visible somatic manifestations of psychosocial trauma remain critically under-diagnosed and untreated. This qualitative study investigates the somatic experiences of women affected by the protracted communal land conflict in Ilobu, Ifon-Osun, and Erin-Osun, Nigeria. Based on a phenomenological research design, data were collected through 12 in-depth interviews, 3 focus group discussions, and 9 key informant interviews with affected women, community leaders, and health workers. Thematic analysis reveals that women's psychological trauma is profoundly embodied, presenting as a spectrum of somatic disorders including reproductive health complications (pregnancy loss, menstrual irregularities), chronic pain, gastrointestinal distress, cardiovascular issues like hypertension, and severe sleep disorders. These symptoms are directly linked by participants to the chronic fear, displacement, and economic devastation experienced during the conflict. The findings underscore a critical gap in humanitarian and clinical responses, which are ill-equipped to recognize or treat trauma expressed through physical ailments. The study concludes that effective intervention in conflict zones requires a paradigm shift towards integrated, trauma-informed healthcare that bridges the mind-body divide, particularly for women who bear a disproportionate burden of gendered precarity.

**Keywords:** Communal Conflict, Gendered Precarity, Global Health, Psychosocial Wellbeing, Somatic Trauma.

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## 1. INTRODUCTION

Communal conflicts over land and resources represent a significant global challenge to public health, stability, and sustainable development. While the immediate violence of such conflicts claims headlines, the enduring, insidious health consequences particularly those mediated through psychological trauma often unfold silently, long after the guns fall silent (Hoppen & Morina 2020; Murthy & Lakshminarayana, 2006). The global health community has increasingly recognized the high prevalence of mental health conditions like post-traumatic stress disorder (PTSD) and depression in conflict-affected populations (WHO 2022; Charlson et al., 2019). However, a critical and less visible dimension of this trauma is its somatic expression, which is the process by which severe psychological distress manifests as physical symptoms (Tol et. al. 2018; Kirmayer & Jarvis 2019).

This phenomenon is especially salient for women in patriarchal, resource-poor settings, where cultural norms, economic dependency, and the burden of caregiving can constrain the verbal expression of emotional suffering (Kleinman, 1980). In such contexts, the body often becomes the primary canvas for articulating profound distress, leading to a range of medically unexplained symptoms that are frequently misdiagnosed or dismissed within biomedical healthcare systems focused on organic pathology (Kirmayer, 2001). The protracted communal land conflict among Ilobu, Ifon-Osun, and Erin-Osun communities in Osun State, Nigeria, provides a potent case study for examining this dynamic. Here, cycles of violence, arson, and displacement have created a sustained environment of threat and loss, with women positioned at the epicentre of its psychosocial fallout.

Existing literature on this and similar conflicts in Nigeria has predominantly focused on the political, legal, and macroeconomic dimensions (Okoli & Atelhe, 2014; Swu & Roy 2025). Where psychosocial impacts are considered, the analysis often remains at the level of generalized anxiety or PTSD, neglecting the nuanced, embodied experiences of the affected. There is a critical empirical gap in understanding how the trauma of recurrent violence, displacement, and livelihood collapse becomes physically inscribed on women's bodies.

This study, therefore, aims to fill this gap by asking: What are the specific somatic manifestations of psychosocial trauma among women in the Ilobu-Ifon-Erin-Osun communal conflict, and how do these women interpret and navigate these physical expressions of their suffering? Through a qualitative, phenomenological investigation, this study documents the "invisible wounds" of the conflict, arguing that somatic complaints constitute a primary and severely neglected health crisis. This research contributes to broader global health and interdisciplinary scholarship seeking to decolonize trauma theory and develop more effective, culturally competent, and gender-sensitive interventions in conflict zones worldwide.

## **2. LITERATURE REVIEW AND THEORETICAL FRAMEWORK**

### **2.1 Roots and repercussions: The Ilobu-Erin-Osun-Ifon-Osun land conflict**

The protracted communal land conflict between Ilobu, Ifon-Osun, and Erin-Osun in Osun State, Nigeria, represents a profound and enduring crisis, rooted not only in competing territorial claims but in the very identity, survival, and future of these interconnected communities. Situated within the Irepodun and Orolu Local Government Areas, these neighbouring towns share a long history of social, cultural, and economic exchange. Yet, beneath this surface of coexistence simmers a deep-seated dispute over the ownership, control, and boundaries of ancestral lands; a dispute that has escalated over decades into a recurring cycle of violence, displacement, and collective trauma.

The historical roots of the conflict are embedded in pre-colonial settlement patterns and post-colonial administrative manipulations. Communities hold divergent, deeply cherished oral histories and ancestral narratives that assert primacy over the fertile territories in question, particularly the lucrative farmlands in areas such as Opapa (Punch 2023). These historical claims were further complicated during the colonial era and subsequent Nigerian governance through inconsistent boundary demarcations and the imposition of statutory land tenure systems, which often conflicted with customary understandings and sowed seeds of legal and perceptual discord (Punch, 2025).

The contemporary escalation of violence, markedly from 2021 onwards, is driven by a volatile confluence of socio-economic and political factors. The primary catalyst remains intense competition for arable land, a resource that is both an economic lifeline and a symbol of heritage (The Nation, 2025). Population growth and agricultural expansion have increased pressure on this finite resource, transforming land from a communal asset into a scarce commodity over which control is fiercely contested. Compounding this scarcity is the politicization of land and chieftaincy. Local elites, traditional institutions, and political actors have frequently instrumentalized the dispute, mobilizing youth militias and deploying ethno-political rhetoric to assert dominance, secure electoral advantages, or consolidate local power, thereby transforming latent tension into overt hostility (The Nation, 2025).

The operational character of the conflict is marked by recurrent, brutal episodes. Cycles of violence typically involve coordinated raids, targeted arson attacks on homes and market stalls, the systematic destruction of standing crops on farmlands, and direct armed clashes. These acts are often followed by retaliatory strikes, creating a self-perpetuating loop of aggression and vengeance that has normalized violence within the socio-political landscape of the region.

The human and material costs of this enduring conflict are catastrophic. Major escalations between 2023 and 2025 alone resulted in significant loss of life, including non-combatants, and the near-total destruction of critical infrastructure. Hundreds of residences and vital market stalls have been reduced to ashes, severing local economic networks. The deliberate razing of vast expanses of farmland which is the region's

economic backbone, has not only caused immediate financial ruin estimated in the billions of Naira but has also jeopardized long-term food security and livelihood sustainability (The Nation, 2025; Punch, 2023).

The most pervasive impact, however, is the mass displacement of civilians. At the peak of hostilities, it is estimated that over 100,000 residents; a staggering proportion of the area's combined population of approximately 150,000-200,000 people were forced to flee their homes (NPC, 2006; The Nation, 2025). These displaced populations, predominantly women, children, and the elderly, have sought precarious refuge in neighbouring towns, overcrowded makeshift camps, or with distant relatives, leading to a severe humanitarian crisis characterized by homelessness, economic destitution, and acute psychosocial distress. This displacement is not a temporary event but a chronic condition that fractures community cohesion, disrupts generational continuity, and leaves a legacy of vulnerability and bitterness that poses the greatest obstacle to sustainable peace and reconciliation.

## **2.2 The mind-body nexus in trauma studies**

The conceptual division between mental and physical health is a persistent, albeit contested, construct in Western medicine. However, a substantial body of evidence affirms that psychological trauma is not confined to the brain but resonates throughout the entire organism. The neurobiological literature details how chronic stress and fear, hallmarks of life in conflict zones, trigger dysregulation of the hypothalamic-pituitary-adrenal (HPA) axis and the autonomic nervous system (Van der Kolk, 2014). This prolonged state of "fight or flight" can manifest in a wide array of somatic symptoms, including gastrointestinal distress, cardiovascular issues, chronic pain, and immune system dysfunction (Kirmayer & Young, 1998). This is not mere metaphor; it is a psychophysiological cascade where the body keeps score of traumatic experience. In resource-poor and humanitarian settings, where diagnostic capabilities are limited and stigma around mental illness is high, these somatic presentations are often the primary, and sometimes only, way distress is brought to clinical attention (Kohrt et al., 2014).

## **2.3 A gendered lens on somatic expression**

The embodiment of trauma is not a gender-neutral process. Globally, epidemiological studies consistently show that women report higher rates of somatic symptoms associated with depression and anxiety than men (Kirmayer & Robbins, 1991). This disparity is influenced by a complex interplay of biological, social, and cultural factors. From a biosocial perspective, women's health, particularly reproductive health, is highly sensitive to psychosocial stressors, with research linking traumatic stress to adverse outcomes such as pregnancy loss, preterm birth, and menstrual irregularities (Wuest, 2001; Giurgescu et al., 2015). Socially, women in many patriarchal contexts, including Nigeria, are often socialized to internalize distress and may face greater constraints in verbally expressing psychological pain, leading to a phenomenon where the "body speaks" what the individual cannot (Grabe, 2020; Kleinman, 1980). Furthermore, the gendered division of labour

places women in relentless caregiving roles during crises, exacerbating their exposure to stressors while simultaneously limiting their opportunities for recovery, thereby increasing their vulnerability to stress-related somatic illness (Perez et al., 2022).

#### **2.4 Somatic trauma in non-western settings**

A critical theoretical pillar of this study is the work of medical anthropology, which challenges the universal application of Western diagnostic categories like PTSD. In many non-Western cultures, distress is articulated through culturally-specific idioms that prioritize bodily complaints over psychological narratives (Rasmussen et.al., 2014; Kirmayer, 2001). Concepts like "thinking too much" or localized syndromes involving heat, pain, or bodily imbalance are common conduits for expressing suffering (Ventevogel, 2016; Kaiser et al., 2015). Applying a Western psychiatric framework that privileges emotional disclosure can therefore lead to a profound clinical mismatch, resulting in the neglect of legitimate suffering. An effective analysis must therefore be culturally congruent, interpreting somatic symptoms not as a lack of psychological sophistication but as a culturally-embedded form of communication and a legitimate manifestation of trauma that is shaped by local ontologies of health and illness.

#### **2.5 Theoretical synthesis: an integrated framework**

This study is guided by an integrated theoretical framework that bridges the neurobiology of trauma, feminist political economy, and cultural phenomenology to create a comprehensive lens for analysing somatic manifestations of conflict-related trauma. This multidimensional approach recognizes that women's physical symptoms cannot be understood through a single disciplinary perspective but rather emerge from the complex interplay of biological, social, cultural, and political factors. The framework posits that the somatic manifestations of trauma observed among women in Ilobu, Ifon-Osun, and Erin-Osun represent a convergence of four distinct yet interconnected dimensions of experience.

First, these somatic manifestations are biologically real, rooted in the fundamental dysregulation of neuroendocrine stress-response systems due to prolonged exposure to violence and insecurity. As Van der Kolk (2014) demonstrates, traumatic experiences become biologically embedded through the persistent activation of the hypothalamic-pituitary-adrenal (HPA) axis and autonomic nervous system, leading to measurable physiological changes that manifest as gastrointestinal distress, cardiovascular issues, chronic pain, and reproductive health complications. This biological reality provides the foundational mechanism through which psychological trauma becomes physically embodied, creating what contemporary trauma theory recognizes as the "body keeping the score" of traumatic experience.

Second, these biological processes are profoundly gendered in their expression and impact, amplified by the specific social and economic vulnerabilities that characterize women's positions in this patriarchal context. Feminist political economy reveals how

women's roles as primary caregivers and their economic dependence on land-based livelihoods which are both directly targeted in the conflict, create unique pathways for trauma embodiment (Perez et al., 2022). The "triple burden" of productive, reproductive, and community-managing roles that women shoulder during crises creates cumulative stress exposures that are both quantitatively greater and qualitatively different from those experienced by men, while simultaneously constraining their opportunities for recovery and healing.

Third, the expression and interpretation of these somatic symptoms are culturally mediated through local idioms of distress and help-seeking pathways that may prioritize traditional or spiritual healing alongside, or in place of, biomedical care. Medical anthropology demonstrates that across non-Western cultures, distress is frequently articulated through culturally-specific somatic idioms rather than psychological narratives (Kirmayer, 2001). In the Yoruba context of this study, this cultural mediation shapes how women perceive, describe, and seek treatment for their physical symptoms, often framing them within local understandings of health and illness that may differ significantly from Western biomedical models.

Finally, these somatic manifestations remain politically ignored, rendered invisible by a humanitarian and clinical response architecture that is structurally siloed, chronically under-resourced, and conceptually ill-equipped to diagnose or treat the mind-body connection in trauma. The global mental health gap identified by Kohrt et al. (2018) is particularly acute in conflict settings, where humanitarian responses prioritize immediate physical needs and security concerns while systematically neglecting the psychosocial dimensions of suffering. This political neglect represents a form of structural violence that compounds the original trauma by failing to provide appropriate recognition and care.

This integrated framework enables a holistic analysis that moves beyond simplistic biomedical reductionism to instead recognize women's somatic complaints as legitimate, complex, and multi-dimensional health outcomes of communal conflict. The framework allows for a more nuanced understanding of how political violence becomes personal pathology, and how social structures become biological realities.

### **3. METHODOLOGY**

This study employed a rigorous qualitative methodology to investigate the nuanced and embodied experiences of women affected by communal conflict, with particular focus on physical manifestations of psychological trauma. A phenomenological research design was adopted to understand the essence and underlying structures of women's somatic experiences, allowing for in-depth exploration of the mind-body connection in trauma beyond clinical diagnoses. The study was conducted in the three adjoining communities of Ilobu, Erin-Osun, and Ifon-Osun in Osun State, Nigeria, where recurrent violent

clashes created a context of chronic threat and instability conducive to studying somatic trauma.

Participant selection utilized a combination of purposive and snowball sampling techniques to ensure inclusion of information-rich cases, with sampling continuing until data saturation was achieved. The final sample consisted of 42 participants, including 12 women for in-depth interviews (with balanced representation across the three communities), 18 women participating in three focus group discussions (one per community), and 12 key informant interviews with community leaders, healthcare workers, religious leaders, and local government officials. This strategic selection ensured methodological triangulation and comprehensive perspectives on somatic trauma manifestations.

Data collection employed multiple methods between June and September 2025, with all interviews and discussions conducted primarily in Yoruba to ensure nuanced communication and rapport building. Semi-structured in-depth interviews explored participants' conflict experiences, physical health complaints, emotional states, and help-seeking behaviours. Focus group discussions facilitated conversations around shared physical health challenges, while key informant interviews provided contextual data on health trends and institutional responses. Non-participant observation documented visible signs of distress and environmental factors affecting health.

The research adhered to strict ethical protocols, receiving approval from the Osun State University Research Ethics Committee. A trauma-informed approach guided all interactions, with informed consent obtained from all participants, assurances of their right to withdraw, and debriefing sessions conducted post-interview. Data analysis followed Braun and Clarke's six-phase thematic analysis approach, supported by NVivo 15 version software for data management while maintaining manual coding for deep textual engagement. Credibility was enhanced through triangulation across data sources and peer debriefing with research supervisors throughout the analytical process.

### **3.1 Findings: the body as an archive of trauma**

The analysis reveals that women's psychological trauma from the communal conflict is profoundly embodied, manifesting through a spectrum of somatic disorders that serve as physical testaments to their suffering. Their bodies have become living archives of the violence, displacement, and perpetual fear they endure. The findings are organized into four key thematic areas of somatic manifestation.

### **3.2 disrupted reproduction and gynaecological distress**

The conflict's trauma directly targeted women's reproductive health, with numerous reports of pregnancy loss and menstrual dysfunction directly attributed to acute fear and displacement. A private health worker from Ilobu provided clinical confirmation of this trend, stating:

"Yes, we've seen cases of people losing pregnancies, women losing pregnancies during that time, also having irregular menstruation. The body responds to the fear." (Private Health Worker KII, Ilobu, 2025)

This clinical observation was corroborated by harrowing personal accounts. One woman from Erin-Osun described how terror triggered immediate physical consequences:

"On that first night of the shooting, I could not sleep. I was using the toilet a lot. My body was just shaking and purging everything." (Women IDI, Erin-Osun, 2025)

These accounts illustrate a direct psychosomatic pathway where the extreme stress of conflict disrupts fundamental biological processes, with reproductive health being particularly vulnerable.

### **3.3 Chronic pain and unexplained ailments**

Women consistently reported persistent physical pains and ailments that emerged or intensified during the conflict period, often without a clear organic cause. A public health worker noted the prevalence of these complaints:

"People had malaria, coughs and colds because of the displacement... and many people could not sleep." (Public Health Worker KII, Ifon-Osun, 2025)

The connection between psychological distress and physical pain was explicitly made by participants. One woman explained:

"This pain in my back and chest started after they burnt our house. The doctor says nothing is wrong, but the pain is still there. It is the worry that has entered my body." (Women IDI, Ilobu, 2025)

Another described how emotional trauma manifested as gastrointestinal symptoms:

"I could not sleep. I was using the toilet a lot. I was only able to regain myself just when everything calmed down." (Women IDI, Erin-Osun, 2025)

These narratives demonstrate how unresolved psychological distress becomes somatised, creating physical suffering that resists conventional medical diagnosis and treatment.

### **3.4 Sleep disorders and hypervigilance as somatic states**

Severe sleep disruption emerged as one of the most pervasive somatic manifestations of trauma, affecting women's physical health and daily functioning. The severity of this disruption was captured in collective testimonies:

"No, we could not sleep properly. We were all afraid." (Children FGD, Ifon-Osun, 2025)

Adult women experienced even more profound sleep disturbances, often accompanied by hypervigilance. A woman from Ifon-Osun described her experience:

"No, we were not able to sleep. I will always be scared that they will burn our house." (Women IDI, Ifon-Osun, 2025)

The duration and intensity of these sleep disorders are evident in another testimony:

"From midnight to 7:30 am in the morning, they [armed group] were still around. We could not sleep at all." (Women FGD, Ifon-Osun, 2025)

Healthcare providers confirmed the clinical severity of these presentations. A private health worker observed:

"When calm returned, they came back. So, people came back with a lot of trauma-related complaints like poor sleep, insomnia, people unable to sleep and depression, you know, anxiety." (Private Health Worker KII, Erin-Osun, 2025)

The same provider specifically noted the impact on women traders:

"Many of them cannot sleep, they cry every day... they lost their goods, their homes, their livelihood." (Private Health Worker KII, Ilobu, 2025)

### **3.5 Cardiovascular and autonomic complaints**

The chronic stress of the conflict manifested in cardiovascular and autonomic nervous system dysregulation, particularly among older women. A public health worker explicitly linked displacement to these conditions:

"People had malaria, coughs and colds because of the displacement, high blood pressure among elders." (Public Health Worker KII, Ifon-Osun, 2025)

The physiological impact of sustained fear was described in visceral terms by participants. One woman recounted her body's response to terror:

"My body was just shaking and purging everything." (Women IDI, Erin-Osun, 2025)

A health worker connected economic loss to physical deterioration:

"They lost their goods, their homes, their livelihood. You see the stress on their faces. They come to the clinic with high blood pressure and sleeplessness." (Public Health Worker KII, Ilobu, 2025)

These findings collectively demonstrate that the women's somatic complaints represent a legitimate, complex health crisis directly resulting from conflict-related trauma. Their

bodies bear witness to the violence in ways that transcend verbal expression, creating a physical burden that compounds their psychological suffering.

#### **4. DISCUSSION**

The findings of this study present a compelling narrative of how profound psychosocial trauma becomes literally embodied, creating a silent epidemic of somatic illness that remains largely invisible to conventional humanitarian and medical responses. The physical suffering documented from reproductive disruptions to autonomic nervous system dysregulation, is not merely coincidental to the conflict but represents the primary language through which women's bodies articulate distress that transcends verbal expression. This discussion interprets these findings through our integrated theoretical framework, examining their implications for clinical practice, humanitarian response, and trauma theory.

##### **4.1 The Gendered somatization of conflict: a biosocial reality**

The data unequivocally demonstrate that somatic manifestations follow distinct gendered pathways, particularly affecting reproductive and cardiovascular health. The cases of pregnancy loss and menstrual irregularity are not random biological events but direct consequences of the extreme activation of stress response systems. From a neurobiological perspective, the chronic hypervigilance described by participants—"We could not sleep at all"—indicates sustained HPA axis activation, which directly suppresses reproductive hormone function and can trigger spontaneous abortion (Giurgescu et al., 2015). Similarly, the high blood pressure reported among women represents the cardiovascular toll of sustained autonomic nervous system arousal. This aligns with Van der Kolk's (2014) concept of the body keeping score, demonstrating that traumatic experience becomes biologically embedded.

However, this biosocial process is profoundly shaped by gender roles. As primary caregivers, women described being responsible for calming children and managing household survival during attacks, necessitating a performance of strength that precluded the open expression of emotional distress. As one woman noted, "I was the one telling them to calm down... but inside me, anxiety caught everyone." This internalization of distress, coupled with the economic precarity of losing livelihoods, creates what Kleinman (1980) would term a "socially sanctioned" pathway for psychological pain to manifest through physical symptoms. The body becomes the only acceptable canvas for expressing suffering that social roles otherwise demand be suppressed.

##### **4.2 Symptom as testimony: The body's narrative of trauma**

The physical symptoms described by participants function as powerful forms of testimony that communicate what language cannot. When a woman states, "The worry has entered my body," she is articulating a phenomenological truth recognized in medical anthropology, that distress is often experienced and expressed through culturally resonant idioms that prioritize bodily complaints over psychological narratives (Kirmayer

& Jarvis 2019). The "pain in my back and chest" that started after a house burning, despite no organic cause being found, represents what Kirmayer & Young (1998) would term a "somatic metaphor", which is a physical representation of emotional burden and loss.

This challenges the Western biomedical model that often dismisses such symptoms as "medically unexplained." From a cultural phenomenology perspective, these symptoms are anything but unexplained; they are eloquent testimonies to experiences of violence, displacement, and loss. The gastrointestinal distress described during attacks—"I was using the toilet a lot"—represents the body's visceral response to terror, where the digestive system literally evacuates as part of a primal survival response. These somatic narratives demand to be read not as diagnostic puzzles but as legitimate accounts of suffering that require interpretation within their cultural and contextual framework.

#### **4.3 Clinical and humanitarian blind spots: the consequences of neglect**

The near-total absence of appropriate clinical or humanitarian response to these somatic manifestations reveals critical systemic failures. Healthcare providers in the region, when consulted, primarily treated malaria and coughs, which are conditions related to displacement, but demonstrated limited capacity to recognize or address the underlying trauma driving many physical complaints. As one health worker acknowledged, "No professional counselling has been provided... people only go to hospitals when they are sick." This represents what Kohrt et al. (2014) and IASC (2022) identify as the "global mental health gap," where somatic presentations of trauma are systematically missed in primary care settings.

The humanitarian response similarly failed to address this dimension of suffering. Aid distributions focused on material needs, "just rice and beans... not like properties, not like bedding", while completely overlooking the embodied trauma that required psychosocial intervention. This neglect has tangible consequences: women turning to moneylenders and accumulating debilitating debt in attempts to restart businesses represents a maladaptive coping strategy that directly stems from the failure to address the somatic and psychological impacts of their losses. The clinical and humanitarian systems thus become complicit in what could be termed a "second injury", first through the original trauma, and again through the failure to recognize and respond to its physical manifestations.

#### **4.4 Toward an embodied approach to trauma recovery**

The findings argue compellingly for a paradigm shift in how trauma is conceptualized and treated in conflict-affected populations. An effective response must begin with recognizing somatic symptoms as legitimate trauma responses requiring integrated care (SAMHSA, 2014). This necessitates training community health workers in trauma-informed care that recognizes the mind-body connection, particularly regarding reproductive and cardiovascular health. It requires integrating basic psychosocial support

into primary healthcare to address what one health worker called "the worry" that manifests as physical pain.

Furthermore, our findings suggest that empowering women's existing coping mechanisms such as the social solidarity networks they formed, could provide crucial platforms for delivering culturally congruent somatic interventions (Jordans et.al., 2016). The collective caregiving and economic cooperation women organized represent indigenous resilience structures that could be strengthened to address trauma more effectively. As one leader observed, "The women were the ones organizing... they were the first responders in our community." Building upon these existing resources represents a more sustainable approach than importing external models that may fail to recognize the embodied nature of local suffering.

Finally, the women of Ilobu, Ifon-Osun, and Erin-Osun demonstrate through their bodily suffering that trauma cannot be compartmentalized into psychological versus physical domains. Their experiences challenge global health frameworks to develop more integrated, culturally intelligent approaches that recognize the body not as a separate entity from the mind, but as its most honest narrator in contexts where verbal expression is constrained by culture, gender, and circumstance (Patel et. al., 2013). Until humanitarian and clinical systems learn to read these somatic testimonies, the invisible wounds of war will continue to fester long after the visible violence has ended.

## 5. CONCLUSION

This study has documented how the invisible wounds of war become visibly inscribed on women's bodies through somatic manifestations of psychosocial trauma. Through detailed qualitative investigation in the conflict-affected communities of Ilobu, Ifon-Osun, and Erin-Osun, we have traced the direct pathways through which chronic fear, displacement, and loss translate into reproductive health complications, chronic pain, sleep disorders, and cardiovascular ailments. The women's bodies have become living archives of the conflict, speaking a language of suffering that transcends verbal expression and exposes the critical limitations of current humanitarian and clinical responses.

This research makes three significant contributions to the literature on conflict, health, and gender. First, it provides empirical evidence for the embodied nature of trauma in a non-Western, communal conflict context, moving beyond psychological diagnostics to capture the somatic reality of suffering. Second, it demonstrates the gendered specificity of these manifestations, showing how women's biological vulnerability, social roles, and economic precarity create unique pathways for trauma embodiment. Third, it reveals the systemic neglect of somatic trauma in both clinical practice and humanitarian response, identifying a critical gap in current intervention frameworks.

The theoretical implications are substantial. The integration of neurobiological, feminist, and anthropological perspectives into this study challenges the mind-body dichotomy that continues to dominate Western medical approaches to trauma. It

demonstrates that in contexts where verbal expression of psychological distress is constrained, the body becomes the primary text upon which trauma is written; a text that demands culturally competent reading rather than biomedical dismissal.

### **5.1 Recommendations**

Based on the empirical findings of this study, the study proposed a comprehensive set of recommendations aimed at addressing the critical gap in recognizing and treating somatic manifestations of trauma in conflict-affected regions. First, the study recommends the systematic integration of somatic trauma recognition into primary healthcare systems through three key interventions (WHO, 2016). This necessitates the development and implementation of specialized training programs for community health workers and primary care providers, focusing specifically on identifying and responding to trauma-related physical symptoms. Additionally, healthcare systems should create and validate simple screening tools designed to identify somatic complaints with high trauma correlation, particularly focusing on reproductive health disruptions, medically unexplained chronic pain, and stress-related cardiovascular symptoms in primary care settings. Furthermore, establishing clear referral pathways between primary health centres and psychosocial support services is essential to ensure that somatic presentations of trauma receive appropriate mental health attention, thereby bridging the critical gap between physical and psychological care.

Second, the study advocates for the development of community-based, trauma-informed interventions that leverage local resources and cultural frameworks. This includes training and deploying community mental health workers specifically equipped to address the mind-body connection in trauma recovery, focusing on somatic symptom management (Mutamba et. al., 2013). Recognizing the important role of indigenous support systems, the study recommends formally engaging and training traditional healers and religious leaders as first-line responders in recognizing somatic trauma and providing culturally appropriate support. Additionally, establishing women-led support groups that explicitly address the physical manifestations of stress and trauma can provide safe spaces for sharing experiences and learning coping strategies that incorporate both traditional wisdom and evidence-based approaches.

Third, the study urges the mainstreaming of gender-responsive and trauma-informed approaches across all humanitarian and development interventions. All humanitarian assistance in conflict zones should incorporate trauma-informed principles that recognize somatic manifestations of distress as legitimate health concerns requiring attention. Economic empowerment programs must be designed to account for the physical health limitations caused by chronic stress and trauma, ensuring that livelihood activities do not exacerbate existing conditions. Moreover, mandating comprehensive gender and trauma sensitivity training for all security personnel and humanitarian workers operating in conflict areas is crucial for creating a supportive environment that does not re-traumatize vulnerable populations.

Finally, the study emphasizes the need to strengthen research and monitoring systems to build a more robust evidence base. Conducting longitudinal studies to track the long-term health consequences of somatic trauma in conflict-affected populations will provide critical insights into the chronic nature of these conditions. Developing specialized monitoring and evaluation frameworks that specifically capture somatic health outcomes in conflict settings will enable more effective program planning and resource allocation. Supporting interdisciplinary research that bridges global health, medical anthropology, and trauma studies is essential for developing more culturally grounded and effective interventions that address the complex, embodied nature of trauma in diverse cultural contexts.

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