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MENTAL HEALTH STUDIES

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

[1*]Magdalene Kanini Mutua & [2]Owen Ngumi

[1]Department of Psychology, Counselling and Educational Foundations, Egerton University

[2]School of Education, Arts and Social Sciences, Zetech University

***Email of the Corresponding Author: katuamagdalen@gmail.com**

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ABSTRACT

Purpose of the Study: The study investigated how post-trauma intervention strategies affect the psychological well-being of women survivors of political violence.

Statement of the Problem: Women survivors of political violence continue to experience trauma, anxiety, emotional instability, and reduced coping capacity. Although formal and informal support systems exist, their accessibility, sustainability, and long-term effectiveness remain limited.

Methodology: The study adopted a convergent mixed-methods design. It involved 200 women survivors and qualitative interviews with ward administrators and leaders of community-based organizations.

Findings: The findings showed statistically significant negative correlations between structured post-trauma interventions and psychological distress. CBT reduced PTSD symptoms ($r = -0.42$, $p = .01$) and anxiety symptoms ($r = -0.37$, $p = .01$). Group therapy also reduced distress. Age, marital status, and employment status significantly influenced participation and recovery outcomes.

Conclusion: The study concludes that post-trauma interventions improve psychological well-being, but sustainable recovery is limited by inadequate counselling staff, fragmented services, and weak follow-up systems.

Recommendation: The study recommends integrated, culturally responsive trauma care combining formal therapy with community-based support systems.

Keywords: *Post-trauma interventions, Psychological well-being, Political violence, Women survivors, Cognitive Behavioral Therapy, Informal settlements, Kenya*

INTRODUCTION

Psychological well-being constitutes a central outcome in trauma research, particularly within contexts of political violence where exposure to distressing events disrupts emotional stability, cognitive functioning, and social integration. It extends beyond the mere absence of mental illness to encompass positive functioning across domains such as emotional regulation, self-acceptance, purpose in life, relational connectedness, and personal growth (Ryff, 2014; Diener et al., 2018). In post-trauma contexts, psychological well-being is often compromised, with survivors experiencing persistent symptoms of post-traumatic stress disorder (PTSD), anxiety, depression, and prolonged grief, alongside diminished agency and social withdrawal (Charlson et al., 2019; World Health Organization [WHO], 2022). Trauma disrupts fundamental assumptions about safety, identity, and predictability, thereby destabilizing both internal psychological processes and external relational systems (Herman, 2015). Consequently, recovery is not an immediate event but a prolonged and multidimensional process requiring sustained intervention to restore functional and meaningful living.

Within this recovery trajectory, post-trauma intervention strategies emerge as critical mechanisms through which psychological well-being may be restored or enhanced. These interventions encompass structured psychological therapies such as Cognitive Behavioral Therapy (CBT), group counselling, trauma-focused psychotherapy, and narrative therapy, as well as community-based and culturally grounded approaches including faith-based support, indigenous healing practices, and social reintegration programs (Hofmann et al., 2021; Cuijpers et al., 2022; WHO, 2018). CBT, in particular, operates through cognitive restructuring, enabling survivors to identify and modify maladaptive thought patterns that sustain emotional distress (Beck & Haigh, 2014). Group therapy facilitates relational healing by providing shared spaces for narrative expression, emotional validation, and social support, which are essential in rebuilding trust and reducing isolation (Ehlers et al., 2010). Beyond formal therapy, coping mechanisms such as spiritual engagement, peer support, and economic participation further contribute to adaptive functioning and resilience, especially in low-resource settings where formal services are limited (Ainamani et al., 2020; Prati & Pietrantoni, 2009). Collectively, these components reflect a layered intervention framework aimed at both symptom reduction and broader psychological reconstruction.

The relationship between post-trauma intervention strategies and psychological well-being is therefore both clinically and socially grounded. Empirical evidence consistently demonstrates that structured interventions significantly reduce trauma-related distress while facilitating

recovery processes aligned with emotional stability, resilience, and post-traumatic growth (Hofmann et al., 2012; Cuijpers et al., 2022). Cognitive-based therapies address internal psychological processes, while group and community-based interventions strengthen relational and social dimensions of recovery (Tol et al., 2013; Bangpan et al., 2017). Nonetheless, the effectiveness of these interventions is contingent upon accessibility, continuity, cultural relevance, and integration within broader support systems. Where interventions are fragmented, short-term, or poorly aligned with local contexts, their impact tends to be partial, leading to symptom reduction without full psychological restoration (Ventevogel et al., 2019; WHO, 2022). Thus, the relationship is not merely direct but moderated by structural, cultural, and socio-economic conditions that shape both participation and outcomes.

Globally, political violence remains a persistent driver of psychological distress, particularly in fragile and transitional democracies where institutional protection is weak and recovery systems are underdeveloped (United Nations, 2023; Armed Conflict Location & Event Data Project [ACLED], 2022). Exposure to violence, displacement, and loss has been associated with high prevalence rates of PTSD, anxiety disorders, and depression across affected populations (Charlson et al., 2019; WHO, 2022). Although high-income settings have increasingly institutionalized trauma-informed care frameworks, including tiered mental health systems and long-term follow-up mechanisms, significant disparities persist in low- and middle-income countries where treatment gaps exceed 70% (WHO, 2022). In such contexts, interventions are often donor-driven, episodic, and insufficiently embedded within public health systems, thereby limiting their long-term effectiveness.

At the regional level, Sub-Saharan Africa continues to experience recurrent episodes of political instability, electoral violence, and communal conflict, all of which generate sustained psychosocial consequences (ACLED, 2022; United Nations, 2023). Mental health systems across the region remain under-resourced, characterized by limited professional capacity, weak referral systems, and minimal integration of trauma-informed care into primary health services (WHO, 2022). As a result, survivors frequently rely on informal support systems, including family networks, religious institutions, and community-based organizations, for psychological coping (Ainamani et al., 2020). While these systems provide culturally relevant and accessible support, they often lack the structured therapeutic approaches required to address severe trauma conditions, thereby creating a gap between emotional support and clinical recovery.

In the Kenyan context, political violence has been a recurrent phenomenon, particularly during electoral cycles, with the 2007/2008 post-election crisis representing one of the most severe

episodes. The violence resulted in widespread displacement, loss of life, and enduring psychological trauma among affected populations (Kenya National Commission on Human Rights [KNCHR], 2008). Subsequent studies have documented high prevalence of PTSD, depression, and anxiety among survivors, particularly women in informal settlements who experienced compounded vulnerabilities including sexual violence, economic disruption, and caregiving burdens (Makumi, 2015; Muchemi, 2018; Onyango & Ojara, 2021). Despite the magnitude of these psychological effects, long-term trauma recovery systems remain fragmented, with limited integration of structured interventions into county-level health frameworks.

Urban informal settlements such as Kibera in Nairobi and Nyalenda, Nyawita, and Kondele in Kisumu represent critical sites where the intersection of political violence and structural vulnerability intensifies psychological risk. These settings are characterised by high population density, poverty, limited access to formal services, and fragile infrastructure, all of which constrain both immediate response and long-term recovery (UN-Habitat, 2020). Evidence from these contexts indicates that while emergency interventions such as Psychological First Aid and humanitarian assistance are often deployed during crises, sustained post-trauma support remains inconsistent and largely dependent on non-governmental organisations and faith-based actors (Ventevogel et al., 2019). Consequently, many survivors experience prolonged distress, with limited access to structured therapies such as CBT and inadequate follow-up mechanisms to support recovery.

It is within this context that the present study is situated. While existing literature has extensively documented trauma prevalence and immediate crisis responses, there remains limited empirical evidence on how structured post-trauma intervention strategies influence long-term psychological well-being among women survivors in informal settlements. The persistence of psychological distress despite the availability of certain support mechanisms raises critical questions regarding the effectiveness, accessibility, and sustainability of current intervention frameworks. Therefore, this study seeks to examine the extent to which post-trauma intervention strategies contribute to psychological recovery, with a particular focus on the interaction between formal therapeutic approaches, culturally embedded practices, and structural conditions within Nairobi and Kisumu informal settlements.

Objective of the Study

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

Hypothesis

Post-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

This study adopted a convergent mixed-methods design to examine the influence of post-trauma response strategies on the psychological well-being of women survivors of political violence in informal settlements of Nairobi (Kibera) and Kisumu (Nyawita, Kondele, and Nyalenda). The quantitative component utilized structured questionnaires administered to 200 women survivors selected through purposive and stratified sampling to ensure representation across the five sites. Post-trauma response strategies were measured using indicators such as access to counselling services, participation in indigenous counselling practices, and engagement in adaptive coping mechanisms. Psychological well-being was assessed using composite measures aligned to low, moderate, high, and optimal functioning categories. Descriptive statistics and Chi-square tests were employed to determine associations between intervention exposure and well-being outcomes.

The qualitative component involved key informant interviews with ward administrators and directors of community-based organizations to contextualize the quantitative findings and explore implementation realities. Data were analyzed thematically to identify patterns relating to intervention accessibility, cultural responsiveness, and recovery experiences. Integration of findings occurred at the interpretation stage to enhance validity and provide a comprehensive understanding of how structured post-trauma strategies influence psychological rebuilding within low-resource urban settings.

RESULTS AND DISCUSSION

This section presents the findings on the influence of post-trauma response strategies on the psychological well-being of women survivors of political violence in selected informal settlements of Nairobi and Kisumu. The results integrate quantitative evidence on counselling access, indigenous healing practices, and coping mechanisms with qualitative insights from

ward administrators and community-based organisation leaders. Together, the findings provide a comprehensive assessment of how sustained post-trauma interventions contribute to varying levels of psychological well-being among survivors.

Demographic Factors and Post-Trauma Interventions

This subsection presents the demographic determinants of participation in post-trauma intervention programs among women survivors of political violence in Nairobi and Kisumu informal settlements.

Table *1*: Chi-Square Results, Demographic Characteristics, and Participation in Post-Trauma Programs

Variable	Chi-Square Value	df	p-value	Result
Age Group	16.32	4	0.002	Significant
Marital Status	9.47	2	0.021	Significant
Socio-Economic Status	4.50	3	0.344	Not Significant
Educational Level	7.39	3	0.061	Marginally Significant
Employment Status	11.23	2	0.008	Significant

The Chi-square analysis confirms that participation in post-trauma intervention programs was not evenly distributed across demographic groups, but rather structured by specific social and positional factors. Age emerged as a statistically significant determinant of engagement (χ^2 = 16.32, p = 0.002), indicating that women in the 30–50 year bracket were more likely to participate in counselling and psychosocial programs. This pattern reflects the dual pressures faced by women in their economically and socially active years, where caregiving roles and household leadership responsibilities may heighten both exposure to trauma and motivation to seek structured support. The finding signals that post-trauma engagement is partly shaped by life-stage responsibilities and perceived relational obligations.

Marital status was also significantly associated with participation ($\chi^2 = 9.47$, $p = 0.021$), though the direction of influence varied across contexts. Quantitatively, married women demonstrated higher levels of engagement, potentially reflecting spousal encouragement or shared concern for family stability. Nonetheless, qualitative evidence revealed a more complex dynamic. Widows and single mothers often sought interventions more proactively due to social isolation and the absence of household support. As one CBO leader noted, *"Widows come to us fast.*

They have no one else." Conversely, in some households, patriarchal control limited women's access to services, with one ward administrator reporting, *"Some men tell their wives not to waste time in counselling meetings."* These patterns underscore how marital structures can either facilitate or constrain psychosocial recovery pathways.

Employment status also demonstrated a significant relationship with participation ($\chi^2 = 11.23$, $p = 0.008$). Economically active women were more likely to access post-trauma programs, suggesting that financial autonomy, exposure to information networks, and enhanced decision-making power contribute to service uptake. Employment may strengthen psychological agency and reduce dependency barriers that inhibit help-seeking. In contrast, unemployment, while common in informal settlements, did not automatically translate into increased engagement despite potentially higher vulnerability.

Educational attainment, although marginally significant ($\chi^2 = 7.39$, $p = 0.061$), revealed a clear directional trend: higher education was associated with greater participation in formal counselling services. Women with secondary or tertiary education demonstrated stronger psychological literacy and lower stigma toward professional support. A CBO leader observed, *"Those who've gone to school understand counselling better. They know it's not a weakness to seek help."* Less-educated women were more likely to rely on informal or faith-based mechanisms, often perceiving professional psychological services as unfamiliar or unnecessary.

Notably, socio-economic status did not show a statistically significant effect ($\chi^2 = 4.50$, $p = 0.344$), suggesting that within the uniformly low-resource environment of informal settlements, income differentials alone did not drive participation patterns. Instead, relational networks, education, and social positioning appeared more influential than income stratification in shaping engagement decisions.

Qualitative findings further highlighted contextual moderators beyond statistical associations. Older women tended to prefer culturally embedded support systems such as church elders or informal gatherings. As one administrator remarked, *"Our older women prefer talking to elders or going to church. Counselling rooms are for the young."* Caregiving burdens also constrained attendance, particularly among mothers and household heads. Stigma surrounding trauma disclosure, especially for survivors of sexual violence, inhibited participation in group-based

settings. A CBO director explained, *"When everybody knows what happened to you, it is hard to sit in a group and speak."*

Collectively, these findings demonstrate that demographic and social-position variables significantly mediate access to and utilisation of post-trauma interventions. Participation is shaped not merely by service availability but by age-related roles, marital dynamics, education-linked awareness, employment-driven autonomy, caregiving responsibilities, and cultural norms. Post-trauma programming that fails to integrate these demographic realities risks perpetuating participation disparities and limiting psychological recovery outcomes among women survivors in informal settlement contexts.

Effectiveness of Post-Trauma Interventions

This subsection evaluates the effectiveness of structured post-trauma interventions in reducing psychological distress among women survivors of political violence in Nairobi and Kisumu informal settlements. The analysis focuses on Cognitive Behavioural Therapy (CBT) and group therapy, examining their statistical association with PTSD and anxiety symptoms.

Table *2:* Pearson Correlation coefficients amongst participation in post-trauma interventions and psychological distress levels

Intervention Type	PTSD Symptoms (r)	p-Value	Anxiety Symptoms (r)	p-Value
Cognitive Behavioural Therapy (CBT)	–0.42	.01	–0.37	.01
Group Therapy	–0.39	.01	–0.33	.01

Note. *Negative correlations specified that the higher the level of participation in interventions, the lower the level of psychological distress associated with it.*

The Pearson correlation results demonstrate statistically significant negative relationships between participation in structured interventions and psychological distress. CBT showed a moderately strong negative correlation with PTSD symptoms ($r = –0.42$, $p = .01$) and anxiety symptoms ($r = –0.37$, $p = .01$), indicating that increased participation in CBT sessions was associated with meaningful reductions in trauma-related symptom severity. Similarly, group therapy exhibited significant negative correlations with PTSD ($r = –0.39$, $p = .01$) and anxiety

($r = –0.33$, $p = .01$). Although slightly weaker than CBT, these coefficients confirm that group-based interventions contributed to measurable symptom reduction.

The direction and consistency of these correlations suggest that structured therapeutic engagement plays a protective and restorative role in trauma recovery. The stronger association observed for CBT aligns with its structured cognitive restructuring mechanisms, which directly target maladaptive thought patterns and emotional dysregulation. Group therapy, while slightly less potent statistically, appears to offer collective validation, emotional ventilation, and relational reinforcement, which are critical components of recovery in communal settings. Together, these findings provide quantitative support for embedding formal psychological services within post-conflict recovery frameworks in informal settlements.

Qualitative findings deepen this interpretation by illustrating how survivors experience these interventions. CBO leaders consistently affirmed the emotional relief generated through counselling spaces. As one respondent noted, *"Even short counselling helps. Once women talk, they feel lighter; but most don't get that chance."* This observation underscores both the therapeutic value of emotional expression and the structural limitations restricting access.

Group counselling was particularly valued for its capacity to reduce isolation and normalise trauma responses. As described by a Kibera-based facilitator, *"They heal by listening to each other. They realise they are not alone."* This reflects the psychosocial function of shared narrative reconstruction, which enhances belonging and mitigates shame. Nonetheless, facilitators acknowledged that group settings may overlook individualised psychological needs, limiting their effectiveness for survivors with severe or complex trauma profiles.

Culturally grounded healing approaches also featured prominently. Ward administrators referenced storytelling circles, pastoral counselling, and elder-mediated reconciliation as important components of emotional reintegration. One administrator observed, *"Elders help women forgive and find peace. That is part of healing."* These indigenous mechanisms were viewed as socially legitimate and accessible, particularly in contexts where formal services were scarce. However, their therapeutic depth varied, and they rarely substituted for structured clinical care in severe cases.

A critical limitation emerging from interviews was the short-term and reactive nature of many interventions. As one CBO leader stated, *"The support stops once the violence is over. Trauma does not stop."* This discontinuity undermines sustained psychological recovery and may

contribute to symptom relapse. Additionally, economic empowerment initiatives were repeatedly described as indirectly therapeutic. A Kisumu-based director explained, *"Once a woman can feed her children, she feels stronger. Business training helps the mind heal too."* Income-generating programs enhanced agency, restored purpose, and strengthened self-worth—factors closely aligned with post-traumatic growth processes.

Overall, the integration of quantitative and qualitative findings indicates that structured psychological interventions, particularly CBT, significantly reduce trauma-related distress, while group and culturally grounded approaches strengthen relational and emotional recovery. Nonetheless, their impact is constrained by inconsistent access, limited professional capacity, and insufficient long-term continuity. The findings therefore affirm both the clinical efficacy of structured interventions and the urgent need for sustained, tiered, and resource-supported post-trauma care systems in informal settlement contexts.

Convergent Analysis: Relationship Between Trauma Interventions and Psychological Well-being

This subsection presents a convergent analysis integrating quantitative correlations and qualitative insights to deepen understanding of how post-trauma interventions influence psychological well-being among women survivors of political violence. By combining statistical evidence with contextual narratives from ward administrators and CBO leaders, the study offers a comprehensive interpretation of intervention effectiveness within informal settlement contexts.

Table *3:* Correlation Between Intervention Type and Psychological Distress Outcomes

Intervention Type	PTSD Symptoms	Anxiety Symptoms	Direction of Relationship
Cognitive Behavioural Therapy (CBT)	Significant correlation ($r = -0.42$, $p < .01$)	Significant correlation ($r = -0.37$, $p < .01$)	Negative
Group Therapy	Significant correlation ($r = -0.39$, $p < .01$)	Significant correlation ($r = -0.33$, $p < .01$)	Negative

Note. $p < .01$. Source: Field Data (2025).

Quantitative findings revealed statistically significant negative correlations between structured therapeutic participation and psychological distress outcomes. Engagement in Cognitive Behavioural Therapy (CBT) was significantly associated with lower PTSD symptoms ($r = –0.42$, $p < .01$) and reduced anxiety symptoms ($r = –0.37$, $p < .01$). Similarly, participation in group therapy demonstrated significant negative relationships with PTSD ($r = –0.39$, $p < .01$) and anxiety ($r = –0.33$, $p < .01$). These coefficients confirm that higher levels of participation in structured interventions were linked to lower levels of trauma-related distress. The magnitude of the associations suggests moderate therapeutic effects, with CBT demonstrating slightly stronger impact relative to group therapy.

These statistical outcomes are consistent with established trauma literature that recognises CBT and structured group therapy as empirically supported treatments for PTSD and anxiety disorders (Beck & Haigh, 2014; Hofmann et al., 2012; Ehlers et al., 2010). In the present context, CBT sessions focused on cognitive restructuring, enabling survivors to challenge self-blame, catastrophic thinking, and persistent fear responses. Group therapy provided a relational healing space, fostering shared narrative reconstruction and reducing isolation. As one CBO director in Kibera explained, *"The women who stayed in the CBT sessions registered higher progress over those who attended once or not at all."* This observation aligns with evidence that treatment adherence and session continuity are critical determinants of therapeutic success.

Nonetheless, qualitative findings illuminate structural and contextual constraints limiting sustained recovery. High dropout rates were attributed to stigma, caregiving burdens, economic pressures, transportation challenges, and limited childcare options. These barriers reduced consistent engagement and weakened long-term impact. As a ward administrator in Nyalenda remarked, *"Most women get help when violence happens, but after that, they are forgotten."* This highlights the episodic and reactive nature of many intervention models.

The convergence of findings further demonstrates that intervention effects were positive but partial. While women who accessed counselling or group programs reported improvements, many remained within moderate distress categories. Quantitative patterns showed symptom reduction rather than complete recovery. Qualitative narratives clarified three principal mechanisms supporting psychological improvement: emotional release through storytelling and dialogue, strengthened social connection reducing isolation, and economic participation restoring agency and purpose. A CBO leader in Kibera observed, *"Whenever women are in business, they tell tales and collaborate. That is where her cure starts."* This suggests that

psychosocial and economic empowerment pathways operate synergistically in trauma recovery.

Culturally embedded interventions also enhanced engagement. Indigenous storytelling circles, elder mediation, and faith-based dialogue facilitated trust and reduced stigma, thereby complementing formal therapeutic services. However, where interventions lacked cultural adaptation or long-term continuity, their impact was limited. Women who did not access sustained therapy—particularly older and less-educated survivors—remained vulnerable to persistent symptoms.

Overall, the convergent analysis affirms that structured psychological interventions, especially CBT, significantly reduce PTSD and anxiety symptoms among women survivors. Nonetheless, their effectiveness is moderated by systemic constraints, cultural integration, treatment continuity, and socio-economic realities. The findings underscore the necessity of integrated, sustained, and culturally responsive post-trauma care models that combine formal therapy, community-based support, and economic empowerment strategies to achieve durable psychological recovery in informal settlement settings.

Testing on the Psychologically Implied Trauma Intervention Strategies to Women Survivors of Political Violence

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

H_{02}: *post-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.*

Table 4: Chi-square Test Results: Employment Status and Psychological Well-being

Hypothesis	Statistical Test	Chi-Square Value (χ^2)	p-value	Decision
H_0: No significant relationship between employment status and psychological well-being	Chi-square Test	11.23	0.008	Reject H_0

Source: Field Data (2025).

A Chi-square test of independence was conducted to assess whether engagement in post-trauma interventions particularly Cognitive Behavioral Therapy (CBT) and community-based

counselling was associated with differences in psychological well-being across demographic categories. Employment status emerged as a significant moderating variable. The Chi-square test produced a value of $\chi^2 = 11.23$ (df = 2, p = 0.008). Since $p < 0.05$, the null hypothesis was rejected for this variable, indicating a statistically significant relationship between employment status and psychological well-being. Employed women were more likely to report improved psychological outcomes, suggesting that economic participation enhances both access to interventions and recovery trajectories.

Further Chi-square analyses revealed that age group ($\chi^2 = 16.32$, df = 4, p = 0.002) and marital status ($\chi^2 = 9.47$, df = 2, p = 0.021) were also significantly associated with psychological well-being outcomes. Educational level demonstrated a marginal association ($\chi^2 = 7.39$, df = 3, p = 0.061), while socio-economic status did not show a statistically significant relationship ($\chi^2 = 4.50$, df = 3, p = 0.344).

Table *5*: Chi-square Summary of Demographic Variables and Psychological Well-being

Variable	Chi-Square Value ($x^{2)}$	Degrees of Freedom (df)	p-value	Result
Age Group	16.32	4	0.002	Significant
Marital Status	9.47	2	0.021	Significant
Socio-Economic Status	4.50	3	0.344	Not Significant
Educational Level	7.39	3	0.061	Marginal
Employment Status	11.23	2	0.008	Significant

Source: Field Data (2025).

These findings indicate that psychological recovery is not uniformly distributed across demographic groups. Rather, employment, age positioning, and marital context shape both participation in interventions and psychological outcomes. Women who were economically active, within productive age brackets, and in supportive marital or social arrangements reported relatively better well-being.

The observed reduction in PTSD and anxiety symptoms among women participating in CBT aligns strongly with the foundational principles of Cognitive Behavioral Therapy. Beck and Haigh (2014) explain that CBT enables individuals to identify and restructure maladaptive cognitions that sustain emotional distress. In this study, consistent participation in CBT

sessions was associated with improved emotional regulation, reduced intrusive thoughts, and enhanced coping capacity. CBO directors reported that structured techniques such as behavioral activation, cognitive reframing, and graded exposure helped women manage hyperarousal, flashbacks, and catastrophic thinking patterns. These findings are consistent with evidence identifying CBT as one of the most effective treatments for trauma-related disorders (Hofmann et al., 2012; Ehlers et al., 2010).

In addition to CBT, group-based and narrative-oriented interventions demonstrated therapeutic value. These approaches resonate with Narrative Restructuring perspectives, which emphasize healing through meaning-making and the re-authoring of trauma narratives. Qualitative accounts confirmed that shared storytelling and collective dialogue reduced isolation, validated survivors' experiences, and strengthened peer solidarity. A CBO director in Kibera noted that women who consistently attended sessions demonstrated greater psychological stability than those who discontinued early, reinforcing the importance of treatment adherence.

Despite statistically significant positive effects, systemic barriers constrained long-term impact. Limited funding, absence of structured follow-up systems, shortage of trained personnel, and fragmented service delivery reduced continuity of care. Cultural stigma surrounding psychological counselling particularly among survivors of sexual violence contributed to non-participation and early dropout. Fear of labelling, community rejection, and perceived shame were frequently cited deterrents. These barriers mirror findings from low-resource and post-conflict settings where structural gaps and stigma limit mental health service uptake (Tol et al., 2011; Ventevogel et al., 2019).

In summary, the statistical evidence confirms that post-trauma interventions significantly influence psychological well-being among women survivors of political violence. However, the magnitude and sustainability of these effects are moderated by demographic positioning and systemic constraints. While structured therapies such as CBT and group counselling demonstrate measurable therapeutic benefits, scaling and sustaining these gains requires strengthened institutional frameworks, reduced stigma, and integrated community-based and professional service models within informal settlements.

Patterns of Post-Trauma Interventions Adopted by Women Survivors

The analysis of post-trauma intervention strategies reveals a layered and context-specific recovery landscape among women survivors of political violence in Nairobi and Kisumu

informal settlements. As presented in Table 6, engagement patterns varied across formal psychological services, faith-based coping, traditional rituals, and community-driven support mechanisms, reflecting both availability and cultural acceptability of interventions.

Table 6: Post-Trauma Intervention Strategies Adopted by Participants

Intervention Strategy	Strongly Disagree (%)	Disagree Slightly (%)	Undecided (%)	Agree (%)	Strongly Agree (%)
Continued personal or group counselling	9.3	2.3	7.0	18.6	62.8
Helped to change thinking (CBT)	11.1	22.1	10.0	27.4	29.5
Increased church/prayer commitment	13.6	13.6	8.7	32.6	31.5
Performed traditional rituals for protection	6.6	3.1	4.6	24.5	61.2
Joined a community support group	57.1	17.4	5.4	7.1	13.0
Moved on with life after forgetting the violence	24.1	13.6	5.2	23.6	33.5

Note. *(1 = Strongly Disagree; 5 = Strongly Agree)*

Source: Field Data (2025)

Participation in continued personal or group counselling emerged as the most strongly endorsed formal intervention, with 62.8% of respondents strongly agreeing that they had engaged in counselling. This suggests that general counselling services were relatively visible and accessible within the study areas. Nonetheless, engagement with structured Cognitive Behavioral Therapy (CBT) was comparatively lower (29.5% strongly agree), indicating that although counselling spaces existed, specialized, structured cognitive interventions were less systematically embedded in community practice. This gap points to uneven integration of evidence-based trauma therapies within informal settlement settings.

Faith-based coping strategies constituted a dominant recovery pathway. A combined 64.1% of respondents agreed or strongly agreed that they had increased their church or prayer commitment following the violence. Spiritual spaces therefore functioned as primary psychosocial anchors, offering emotional regulation, communal solidarity, and culturally legitimate forms of healing. Similarly, engagement in traditional protective rituals was substantial (61.2% strongly agree), particularly within Kisumu contexts, demonstrating the enduring relevance of indigenous healing frameworks. These findings confirm that recovery processes are deeply intertwined with local belief systems and culturally embedded practices.

Conversely, formal community support groups were markedly underutilized, with 57.1% strongly disagreeing that they had joined such groups. This suggests structural weaknesses in organized peer-based psychosocial programming, despite its recognized therapeutic potential. The low uptake may reflect limited availability, inadequate mobilization, stigma, or distrust in semi-formal group structures. Notably, while 33.5% strongly agreed that they had "moved on with life after forgetting the violence," a significant proportion continued to report lingering distress, indicating that self-declared coping does not necessarily equate to full psychological recovery.

Collectively, the findings depict a multidimensional coping ecology. Women combined formal counselling, spirituality, indigenous rituals, and self-directed resilience strategies in navigating trauma recovery. Religious and traditional practices often complemented—or substituted—professional psychological services, particularly where stigma, cost, or limited service continuity constrained formal care. The relatively modest uptake of CBT highlights the need for greater community integration of structured, evidence-based therapies within culturally resonant delivery models.

Qualitative findings reinforce these quantitative trends. Survivors frequently expressed preference for community-based and culturally familiar forms of support over formal clinical interventions. As one ward administrator in Kondele noted, *"Women find peace in church prayers and listening to sermons more than going for formal counselling."* Group storytelling and communal dialogue were described as emotionally liberating: *"Storytelling after trauma helps women release pain without shame."* These accounts underscore the value of narrative expression within culturally grounded healing spaces.

Economic empowerment also surfaced as an indirect yet influential psychosocial strategy. Participation in small businesses and income-generating activities restored agency, reduced rumination, and strengthened perceived self-worth. As observed by a CBO staff member in Nyalenda, economic engagement functioned both as distraction and dignity restoration. Nonetheless, respondents consistently emphasized the short-term and fragmented nature of formal interventions, with limited follow-up mechanisms and inconsistent NGO presence.

In summary, post-trauma recovery among women survivors in informal settlements is not confined to clinical therapy. It unfolds across intersecting domains of spirituality, culture, community solidarity, and pragmatic survival strategies. Formal psychological interventions are beneficial where available, but sustainable recovery requires culturally adapted, community-integrated models that bridge professional therapy with faith-based, indigenous, and economic support systems.

Post-Trauma Support Structures

Despite the observable benefits of selected trauma interventions, the study identified persistent structural and systemic gaps that continue to undermine the effectiveness and sustainability of psychological recovery efforts among women survivors of political violence in informal settlements. These limitations are not isolated; they reflect deeper weaknesses within the broader psychological well-being support architecture operating in low-resource, high-vulnerability environments.

Table *7*: Quantitative Findings on Key Indicators

Theme	Description	Key Findings
Displacement Due to Violence	Individuals and families were forced to evacuate their homes due to electioneering violence.	60.1% strongly agreed that they were displaced.
Community Support	Perceived support received from others for basic needs during the crisis.	33% agreed, 29.6% strongly agreed, over 29% expressed negative or undecided responses.
Emotional Support and Debriefing	Assistance in sharing experiences through Psychological First Aid (PFA) and debriefing.	60.6% indicated some level of agreement on receiving emotional support.

Theme	Description	Key Findings
Value of Support Received	Influence of the support on the well-being of individuals and families.	56.6% found the support helpful, but many expressed disagreement or uncertainty.
Long-term Emotional Pain	Ongoing distress is experienced when recalling the violence despite its cessation.	68% strongly agreed that memories of violence continue to cause pain.
Perceived Help After Violence	Participants expressed limited perceptions of support received after the violence.	Only 13.3% strongly agreed they received help; 78.8% had missing responses.
Counselling Engagement	Levels of engagement with personal or group counselling varied among participants.	27.6% strongly agreed they continued counselling; 31.0% disagreed or were undecided.
Cognitive Behavioural Therapy (CBT) Influence	Participants reported on the effectiveness of CBT in changing perceptions about attackers.	58.2% agreed or strongly agreed about CBT's effectiveness, while 24.6% expressed disagreement.
Spiritual Commitment	Many participants turned to spiritual practices as a means of coping post-violence.	59.1% strongly agreed they became more committed to prayer or faith after the violence.

First, access to formal counselling services remains severely constrained. Survivors in marginalised zones such as Sarangombe and Kibera Makina reported limited or no contact with trained psychological professionals. In practice, this forces many women to rely almost exclusively on informal coping pathways, including prayer groups and peer-based discussions. While emotionally supportive, these avenues lack the structured therapeutic depth required for evidence-based trauma treatment. The limited reach of trained counsellors restricts the meaningful implementation of approaches such as Cognitive Behavioral Therapy (CBT) and Narrative Therapy, both of which require professional guidance to effectively address maladaptive cognitions, intrusive memories, and trauma-related anxiety.

Second, the shortage of trained trauma counsellors at both county facilities and community-based organizations (CBOs) significantly affects service quality. Key informants consistently reported overwhelming caseloads among the few available professionals. This not only reduces therapeutic intensity but also compromises follow-up care. In response, communities often

depend on non-professional actors such as elders, faith leaders, and women's group coordinators. Although culturally embedded and socially accessible, these actors are not equipped to manage severe PTSD, dissociation, or chronic depression. Consequently, survivors with complex trauma presentations remain underserved.

Third, there is an overreliance on informal community structures without adequate integration of structured, trauma-informed models. Faith-based leaders, Nyumba Kumi elders, and women's savings groups provide emotional solidarity and social belonging. Nonetheless, these systems rarely incorporate structured cognitive restructuring, graded exposure techniques, or narrative reframing methods required for deeper psychological processing. As a result, symptoms such as hypervigilance, avoidance, emotional numbing, and recurrent flashbacks often persist beyond the immediate post-violence period.

The quantitative findings reinforce these structural concerns. While 60.1% strongly agreed they were displaced due to violence, and 60.6% reported receiving some form of emotional support, long-term emotional pain remained pronounced, with 68% strongly agreeing that memories of violence continued to cause distress. Only 13.3% strongly agreed they received adequate help after the violence, and counselling engagement remained uneven. Although 59.1% reported increased spiritual commitment and 58.2% acknowledged CBT's influence, the coexistence of high residual distress indicates that current support mechanisms are insufficient in resolving deeper trauma outcomes.

Qualitative accounts further illuminate institutional weaknesses. Support structures in both Nairobi (particularly Kibera) and Kisumu (Nyalenda, Nyawita, and Kondele) were largely NGO-mediated and community-driven, with minimal sustained government involvement. As one ward administrator in Nyalenda noted, *"Most of the trauma work here is done by NGOs. Government waits for reports but doesn't follow up."* This observation reflects a reactive rather than integrated public response model. Similarly, a CBO staff member in Kibera explained, *"When women are in pain, they first go to their church or their elder. Counselling comes later, if at all."* Such patterns demonstrate the dominance of culturally familiar pathways in the absence of formal infrastructure.

At the county level, formal trauma infrastructure was either weak or nonexistent. There were no dedicated trauma recovery centers, structured safe shelters, or operational crisis response units. Referral hospitals such as Jaramogi were nominally responsible for trauma care, yet

geographical distance and financial constraints rendered them inaccessible to many survivors. CBO leaders described interventions as short-term and donor-dependent. As one respondent from Kisumu observed, *"After one month or two, the programs end. Then women are on their own again."* This short-cycle programming undermines continuity of care and increases relapse risk.

Additionally, systemic fragmentation limits coordination between security, health, and administrative sectors. Data collection and reporting were prioritized over service delivery, and referral systems lacked structured monitoring. Heavy reliance on NGOs and faith-based actors exposes trauma recovery to funding volatility and project-based discontinuity. Without institutionalization at county level, interventions remain episodic rather than sustained.

In summary, post-trauma support systems in Nairobi and Kisumu informal settlements are predominantly community-based and NGO-led, with limited government integration. Women survivors rely extensively on religious, cultural, and peer networks to navigate recovery. While these systems provide essential emotional buffering, the absence of structured, long-term, trauma-informed psychological services significantly constrains sustainable recovery outcomes. Addressing these systemic gaps requires capacity building of local counsellors, institutionalization of trauma screening and follow-up mechanisms, and integration of culturally grounded support systems with professional evidence-based therapies.

HYPOTHESIS TESTING

The study tested the null hypothesis that post-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. The findings provided sufficient statistical evidence to reject the null hypothesis. Pearson correlation analysis established statistically significant negative relationships between participation in structured post-trauma interventions and levels of psychological distress. Cognitive Behavioral Therapy (CBT) demonstrated a significant negative correlation with PTSD symptoms ($r = –0.42$, $p < .01$) and anxiety symptoms ($r = –0.37$, $p < .01$), while group therapy similarly showed significant negative relationships with PTSD symptoms ($r = –0.39$, $p < .01$) and anxiety symptoms ($r = –0.33$, $p < .01$). These findings indicate that increased participation in structured intervention programs was associated with reduced trauma-related psychological distress.

Further statistical analysis using Chi-square tests reinforced the significance of post-trauma interventions in influencing psychological well-being outcomes. Employment status was significantly associated with psychological well-being ($\chi^2 = 11.23$, $p = 0.008$), while age group ($\chi^2 = 16.32$, $p = 0.002$) and marital status ($\chi^2 = 9.47$, $p = 0.021$) also demonstrated statistically significant relationships with intervention participation and recovery outcomes. These results suggest that psychological recovery among women survivors is not only shaped by exposure to intervention strategies but is also conditioned by demographic and socio-economic positioning within informal settlement environments. Consequently, the study concludes that post-trauma intervention strategies significantly influence the psychological well-being of women survivors of political violence.

CONCLUSION

The study concludes that post-trauma intervention strategies significantly influence the psychological well-being of women survivors of political violence in Nairobi and Kisumu informal settlements. Structured interventions, particularly CBT and group therapy, are associated with measurable reductions in PTSD and anxiety symptoms. Demographic variables such as age, employment status, and marital status further shape participation and recovery outcomes. However, systemic limitations, including inadequate professional capacity, fragmented service delivery, and short-term NGO-led programming, restrict the depth and sustainability of recovery. Informal community and faith-based networks provide essential emotional support but cannot substitute for structured, trauma-informed psychological care. Sustainable psychological recovery requires integrated, tiered, and institutionally supported intervention frameworks.

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