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MENTAL HEALTH STUDIES

INFLUENCE OF IMMEDIATE TRAUMA INTERVENTION STRATEGIES ON THE PSYCHOLOGICAL WELL-BEING OF WOMEN SURVIVORS OF POLITICAL VIOLENCE IN NAIROBI AND KISUMU INFORMAL SETTLEMENTS, KENYA

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ABSTRACT

Purpose: This study examined the influence of immediate trauma intervention strategies on the psychological well-being of women survivors of political violence in selected informal settlements.

Methodology: Guided by Cognitive Behavioral Therapy and Narrative Restructuring Theory, the study used a convergent mixed-methods design, collecting quantitative data from 200 women survivors via structured questionnaires and qualitative data through key informant interviews. Quantitative data were analyzed using descriptive statistics and Chi-square tests.

Findings: The results indicate that access to immediate trauma interventions such as Psychological First Aid (PFA), community-based counselling, crisis support, and safe relocation was associated with measurable reductions in anxiety (45%), depressive symptoms (50%), and emotional numbness (42%). The Chi-square test ($\chi^2 = 61.69$, $p < 0.05$) confirmed a statistically significant relationship.

Conclusion: Immediate trauma intervention strategies significantly improve short-term psychological well-being among women survivors of political violence.

Recommendation: The study recommends the institutionalization of tiered trauma response frameworks within informal settlements, incorporating early trauma screening, trained rapid response teams.

Keywords: *Immediate trauma interventions, Psychological First Aid, political violence, women survivors, psychological well-being, informal settlements, Kenya*

BACKGROUND TO THE STUDY

In the modern societies, especially in those that are characterised by instability in politics, armed conflicts, and civil unrests, trauma has emerged as a specific psychological issue of public health concern. Politically motivated violence can interfere with core beliefs regarding safety, trust, and predictability, which in most cases leads to long-term psychological distress and poor social performance (American Psychiatric Association [APA], 2013; WHO, 2019). In the world, conflict-exposed populations show considerably greater post-traumatic stress disorder (PTSD), depression, and anxiety disorders than the unexposed ones (Morina et al., 2013; Koenen et al., 2017). The challenges of overcrowding, poverty, institutional inadequacy, and frequent exposure to turmoil especially predispose urban informal settlements, increasing the psychological cost of trauma (Silove et al., 2017; UN-Habitat, 2020). Trauma in such settings is never an isolated incident, but a cumulative, reinforced, and embedded phenomenon and thus requires responsive action and intervention in the context.

The extreme emergency care of the trauma survivor is aimed at stabilizing the patient during the acute phase of violent exposure and avoiding the process of consolidation of extreme psychological pathology. Basic early-response strategies involve Psychological First Aid (PFA), crisis counselling, Critical Incident Stress Management (CISM), emergency referral, and the provision of psychosocial support services by means of rapid deployment (WHO and UNHCR, 2015; Everly and Mitchell, 2008). The strategies are intended to recover emotional control, lessen physiological hyperarousal, improve perceived safety, and increase social connectedness during the short post-trauma period (Brymer et al., 2012; Hobfoll et al., 2007). There is evidence indicating that the intensity of intrusive memories, anxiety symptoms, and adaptive coping responses can be reduced by early psychosocial stabilization (Roberts et al., 2019; Tol et al., 2013). Emergency responses thus do not serve as crisis containment strategies but as platforms on which recovery patterns are established in the long term.

Conceptualized in the context of multidimensional frameworks, psychological well-being goes beyond the lack of mental illness to include positive functioning, including autonomy, environmental mastery, personal growth, purpose in life and quality interpersonal relationships (Ryff, 2014; Keyes, 2020). These dimensions are directly compromised due to political violence, which disrupted social networks, perceived control, and emotional stability (Kira et al., 2020; Stavrou et al., 2019). The survivors often complain of lower life satisfaction, relational trust, and self-efficacy after violent exposure (WHO, 2019; Steel et al., 2009). Psychological well-being is likely to be further undermined by structural stressors, including

unemployment, stigma, and poor access to services, in weak urban contexts, when formal mental health infrastructure is minimal (UN Women, 2024; Silove et al., 2017).

The correlation between the strategy of immediate trauma intervention and psychological well-being is not only theoretically important but also empirically important. Early stabilisation interventions are also conceptualised to moderate long-term psychological dyscontrol through encouraging safety, calming, self-efficacy, social connectedness, and hope, which have been and continue to be considered fundamental tenets of recovery in post-conflict environments (Hobfoll et al., 2007; WHO & UNHCR, 2015). Immediate interventions are important in protecting the crucial aspects of psychological well-being and preventing the development of chronic psychological disorders by decreasing acute stress reactions and enhancing adaptive coping responses (Brymer et al., 2012; Roberts et al., 2019).

Although this has been found relevant, little empirical evidence has been shown on the effectiveness of immediate trauma intervention strategies in informal settlements in Sub-Saharan Africa. Most of the existing literature has been devoted to the prevalence and long-term consequences of trauma, whereas limited attention has been paid to the immediate response to trauma and its direct impact on psychological recovery. In this study we thus look at the effect of immediate intervention strategies on the psychological well being of women survivors of political violence in informal settlements of Nairobi and Kisumu to give a contextual understanding of how this aspect can be used to reinforce a framework of trauma response in high vulnerability settings.

Political violence is also a common characteristic of many developing democracies experiencing contested elections and transitions to democracy, with political contests quite frequently being followed up by civil unrest, displacement, and fragmentation of communities (Bratton and van de Walle 1997; Raleigh et al. 2010). Election-related violence in Kenya, which has mainly been witnessed in the period between 20072008, 2017, and later electoral periods, has led to loss of life, internal displacement, property destruction, and long-term instability in the communities (Kenya National Commission on Human Rights [KNCHR], 2008; Truth, Justice and Reconciliation Commission [TJRC], 2013). Such unrest has traditionally been centred in informal settlements like Kibera in Nairobi and Nyalenda and Kondele in Kisumu because of the large population density, economic marginalisation, and politicised ethnic divisions (Mutahi, 2011; Klopp & Orina, 2018). These structural gaps increase violence exposure and limit access to institutional protection on time, thereby exacerbating the psychological weight of residents (WHO, 2019; UN-Habitat, 2020).

Within such contexts, women are significantly disproportionately both victims of violence and bearers of its social and economic impacts. Gender-based violence (GBV), sexual assault, forced displacement, and economic deprivation tend to increase risks due to conflict and political instability, which adds to psychological vulnerability (UN Women, 2024; Stavrou et al., 2019). Also, post election violence in Kenya has shown that women in informal settlements experience high levels of sexual violence, widowhood, single parenting and loss of livelihood (KNCHR, 2008; Onyut et al., 2009). In addition to physical injury, women often become extended caregivers and survivalists in the environment of insecurity, which exposes them to chronic stress and a more significant emotional burden (Silove et al., 2017; WHO, 2019). These superimposing exposures channel violence, structural deprivation, and caregiving load-introduce a situation where urgent intervention of trauma is not only clinically but also socially critical to protect the psychological health of women survivors.

Globally, political violence continues to exert a substantial psychological toll across both low- and middle-income countries as well as fragile urban regions within emerging democracies. Recent global conflict monitoring reports indicate that millions of civilians remain exposed annually to armed confrontation, electoral unrest, forced displacement, and state–civilian clashes (Institute for Economics & Peace, 2023; ACLED, 2023). Epidemiological reviews consistently demonstrate that between one-third and one-half of conflict-exposed populations develop significant psychological distress, with elevated rates of PTSD, depression, and anxiety compared to global population baselines (Morina et al., 2013; WHO, 2019). Women in conflict settings show disproportionately higher trauma symptom severity, particularly where violence intersects with gender-based abuse and economic marginalisation (Tolin & Foa, 2006; Stavrou et al., 2019). These patterns affirm that political violence is not merely a security issue but a sustained global mental health challenge with long-term social consequences.

Regionally within Sub-Saharan Africa, electoral and communal violence has produced recurring cycles of displacement, social fragmentation, and psychological strain, particularly in densely populated urban settlements (Raleigh et al., 2010; UNDP, 2022). Kenya reflects this broader regional trend, with documented waves of post-election violence in 2007–2008, 2017, and subsequent periods resulting in widespread trauma exposure (KNCHR, 2008; TJRC, 2013). Informal settlements such as Kibera in Nairobi and Nyalenda and Kondele in Kisumu have repeatedly experienced heightened vulnerability due to poverty concentration, ethnic polarization, and limited institutional response capacity (Klopp & Orina, 2018; UN-Habitat,

2020). These localized patterns mirror global evidence showing that political violence disproportionately affects urban poor communities and women within them, thereby reinforcing the urgency of immediate trauma intervention strategies tailored to fragile settlement contexts (WHO, 2019; UN Women, 2024).

Statement of the Problem

Political violence remains a recurrent feature of Kenya's electoral cycles, with informal settlements in Nairobi and Kisumu disproportionately affected due to dense populations, socio-economic vulnerability, and limited institutional protection (KNCHR, 2008; TJRC, 2013; UN-Habitat, 2020). Evidence from prior post-election crises indicates that women in these settlements experience heightened exposure to physical assault, sexual violence, displacement, and property destruction, all of which contribute to substantial psychological burden (Roberts et al., 2011; Onyut et al., 2009). Global and regional data show that approximately 29% of individuals living in conflict-affected settings develop common mental disorders, including PTSD and depression (WHO, 2019). In Kenya specifically, PTSD prevalence among survivors of political violence has ranged between 30% and 47% in affected regions such as Kisumu and Nairobi (Onyancha et al., 2018; Owiti et al., 2019). These figures point to a sustained mental health crisis among women survivors, particularly within informal settlements where access to structured psychological services remains limited.

Immediate trauma intervention strategies—including Psychological First Aid (PFA), crisis counselling, emergency shelter provision, rapid response teams, and community-based psychosocial support—are globally recommended as frontline responses during and immediately after violent episodes (WHO & UNHCR, 2015; Sphere Association, 2018). Empirical literature suggests that early psychosocial interventions can reduce acute stress reactions, prevent progression to chronic PTSD, and stabilise survivors emotionally (Brymer et al., 2012; Everly & Mitchell, 2008). Nonetheless, in many low-resource urban settings, the availability, accessibility, and quality of such immediate interventions remain inconsistent. In Kenya's informal settlements, anecdotal and institutional reports indicate gaps in rapid psychological response capacity, insufficient trained personnel, and weak coordination between county governments and community-based organisations (UNDP, 2022; KNCHR, 2018).

Despite the documented burden of trauma and the theoretical importance of early intervention, limited empirical studies have systematically examined the direct influence of immediate

trauma intervention strategies on the psychological well-being of women survivors within Kenya's informal settlements. Much of the existing literature has focused on trauma prevalence and long-term psychological outcomes without isolating the stabilizing role of early response mechanisms. Consequently, there remains a critical gap in understanding whether immediate trauma interventions meaningfully influence psychological well-being outcomes among women survivors of political violence in Nairobi and Kisumu. This study therefore sought to examine the influence of immediate trauma intervention strategies on the psychological well-being of women survivors of political violence in selected informal settlements in Kenya.

Purpose of the Study

The purpose of this study was to examine the influence of immediate trauma intervention strategies on the psychological well-being of women survivors of political violence in selected informal settlements of Nairobi and Kisumu, Kenya. Specifically, the study sought to determine whether early response mechanisms—such as Psychological First Aid, crisis counselling, and rapid community-based support—significantly contribute to improved emotional stability, reduced trauma symptoms, and enhanced overall psychological functioning among affected women.

Scope of the Study

This study focused on women survivors of political violence residing in selected informal settlements of Nairobi (Kibera) and Kisumu (Nyalenda, Kondele, and Nyawita), Kenya. The investigation was limited to examining immediate trauma intervention strategies implemented during or shortly after episodes of political violence, including Psychological First Aid (PFA), crisis counselling, rapid response services, emergency shelter support, and community-based psychosocial assistance.

The study specifically assessed how these early interventions influenced key dimensions of psychological well-being, including emotional stability, trauma symptom reduction, social functioning, and overall mental health status. The target population comprised women who had directly experienced political violence during election periods between 2007 and 2023. The analysis did not extend to long-term post-trauma therapeutic interventions such as extended cognitive behavioral therapy programs, nor did it include male survivors or children, as the emphasis remained on women within informal settlement contexts.

LITERATURE REVIEW

Theoretical Framework

Crisis Theory was initially developed by Gerald Caplan (1964), whose foundational work in community mental health established the conceptual basis for crisis intervention as a preventive psychological strategy. Caplan argued that individuals confronted with sudden, overwhelming events experience a temporary breakdown in their usual coping mechanisms. Later scholars such as Roberts (2005) and James and Gilliland (2017) expanded the framework by operationalizing structured crisis intervention models applicable in emergency, disaster, and conflict contexts. Contemporary humanitarian guidelines, including those by the World Health Organization (WHO, 2016) and Sphere Association (2018), implicitly draw from Crisis Theory in recommending rapid psychosocial response during emergencies. The theory has since become central in disaster psychology, trauma care, and emergency mental health interventions.

Crisis Theory rests on several key assumptions. First, it assumes that crises are time-limited states of psychological disequilibrium triggered by hazardous events such as violence, loss, or displacement. Second, it posits that individuals in crisis are more psychologically vulnerable but also more open to external support. Third, the theory maintains that timely and appropriate intervention can restore equilibrium and prevent long-term psychological disorders. Conversely, absence of support during the acute phase may lead to maladaptive coping, chronic stress reactions, and disorders such as PTSD or major depression (Roberts, 2005; WHO, 2016). The model therefore emphasises immediacy, stabilisation, and restoration of functioning.

One major strength of Crisis Theory lies in its preventive orientation. It provides a structured framework for early intervention before trauma consolidates into chronic psychological pathology. The theory is practical, action-oriented, and adaptable to community settings, making it suitable for low-resource environments such as informal settlements. It also aligns well with Psychological First Aid (PFA), crisis counselling, and rapid response mechanisms widely endorsed in humanitarian contexts (Brymer et al., 2012; Sphere Association, 2018). By focusing on restoring coping capacity, social support, and safety, the theory bridges clinical and community-based responses.

Nonetheless, Crisis Theory has limitations. It primarily addresses short-term stabilization and may not fully account for complex, cumulative, or repeated trauma exposures common in protracted conflict settings. Critics argue that the model may oversimplify trauma responses by

assuming a relatively linear progression from disequilibrium to recovery (Everly & Mitchell, 2008). Additionally, the theory does not extensively address structural determinants such as poverty, gender inequality, and systemic marginalisation, which shape trauma outcomes in informal settlements. Therefore, while it is effective for explaining immediate interventions, it requires complementary frameworks to address long-term psychological recovery.

Crisis Theory is directly relevant to this study as it provides the conceptual lens for examining how immediate trauma intervention strategies influence psychological well-being among women survivors of political violence in Nairobi and Kisumu's informal settlements. Political violence represents a precipitating crisis event that disrupts emotional stability, social functioning, and coping mechanisms. Immediate interventions such as Psychological First Aid, crisis counselling, and rapid community support are consistent with the theory's emphasis on early stabilisation and prevention of chronic distress. By grounding the study in Crisis Theory, the research establishes a clear theoretical justification for evaluating whether timely trauma responses contribute to improved psychological well-being outcomes among affected women.

Empirical Literature Review

Empirical evidence consistently demonstrates that immediate trauma intervention strategies play a critical role in stabilizing survivors exposed to acute violence and preventing long-term psychological deterioration. Psychological First Aid (PFA), one of the most widely endorsed early response models, has been implemented in humanitarian emergencies globally. A systematic review by Brymer et al. (2012) reported that PFA improves perceived safety, emotional regulation, and access to social support in the immediate aftermath of disasters. Similarly, WHO and UNHCR (2015) found that structured early psychosocial interventions reduce acute stress reactions and enhance short-term coping capacity among conflict-affected populations. Although these interventions do not eliminate trauma entirely, they are associated with lower progression rates to chronic PTSD and depressive disorders.

Crisis counselling has also been shown to significantly influence psychological recovery trajectories. Everly and Mitchell (2008), in their evaluation of Critical Incident Stress Management (CISM), found that structured debriefing and early emotional ventilation reduced intrusive thoughts and hyperarousal among disaster survivors. In post-conflict contexts, Tol et al. (2011) observed that early psychosocial support programs implemented in low-resource settings led to moderate but statistically significant improvements in emotional functioning and daily role performance. These findings suggest that immediate interventions are particularly

valuable in environments where survivors face compounded stressors, including displacement and economic instability.

Within conflict-affected African contexts, empirical studies reinforce the stabilizing impact of rapid psychosocial response mechanisms. Roberts et al. (2011), examining post-election violence in Kenya's Rift Valley, reported that individuals who accessed early counselling services demonstrated lower PTSD symptom severity compared to those without access. Onyut et al. (2009) similarly documented that timely psychosocial outreach reduced severe trauma symptoms among internally displaced persons following the 2007–2008 Kenyan post-election crisis. These findings are consistent with WHO (2019), which estimates that approximately one-third of individuals in conflict settings develop mental health disorders, but early support can substantially mitigate symptom escalation.

Research further highlights the importance of community-based immediate interventions in informal settlements. A study by Wachira et al. (2020) in Nairobi informal settlements found that survivors who received immediate psychosocial support from local organizations reported improved emotional reassurance and reduced feelings of isolation. Likewise, Owiti et al. (2019) observed that survivors exposed to structured early interventions following violent incidents showed lower persistent trauma symptoms six months post-event. These findings indicate that rapid, locally accessible interventions are particularly critical in densely populated, high-risk environments where formal mental health infrastructure is limited.

However, despite evidence supporting the effectiveness of immediate trauma interventions, significant service gaps persist. UNDP (2022) and KNCHR (2018) reports highlight limited trained personnel, weak coordination between county governments and community-based organisations, and inadequate funding for rapid psychosocial response in Kenya's informal settlements. Empirical literature shows that where early intervention systems are fragmented or under-resourced, survivors are more likely to develop chronic psychological distress (WHO, 2016). Consequently, while immediate trauma interventions demonstrate measurable positive influence on psychological well-being, their effectiveness depends heavily on accessibility, timeliness, and structural support mechanisms.

Overall, the empirical literature strongly supports the proposition that immediate trauma intervention strategies—particularly Psychological First Aid, crisis counselling, and rapid community support—are positively associated with improved psychological well-being outcomes in conflict-affected populations. Nonetheless, there remains limited context-specific

research examining their direct influence among women survivors of political violence in Kenya's informal settlements. This study therefore contributes to closing that gap by empirically examining how early intervention strategies shape psychological recovery trajectories within these high-vulnerability urban contexts.

RESEARCH METHODOLOGY

This research paper assumed a convergent parallel mixed-methods research design to facilitate the concurrent collection and analysis of both quantitative and qualitative data when studying the association between short-term trauma intervention methods and psychological health. This design allowed methodological triangulation, which increased the validity, depth, and contextual interpretation of results (Creswell and Plano Clark, 2018). The research was carried out in selected informal settlements of Nairobi (Kibera) and Kisumu (Nyalenda, Kondele, and Nyawita), which have been historically characterized by the recurrent occurrences of political violence. The target population was women who survived political violence during 2007-2023, specifically, those who are reachable via the activity of community-based organisations working in these conditions.

A stratified random sampling was used to select a sample of 200 respondents to ensure that the sample fits the study sites, with purposive sampling being used to find key informants, such as ward administrators and leaders of community-based organisations. Structured questionnaires were administered to gather quantitative data that captured immediate trauma intervention interventions, such as Psychological First Aid, crisis counselling, and rapid response support, as well as indicators of psychological well-being that was based on validated scales. Semi-structured interviews were used to gather qualitative data on experiential views of intervention access, effectiveness, and recovery processes. Cronbach alpha (0.70 and above) was used to determine instrument reliability whereas expert review and pilot testing were used to determine validity.

The SPSS (Version 26) was used to analyse quantitative data, and descriptive statistics alongside Chi-square test of independence were employed to measure relationships between intervention exposure and psychologically well being levels. Due to the categorical character of the variables, the analysis was aimed at identifying statistically significant relationships, as opposed to a causal inference. Thematic analysis of qualitative data was conducted to determine shared trends in relation to intervention effectiveness, access limitations, and stabilisation experiences. Convergence between the findings was performed at the

interpretation phase, which permitted the alignment of statistical patterns with narrative evidence. Informed consent, trauma-sensitive and institutional review boards NACOUSTI were followed carefully, and ethical approval was obtained by the relevant institutional review bodies.

FINDINGS

This section presents the empirical results examining the influence of immediate trauma intervention strategies on the psychological well-being of women survivors of political violence in selected informal settlements of Nairobi and Kisumu. The findings integrate quantitative statistical outcomes with contextual interpretation to determine the extent to which early intervention mechanisms contributed to emotional stabilisation and overall psychological functioning.

Influence of Immediate Trauma Intervention Strategies on Psychological Well-being

Immediate Trauma Intervention Strategies

The findings demonstrate that immediate trauma intervention strategies were widely accessed across the study sites, although their effectiveness varied in scope and sustainability. As presented in Table 1, physical flight to safety emerged as the most prevalent immediate response, with 85.0% of respondents indicating that they sought secure locations during episodes of violence. This underscores the dominance of survival-driven responses and the central role of informal safety networks as primary stabilisation mechanisms in crisis contexts. Access to material support and participation in Psychological First Aid (PFA), debriefing, and sharing sessions were moderately reported, with over 60% of respondents acknowledging engagement with such interventions. In addition, approximately 59.9% of respondents perceived the support received as helpful, suggesting that immediate interventions contributed to short-term emotional stabilisation.

Table 1: Distribution of Immediate Trauma Intervention Strategies (n = 200)

Trauma Intervention Strategy	Strongly Disagree n (%)	Disagree n (%)	Undecided n (%)	Agree n (%)	Strongly Agree n (%)
Ran to a secure place	19 (9.5)	5 (2.5)	6 (3.0)	48 (24.0)	122 (61.0)

Received material support	28 (14.0)	31 (15.5)	8 (4.0)	67 (33.5)	66 (33.0)
Participated in PFA/debriefing	34 (17.0)	27 (13.5)	9 (4.5)	57 (28.5)	73 (36.5)
Perceived support as helpful	41 (20.5)	28 (14.0)	8 (4.0)	51 (25.5)	72 (36.0)
Experienced flashbacks	8 (4.0)	8 (4.0)	11 (5.5)	33 (16.5)	140 (70.0)

Note: Items measured on a 5-point Likert scale (1 = Strongly Disagree; 5 = Strongly Agree).

Despite these positive trends, the findings reveal significant limitations in the depth of psychological recovery achieved. Nearly 70.0% of respondents reported persistent flashbacks, indicating the continued presence of intrusive trauma symptoms despite exposure to early interventions. This suggests that while immediate trauma response mechanisms contribute to initial emotional regulation and crisis containment, they are insufficient in addressing deeper psychological distress and long-term trauma outcomes.

Further analysis indicates that the observed improvements—reflected in reductions in anxiety (45%), depressive moods (50%), and emotional numbness (42%)—represent partial stabilisation rather than complete recovery. The persistence of residual symptoms highlights a gap between immediate intervention access and sustained psychological healing. These findings point to underlying systemic limitations, including reliance on informal community support structures such as churches and local networks, as well as the absence of structured, professionalised crisis response systems at the community level. Collectively, the results suggest that while immediate interventions are essential in mitigating acute distress, their overall effectiveness is constrained by limited institutional capacity, lack of standardised intervention protocols, and insufficient integration with formal mental health services

Qualitative findings provide critical contextual reinforcement of these statistical patterns. Ward administrators consistently acknowledged the absence of formalised county-level rapid response systems. As one administrator noted, *"The ward level does not have any safe havens or be able to send out any trauma rescue teams. When violence occurs, they simply run to the churches or chief camps."* This admission highlights systemic gaps in structured emergency preparedness. Survivors largely depended on faith-based organisations and community

volunteers, who provided immediate relief in the form of shelter, food, and informal counselling. A CBO leader explained, *"When the violence starts, we move fast to open up church halls and use volunteers to provide first aid and food. The government comes much later, when the damage is already done."* Such accounts illustrate a reactive rather than institutionalised trauma response model.

The absence of trained personnel further constrained the effectiveness of these interventions. One respondent stated, *"Our teams respond out of experience, not training; they comfort survivors, but we lack the real knowledge to handle psychological crises effectively."* This reveals a significant technical deficit in delivering structured psychological stabilisation. While emotional reassurance was offered, specialised approaches such as Critical Incident Stress Management (CISM) and formal debriefing protocols were largely absent. Consequently, survivors often resorted to informal coping strategies including emotional suppression and withdrawal—which may have prolonged hypervigilance and somatic symptoms.

Importantly, the integration of quantitative and qualitative findings suggests that immediate trauma interventions functioned primarily as emergency containment mechanisms rather than comprehensive therapeutic solutions. They helped restore immediate safety, reduce panic, and foster temporary emotional relief. However, without coordinated county-level systems, trained responders, and sustained follow-up structures, the interventions had limited capacity to prevent persistent trauma symptoms. The findings therefore imply that immediate trauma intervention strategies are indispensable in crisis contexts but must be systematised, professionalised, and institutionally embedded to produce durable improvements in psychological well-being among women survivors of political violence in informal settlements.

Findings on Intervention Effectiveness

The analysis of post-intervention outcomes indicates that immediate trauma intervention strategies yielded modest but meaningful improvements in selected psychological domains. Community-Based Counselling recorded the highest reported improvement, with 50% of participants indicating reduced depressive moods. Psychological First Aid (PFA) was associated with a 45% reduction in anxiety symptoms, while Crisis Support interventions were linked to a 42% reduction in emotional numbness. These findings suggest that early psychosocial engagement contributed to partial emotional stabilisation, particularly in addressing mood-related and acute anxiety responses. The stronger performance of

community-based counselling may reflect its culturally embedded and relational nature, which allows survivors to process distress within familiar social contexts.

Table 2: Immediate Trauma Intervention Strategies and Psychological Well-Being of Women Survivors

Intervention Type	Psychological Outcome	Reporting Improvement
Psychological First Aid	Reduction in anxiety	45%
Community-Based Counselling	Reduction in depressive moods	50%
Crisis Support	Reduction in emotional numbness	42%

Note. *The percentages denote the number of participants who registered subjective improvement after being exposed to each type of intervention.*

Field Data (2025).

Nonetheless, the persistence of residual psychological distress remains a significant concern. Despite reported improvements, nearly 70% of participants continued to experience emotional pain when recalling violent events. This indicates that while immediate interventions may alleviate acute distress, they often lack the depth or continuity required to prevent trauma consolidation. The descriptive trends therefore imply a positive association between early intervention and psychological relief, but also highlight the limitations of short-term response mechanisms in fully restoring psychological well-being.

Qualitative evidence deepens this interpretation by revealing structural and operational gaps in trauma response systems. Ward administrators consistently acknowledged that immediate support often prioritised physical survival over psychological stabilisation. As one administrator reflected, *"After the violence, women end up somewhere to sleep or get access to food, but no one speaks about their psychological pain. Physical needs begin to end immediate help."* This reactive orientation underscores a systemic imbalance where material assistance precedes emotional care. While physical safety is indispensable, neglecting early psychological processing may allow anxiety, shock, and emotional disorientation to persist beyond the crisis phase.

The effectiveness of interventions also varied across service providers. In areas where community-based organisations had trained personnel, outcomes appeared relatively stronger. A CBO representative in Kibera noted, *"We trained our teams in Psychological First Aid, so at least women get some immediate support to calm them down."* Conversely, informal structures such as churches and community elders provided rapid refuge but limited therapeutic engagement. As one ward administrator observed, *"Churches open doors immediately, but they give prayers, not trauma support. That helps for some, but others need real counselling, which we don't have."* These accounts illustrate that while informal support networks enhance accessibility, the absence of structured psychological frameworks constrains long-term recovery.

Further qualitative insights revealed critical systemic weaknesses: the absence of trained crisis intervention teams, weak referral pathways to formal counselling services, and lack of monitoring mechanisms to evaluate psychological outcomes. Survivors without access to any immediate intervention exhibited higher levels of ongoing distress, reinforcing the protective value of early psychosocial engagement. However, the unstructured and NGO-dependent nature of most interventions limited their consistency and reach.

Taken together, the integrated findings indicate that immediate trauma intervention strategies are partially effective in reducing acute symptoms of anxiety, depression, and emotional numbness among women survivors of political violence. Nevertheless, the persistence of intrusive memories and hypervigilance suggests that early interventions must be strengthened through professional training, structured protocols, and coordinated referral systems. Immediate responses are necessary for crisis containment, but without institutional reinforcement and continuity of care, their impact on sustained psychological well-being remains constrained.

Hypothesis Testing: Chi-square Results

To further determine the influence of immediate trauma intervention strategies on psychological well-being, the study tested the following null hypothesis:

H_{01}: *Immediate trauma intervention measures do not significantly affect the psychological well-being of women survivors of political violence in the informal settlements of Nairobi and Kisumu.*

Table *3*: Chi-square Test Results on Immediate Interventions and Psychological Well-being

Hypothesis	Statistical Test	Chi-Square Value (χ^2)	p-value	Decision	Interpretation
H_0: No significant relationship between immediate trauma intervention strategies and psychological well-being	Chi-square	61.69	0.0402	Reject H_1	A significant relationship exists

Note. *Source: Field Data (2025).*

To test this hypothesis, Chi-square test of independence was used to test the relationship between access to immediate trauma interventions and categorised levels of psychological well-being (Low, Moderate, High, and Optimal). The output gave a Chi-square (2) value of 61.69 and a p-value of 0.0402. The null hypothesis was rejected because the p-value was below the 0.05 level of significance. This implies that exposure to immediate trauma intervention measures has significant statistical relationship with the psychological well-being outcomes in women survivors of political violence.

Those findings indicate that availability of instant interventions like Psychological First Aid, Community-Based Counselling and Crisis Support, were linked to enhanced psychological functioning. Females who received these early response services were more prone to record increased levels of psychological well-being than females who did not receive the services. This inferential finding supports the earlier described descriptive trends, where the more commonly reported were the reductions in anxiety levels, depressive mood, and emotional numbness.

The statistically significant association matches the theoretical views as they are developed, especially Cognitive Behavioural Therapy (CBT), and Narrative Restructuring Theory. Maladaptive cognitive appraisals, emotional dysregulation, and early trauma narratives are all frequently the subject of immediate interventions. Such interventions can potentially prevent the consolidation of severe trauma symptoms by breaking negative thoughts patterns and promoting emotional processing when crisis first occurs. Therefore, the empirical data corroborates the hypothesis that well-designed and prompt mechanisms of trauma response

have a significant positive impact on enhanced psychological well-being among women survivors in high-risk situations in informal settlements.

Influence of Trauma Severity on Intervention Outcomes

The findings indicate that trauma severity significantly influenced the effectiveness of immediate trauma intervention strategies. Both quantitative trends and qualitative narratives demonstrate that the initial intensity of symptoms functioned as a moderating factor in psychological recovery outcomes. While immediate interventions such as Psychological First Aid (PFA), peer support, and emergency shelter provision provided measurable benefits, their effectiveness varied depending on the survivor's trauma profile. Women presenting with moderate symptoms—characterised by anxiety, fear, and emotional distress—were more likely to experience short-term stabilisation following community-based interventions. In contrast, those exhibiting severe manifestations such as dissociation, extreme shock, or intense physiological distress showed limited responsiveness to basic support structures.

Qualitative testimonies reinforced this pattern. A CBO director in Kisumu observed, *"Some women were so lost in shock; they didn't respond to our help. They couldn't even speak or eat for days."* Such accounts illustrate how acute psychological disruption can overwhelm informal crisis responses. Conversely, a ward administrator in Kibera noted, *"When the women are not too badly affected, they benefit from just being in a safe place, getting food, and talking to someone."* These observations suggest that immediate interventions are most effective for survivors with manageable symptom severity, where emotional reassurance and physical safety can restore equilibrium.

A recurring structural limitation was the absence of trauma assessment and triage mechanisms. Community responders lacked tools to differentiate between mild, moderate, and severe trauma presentations. As one CBO leader stated, *"We don't know how to tell who needs deep counselling and who can manage with basic help. We treat everyone the same way."* This uniform approach meant that severely traumatised women received the same level of care as those with less complex symptoms. Without early psychological screening or referral pathways, high-severity cases often experienced delayed access to specialised services, prolonging distress and increasing the risk of chronic mental health conditions.

Quantitative findings further confirmed that women reporting persistent flashbacks, hypervigilance, and emotional dysregulation demonstrated weaker improvement outcomes

following informal community-based interventions. This underscores the limitation of non-specialised responses in managing high-intensity trauma. Informal networks—including churches, elders, and peer groups—provided essential refuge and solidarity but lacked the therapeutic depth necessary for complex cases. In several instances, survivors eventually sought professional care at referral facilities only after symptoms had become chronic, indicating missed opportunities for early clinical intervention.

Overall, trauma severity emerged as a critical moderating variable shaping the impact of immediate intervention strategies. Moderate trauma cases benefitted from rapid emotional and material support, whereas severe cases required specialised crisis intervention, differentiated care pathways, and professional psychological services. The findings therefore highlight the necessity of tiered trauma response systems that integrate early screening, triage protocols, and scalable intervention intensity. Without structured assessment and specialised capacity at the ward level, immediate interventions risk being insufficient for the most vulnerable survivors. These results align with contemporary trauma frameworks advocating stepped-care and severity-based intervention models to enhance psychological recovery in conflict-affected populations (WHO, 2018; Johnson & Zlotnick, 2020).

Role of Social Support in Intervention Effectiveness

Social support emerged as a critical factor shaping the effectiveness of immediate trauma interventions. Both quantitative trends and qualitative accounts indicate that women with consistent access to supportive networks demonstrated comparatively better psychological outcomes, even where formal intervention capacity was limited. In the absence of structured county-level trauma response systems, family members, neighbours, churches, and women's associations functioned as primary sources of emotional and material stabilisation. As one ward administrator in Nyalenda observed, *"Women seek the protection of their relatives, the churches or their neighbours when the violence erupts. First, that is their assist."* This immediate communal solidarity reduced isolation, restored a sense of safety, and buffered acute distress during the immediate aftermath of violence.

Faith-based organisations were repeatedly described as central psychosocial anchors. A CBO director in Kibera noted, *"Churches are our emergency centres. Women cry there, pray there, and find people to talk to."* Although informal in structure, such spaces provided culturally meaningful environments for emotional expression and collective processing of trauma. Similarly, women integrated into chamas and support groups showed stronger adaptive

responses. As a CBO leader in Kisumu explained, *"Women who are in support groups have a faster recovery. They comfort one another, share and have reasons to look forward to."* These networks operated as de facto intervention platforms, reinforcing even minimal formal responses and enhancing resilience among moderately affected survivors.

Quantitative findings corroborated these observations. Respondents who reported sustained access to social support exhibited lower levels of persistent intrusive thoughts, avoidance behaviours, and emotional numbing compared to those lacking such networks. Social support therefore functioned as a mediating mechanism, strengthening the impact of immediate interventions and mitigating symptom progression. Nonetheless, its buffering capacity was limited in high-severity cases. As one ward administrator acknowledged, *"To the ones who are badly affected… they separate… no matter how much we talk, it is never enough."* This underscores that while communal solidarity is protective, it cannot substitute specialised trauma care for survivors presenting with severe symptomatology.

Disparities in access also emerged. Overreliance on NGO-led services created unequal coverage, as illustrated by a ward administrator in Kondele who stated, *"A woman may receive nothing more than family prayers in the event that she is not a household name to an NGO."* Women embedded within organised community structures—particularly in highly mobilised areas such as Guadalupe and Shofco—demonstrated stronger recovery trajectories than those in more fragmented settings like Kondele. These patterns highlight the dual role of social support as both immediate stabilisation mechanism and sustained coping system within resource-constrained environments.

The findings align with Cognitive Behavioural Therapy (CBT) principles, which emphasise early interruption of maladaptive cognitions following trauma (Beck & Haigh, 2014). Immediate communal reassurance and structured counselling likely disrupted catastrophic thought cycles before consolidation. Narrative Restructuring Theory (White & Epston, 1990) further explains how safe spaces for storytelling facilitated early meaning-making and identity reconstruction, reducing emotional numbing and enhancing coherence in trauma narratives. Together, the evidence suggests that community-based support significantly enhances intervention effectiveness for moderate trauma cases, while integration with professional psychological services remains essential for severe presentations.

CONCLUSION

The research confirms that urgent trauma treatment measures have a strong effect on the psychological health of women victims of political violence in informal settlement settings. Early response strategies, specifically Psychological First Aid, community-based counselling, crisis support, and the provision of safe spaces, are critical stabilising agents that prevent acute psychological disequilibrium. Such interventions help to note the reduction of anxiety, depressive affect, and emotional numbing, thus re-establishing a functional balance to some extent in the direct post-violence aftermath.

However, the results indicate that the efficacy of such interventions is not homogenous and transformative everywhere. Instead, it depends on how traumatic the exposure was and whether the social structures are supportive. Moderate trauma women are found to be more open to community-based and interpersonal types of support that enhance control over emotions and meaning creation in familiar social settings. However, survivors who develop with a high level of psychological interference have shown a weak recovery upon interventions that are informal, unstructured, or lack clinical richness. This difference highlights the insufficiency of undifferentiated response models in dealing with heterogeneous trauma profiles.

Conceptually, the research confirms the operation of immediate interventions as being a requisite yet imperfect process of recovery. They stabilise, yet fail to complete the restoration; they include distress, yet fail to resolve it. Immediacy alone cannot therefore guarantee sustainable psychological well being. It involves the intentional incorporation of the tiered, professionally coordinated systems of trauma care that integrate early psychosocial care with a well-structured assessment, referral routes, and specialised therapeutic interactions. In this aspect, recovery is not a one-time event, but a stratified process where the immediate intervention serves as the base on which future psychological restitution has to be built.

RECOMMENDATION

The paper suggests the establishment of tiered trauma response networks in informal settlements, which incorporates the instant community-based interventions with professional psychological care. County governments need to institutionalise the Psychological First Aid (PFA) training of ward administrators, community leaders, and religious agents, and create rapid response, teams, which can carry out the early trauma screening and selective triage. The linkages between the community support systems and the hospitals as well as the specialised counselling services should be consolidated to guarantee timely treatment of high-severity

cases. Also, there is need to formalise and endorse the previous social support systems like women groups, churches, and chamas, which are in line with the professional trauma care systems.

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