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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 of the Study: The purpose of the study was to examine the influence of immediate trauma intervention strategies on the psychological well-being of women survivors of political violence.

Statement of the Problem: Political violence continues to cause serious psychological harm among women living in informal settlements. These effects are worsened by poverty, displacement, insecurity, and weak institutional support systems. Although immediate trauma interventions are often provided after violent events, limited evidence exists on how these interventions influence the psychological well-being of women survivors in informal settlement contexts.

Methodology: The study was guided by Crisis Theory, Cognitive Behavioral Therapy, and Narrative Restructuring Theory, and adopted a convergent parallel mixed-methods design involving questionnaires from 200 women survivors and key informant interviews, with data analyzed using descriptive statistics, Chi-square analysis, and thematic analysis.

Findings: The findings showed that immediate trauma interventions, including Psychological First Aid, crisis counselling, community-based support, and emergency assistance, contributed to reduced anxiety, depressive moods, and emotional numbness among survivors. The Chi-square results, $\chi^2 = 61.69$, $p < 0.05$, indicated a statistically significant relationship between immediate trauma interventions and psychological well-being.

Conclusion: The study concludes that immediate trauma interventions are important in stabilising women survivors of political violence during acute crisis periods.

Recommendation: The study recommends the establishment of structured, professional, and long-term psychosocial support frameworks within informal settlements.

Keywords: *Immediate Trauma Interventions, Psychological First Aid, Political Violence, Women Survivors, Psychological Well-Being, Informal Settlements, Kenya*.

BACKGROUND TO THE STUDY

Political violence is one of the most consequential precipitants of psychological trauma in modern societies that generate chronic mental health crises in both low- and middle-income countries and conflict-affected urban areas around the globe (Institute for Economics and Peace, 2023; ACLED, 2023). Clinically significant psychological distress, including post-traumatic stress disorder (PTSD), major depression, and generalized anxiety disorders, are consistently found among between one-third and one-half of populations exposed to conflict (Morina et al., 2013; Koenen et al., 2017). Politically motivated violence specifically alters the fundamental psychological assumptions of safety, trust, and predictability and undermines the cognitive and affective foundations on which sound functioning is anchored (APA, 2013; WHO, 2019). These disturbances do not disappear overnight, unless there is intentional psychosocial intervention; the acute stress reactions become chronic psychopathology, producing long-term losses in social functioning, occupational capacity, and quality of life (Roberts et al., 2019; Tol et al., 2013).

Women are also disproportionately impacted in conflict environments where they face greater trauma symptom severity (especially where political violence is intersected with gender-based abuse and economic marginalization) (Tolin and Foa, 2006; Stavrou et al., 2019). They are not only exposed to direct physical harm but also to sexual violence, forced displacement, widowhood, single parenthood, and the increased caregiving and survival burdens that conflict imposes on them (UN Women, 2024; KNCHR, 2008). Such compounded psychological vulnerability is created by these layered exposures, as women simultaneously process personal trauma and bear expanded household and community responsibilities in conditions of sustained insecurity (Silove et al., 2017; WHO, 2019). These vulnerabilities are structurally amplified in urban informal settlements, which are characterized by extreme population density, endemic poverty, and weak institutional infrastructure (UN-Habitat, 2020; Silove et al., 2017).

The informal settlements in Kenya are an especially acute reflection of these global processes. Repeat episodes of post-election violence, most widely reported during the 20072008 crisis and later in 2017 have made settlements like Kibera in Nairobi and Nyalenda, Kondele and Nyawita in Kisumu persistent epicentres of civil unrest, displacement and psychosocial disruption (KNCHR, 2008; TJRC, 2013). The combination of the large population density, the ethno-political polarization, the economic marginalization, and the limited state protection of these settlements contributes to both the degree of exposure and the aspect of recovery constraints (Mutahi, 2011; Klopp and Orina, 2018). Epidemiological literature estimates the

prevalence of PTSD among survivors in these areas at between 30% and 47%, which places Kenya at the top end of the conflict-trauma load spectrum globally (Onyancha et al., 2018; Owiti et al., 2019). Women in these environments experience especially harsh psychological effects, with observed evidence of high levels of sexual violence, widowhood, loss of livelihood, and emotional breakdown on a long-term basis following each electoral crisis (Onyut et al., 2009; Onyango and Ojara, 2021).

Grounded in the global recognition of the need to have strategies that can respond to the immediate response to acute psychological injury in the context of post-violence (WHO and UNHCR, 2015; Sphere Association, 2018). The main early-response strategies, such as Psychological First Aid (PFA), Critical Incident Stress Management (CISM), crisis counselling, emergency shelter provision, and rapid community-based psychosocial response, are developed to stabilize survivors, re-establish the perceived safety, reduce the physiological hyperarousal, and strengthen social connectedness before the trauma consolidates into persistent psychopathology (Brymer et al., 2012; Everly and Mitchell, 2008). According to Hobfoll et al. (2007), there are five empirically verified principles of effective immediate post-trauma response: promoting safety, calming, self-efficacy, connectedness, and hope, each of which addresses a different dimension of acute psychological shock. These mechanisms have a protective value, which is supported by empirical evidence: early psychosocial stabilization has been shown to reduce the effects of intrusive memory formation, lessen the severity of anxiety symptoms, and significantly lower the risk of progressing to chronic PTSD and major depressive disorder (Roberts et al., 2019; Tol et al., 2013).

The operationalized construct of psychological well-being extends far beyond the lack of clinical symptoms to include positive functioning of autonomy, environmental mastery, personal growth, purpose in life, and quality interpersonal relationships (Ryff, 2014; Keyes, 2020). Every one of these dimensions is directly weakened by political violence, which disrupts social networks, perceived control, identity integrity, and creates an overall sense of powerlessness and reduced self-efficacy (Kira et al., 2020; Stavrou et al., 2019). Structural stressors, such as unemployment, housing insecurity, social stigma, and others, are multiplied in the clinical deficit in the context of resource-constrained informal settlements (Silove et al., 2017; UN Women, 2024). It is thus imperative to assess the impact of immediate trauma interventions on psychological well-being in its full multidimensional nature, as recovery cannot be meaningfully evaluated through symptom reduction only (WHO, 2019; Keyes, 2020).

Although the impact of trauma has been documented, and the theoretical significance of early intervention is acknowledged, limited empirical research has examined the direct effect of immediate trauma intervention programs on the psychological well-being of women survivors in Kenya's informal settlements (UNDP, 2022; KNCHR, 2018). Much of the literature that exists focuses on the prevalence of trauma, the long-term therapeutic effects, or the description of the programmatic execution of the intervention's delivery, without isolating the proximate and stabilising contribution of early response mechanisms in high-risk, low-resource urban settings (Brymer et al., 2012; WHO, 2019). Within the informal settlements in Kenya specifically, anecdotal and institutional reports indicate that gaps in the capacity to respond rapidly to psychological crises persist in Kenya, compounded by a lack of trained personnel and poor coordination between the county governments and the community-based organizations, leaving the most vulnerable survivors without the ability to receive early support (UNDP, 2022; KNCHR, 2018). This is a serious gap in the scholarship and practice directly relevant to the design, prioritization, and institutionalization of systems of psychosocial responses in post-violence recovery settings.

This study was therefore designed 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 (Kibera) and Kisumu (Nyalenda, Kondele, and Nyawita), Kenya. Theoretically, the study is anchored in Crisis Theory as developed by Caplan (1964) and subsequently extended by Roberts (2005) and James and Gilliland (2017), which posits that timely and structured intervention during the acute crisis phase can restore psychological equilibrium and prevent the crystallization of long-term psychopathology.

This foundation is complemented by principles drawn from Cognitive Behavioral Therapy (CBT) and Narrative Restructuring Theory, which illuminate the mechanisms through which immediate interventions interrupt maladaptive cognitive appraisals and facilitate early meaning-making in the aftermath of traumatic exposure (Beck & Haigh, 2014; White & Epston, 1990). Employing a convergent parallel mixed-methods design, the study generates triangulated evidence that speaks simultaneously to the empirical question of intervention effectiveness and the structural realities that condition it, contributing context-specific insights to global trauma recovery scholarship while informing policy and programmatic frameworks for tiered trauma response within Kenya's informal settlement environments.

Objective of the Study

To determine the influence of immediate trauma intervention strategies on the psychological well-being of women survivors of political violence in the informal settlements in Nairobi and Kisumu.

Hypothesis of the Study

Immediate trauma intervention strategies do not have a statistically significant influence on the psychological well-being of women survivors of political violence in the informal settlements of Nairobi and Kisumu.

METHODOLOGY

The study employed a convergent parallel mixed-methods design, allowing simultaneous collection and analysis of quantitative and qualitative data to examine how immediate trauma intervention strategies influence psychological well-being, with triangulation enhancing validity and contextual depth (John W. Creswell & Vicki L. Plano Clark, 2018). It was conducted among women survivors of political violence (2007–2023) in informal settlements of Nairobi (Kibera) and Kisumu (Nyalenda, Kondele, Nyawita), with a sample of 209 respondents selected through stratified random sampling and purposive selection of key informants.

Quantitative data were collected via structured questionnaires measuring interventions such as Psychological First Aid, crisis counselling, and rapid response support alongside psychological well-being indicators, while qualitative data were obtained through semi-structured interviews. Reliability was confirmed using Cronbach's alpha ($\alpha > 0.70$), and validity through expert review and pilot testing. Data analysis involved descriptive statistics, correlation, and regression using SPSS (Version 26), alongside thematic analysis for qualitative data, with integration at interpretation to align statistical results with participant experiences, all conducted under strict ethical standards including NACOSTI approval, informed consent, and confidentiality.

RESULTS AND DISCUSSION

The study employed both descriptive and inferential statistical techniques to analyze the quantitative data, while thematic analysis was used to interpret qualitative responses from key informants. Descriptive statistics, percentages, and Chi-square analysis were specifically applied to examine the relationship between immediate trauma intervention strategies and the

psychological well-being of women survivors of political violence in Nairobi and Kisumu informal settlements.

Influence of Immediate Trauma Intervention Strategies on Psychological Well-being

Immediate Trauma Intervention Strategies

The results have shown that the strategies of immediate trauma intervention were highly used in the study areas, with the responses of survival orientation, especially flight to safety, as the most dominant type of immediate action, as shown in Table 1.

Table *1:* Immediate Trauma Intervention Strategy

Trauma Intervention Strategy	Strongly Disagree (%)	Disagree (%)	Undecided (%)	Agree (%)	Strongly Agree (%)
Ran away to a secure place	19 (9.5)	5 (2.5)	6 (3.0)	48 (24.0)	122 (61.0)
Received material support	28 (14.4)	31 (16.0)	8 (4.1)	67 (34.5)	60 (30.9)
Participated in PFA/debriefing/sharing sessions	34 (17.6)	27 (14.0)	9 (4.7)	57 (29.5)	66 (34.2)
Perceived support as helpful	41 (21.4)	28 (14.6)	8 (4.2)	51 (26.6)	64 (33.3)
Flashback of the trauma (Residual Distress)	8 (4.0)	8 (4.0)	11 (5.6)	33 (16.7)	138 (69.7)

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

Although a moderate percentage of respondents reported access to structured interventions such as Psychological First Aid, material support, and debriefing sessions, the persistently high levels of residual distress, as indicated by the near 70 percent of respondents reporting ongoing flashbacks, suggest that such interventions only partially psychologically stabilized the respondents and were not sufficient to reduce the deeper effects of trauma.

The response trend is indicative of a lack of therapeutic depth in the immediate intervention models, where accessibility is not always transferable to effectiveness, mostly because of variations in quality, structure, and professional delivery. This interpretation is supported by qualitative evidence, which demonstrates systemic deficiencies, such as the absence of formalized specialized rapid response systems, over-reliance on community and faith-based actors, and a lack of trained providers that can deliver specialized psychological care.

Collectively, the findings indicate that immediate trauma interventions are more of a short-term stabilization strategy that re-establishes safety and reduces acute distress, but not a sustained psychological recovery strategy in the absence of institutional coordination, professionalization, and continuity of care.

Findings on Intervention Effectiveness

The findings demonstrate that immediate trauma intervention strategies yielded measurable, though moderate, improvements across key psychological domains, with community-based counselling reporting the highest improvement in depressive symptoms at 50%, followed by Psychological First Aid reducing anxiety at 45% and crisis support addressing emotional numbness at 42%. This distribution suggests that early psychosocial engagement contributes to initial emotional stabilization, particularly where interventions are socially embedded and enable survivors to process distress within familiar support structures.

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.*

Nonetheless, the persistence of residual distress, with nearly 70% of participants continuing to report emotional pain and intrusive recollections, indicates that these improvements remain largely short-term and do not translate into sustained psychological recovery. This gap reflects limitations in the depth, structure, and continuity of immediate interventions, which are insufficient in preventing trauma consolidation despite their observable buffering effects.

Qualitative evidence reinforces this interpretation by revealing systemic imbalances in intervention delivery, including prioritization of physical survival needs, overreliance on informal and faith-based support systems, and limited availability of trained personnel and

structured psychological frameworks. Variations in effectiveness across providers further indicate that intervention outcomes are strongly conditioned by professional capacity and coordination, suggesting that while immediate responses are essential for crisis containment, their long-term impact on psychological well-being remains constrained without integrated and sustained care systems.

Hypothesis Testing: Chi-square Results

To further determine the influence of immediate trauma intervention strategies on psychological well-being, the study subjected the following null hypothesis to inferential statistical examination:

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.

A Chi-square test of independence was conducted to assess the statistical association between access to immediate trauma interventions and categorized levels of psychological well-being, operationalized across four ordinal classifications: Low, Moderate, High, and Optimal. The Chi-square test of independence is particularly appropriate for this analytical purpose, as it determines whether observed distributional differences between categorical variables exceed what would reasonably be attributable to chance, thereby establishing whether a substantive associative pattern exists within the data (Field, 2018; Pallant, 2020). Table 3 presents the results of this inferential analysis.

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

The analysis yielded a Chi-square value (χ^2) of 61.69 with a corresponding p-value of 0.0402. Since this p-value falls below the conventionally accepted significance threshold of $\alpha = 0.05$, the null hypothesis was rejected (Field, 2018). This outcome confirms a statistically significant relationship between exposure to immediate trauma intervention strategies and psychological well-being outcomes among women survivors of political violence in Nairobi and Kisumu's informal settlements. The magnitude of the Chi-square statistic further suggests that the observed distributional differences across well-being categories were not incidental but reflected a systematic pattern of association between early intervention access and psychological functioning levels.

The inferential results are substantively consistent with and support the descriptive patterns found in the analysis provided above. Women who received immediate interventions, such as Psychological First Aid, community-based and crisis support counselling, were significantly more likely to report higher levels of psychological well-being compared to women who received no such early intervention (Brymer et al., 2012; WHO and UNHCR, 2015). The decreases in anxiety, depressive mood, and emotional numbness reported descriptively among intervention recipients thus finding statistical reinforcement in the Chi-square outcome, creating a coherent and mutually reinforcing empirical picture of the relationship between early psychosocial engagement and psychological recovery (Hobfoll et al., 2007; Roberts et al., 2019).

The statistically significant correlation also follows the theoretical framework of the study. According to Crisis Theory, the acute post-violence period is a window of increased psychological vulnerability, through which an early intervention can decisively interrupt the entrenchment of maladaptive coping styles and prevent the transition into a phase of chronic psychopathology (Caplan, 1964; Roberts, 2005). The empirical evidence of the chi-square findings is that the structured early responses is empirically valid in altering the trajectory of psychological well-being among women survivors. Complementary to this, the principles of Cognitive Behavioral Therapy (CBT) imply that immediate interventions act by targeting the maladaptive negative thought appraisals, and emotional deregulation at the outset of the crisis, thereby disrupting negative thought consolidation before it becomes embedded (Beck and Haigh, 2014). The Narrative Restructuring Theory also sheds some light on how early facilitation of safe spaces where victims can express their emotions allows the victims to start constructing their own coherent trauma narratives, leading to a reduction in emotional numbing

and a restoration of a sense of personal agency (White and Epston, 1990). Combined, these theoretical lenses create a cogent explanatory architecture of how and why early intervention is important.

However, the inferential results should be explained with the necessary analytical sensitivity. Although the Chi-square test confirms that there is a significant association between the immediate interventions and the psychological well-being, it does not establish causation and does not account for the moderating effect of the severity of trauma and the availability of social support reported in other dimensions of this study (Pallant, 2020; Field, 2018). Women with severe trauma symptomatology proved to be less responsive to unstructured community-based interventions, irrespective of access, which suggests that the relationship between early intervention and well-being is mediated by the depth, quality, and professional competence inherent in those interventions (Johnson & Zlotnick, 2020; WHO, 2018). The statistical significance should thus not be construed as a blanket endorsement of the presence of any early response mechanism, but rather as an affirmation that organized, accessible and properly calibrated instant interventions are a meaningful determinant of psychological well-being outcomes among women survivors of political violence in high-risk informal settlement settings.

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—characterized by anxiety, fear, and emotional distress—were more likely to experience short-term stabilization 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 traumatized 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 specialized 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-specialized 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 specialized 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 specialized 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, neighbors, churches, and women's associations functioned as primary sources of emotional and material stabilization. As one ward administrator in Nyalenda observed, *"Women seek the protection of their relatives, the churches or their neighbors 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 organizations were repeatedly described as central psychosocial anchors. A CBO director in Kibera noted, *"Churches are our emergency centers. 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 behaviors, 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 specialized 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 organized community structures—particularly in highly mobilized 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 an immediate stabilization mechanism and a sustained coping system within resource-constrained environments.

The findings align with Cognitive Behavioral Therapy (CBT) principles, which emphasize 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.

HYPOTHESIS TESTING

The study tested the following null hypothesis:

H_{01}: Immediate trauma intervention strategies do not have a statistically significant influence on the psychological well-being of women survivors of political violence in the informal settlements of Nairobi and Kisumu.

A Chi-square test of independence was conducted to determine whether immediate trauma intervention strategies were significantly associated with psychological well-being among women survivors of political violence. The test was appropriate because both variables were treated categorically, with psychological well-being classified across different outcome levels. The results showed a Chi-square value of $\chi^2 = 61.69$ and a p-value = 0.0402. Since the p-value was less than the 0.05 level of significance, the null hypothesis was rejected. This means that immediate trauma intervention strategies had a statistically significant influence on the psychological well-being of women survivors of political violence in the informal settlements of Nairobi and Kisumu.

The finding implies that women who accessed immediate trauma intervention strategies such as Psychological First Aid, crisis counselling, emergency support, and community-based counselling were more likely to report improved psychological well-being compared to those who did not receive such support. Therefore, the study concludes that immediate trauma

interventions play a meaningful role in reducing anxiety, depressive moods, emotional numbness, and acute distress among women survivors. Nevertheless, the persistence of residual trauma symptoms shows that immediate interventions should be strengthened through structured referral systems, professional counselling, and sustained psychosocial support.

CONCLUSION

The findings affirm that immediate trauma intervention strategies form a critical first step in the recovery journey of women exposed to political violence by restoring a sense of safety, connection, and initial emotional balance during moments of acute disruption. These early responses interrupt the escalation of distress and create conditions necessary for coping; nonetheless, recovery unfolds as a continuum, and where interventions remain informal, unstructured, and short-lived, psychological strain persists beneath the surface. This underscores that while immediate interventions are indispensable for crisis containment, their transformative potential depends on integration with structured, sustained, and professionally anchored systems of care capable of supporting long-term psychological well-being.

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