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Post-Trauma Interventions and Psychological Well-Being among Women Survivors of Political Violence in Urban Informal Settlements in Kenya

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Abstract

This study examines the influence of post-trauma intervention strategies on the psychological well-being of women survivors of political violence in informal settlements in Nairobi and Kisumu, Kenya. While prior research has extensively documented trauma prevalence in post-election contexts, limited empirical evidence exists on the effectiveness of sustained post-trauma interventions in low-resource urban settings. This study addresses this gap by assessing whether structured interventions contribute to measurable improvements in psychological outcomes. A convergent mixed-methods design was employed, combining survey data from 200 women survivors with key informant interviews from ward administrators and community-based organization leaders. Quantitative analysis revealed statistically significant negative correlations between participation in structured interventions and psychological distress. Cognitive Behavioural Therapy (CBT) demonstrated a moderate association with reduced PTSD symptoms ($r = –0.42$, $p < .01$) and anxiety ($r = –0.37$, $p < .01$), while group therapy showed similar but slightly weaker effects on PTSD ($r = –0.39$, $p < .01$) and anxiety ($r = –0.33$, $p < .01$). Chi-square results further indicated that demographic factors such as age ($\chi^2 = 16.32$, $p = 0.002$), marital status ($\chi^2 = 9.47$, $p = 0.021$), and employment status ($\chi^2 = 11.23$, $p = 0.008$) significantly influenced both intervention participation and psychological well-being outcomes. Qualitative findings revealed that the effectiveness of these interventions is constrained by structural limitations, including limited access to trained counsellors, fragmented service delivery, stigma, and weak follow-up systems. Informal support mechanisms, particularly faith-based and community networks, were widely utilized but lacked structured therapeutic capacity for severe trauma cases. The study concludes that post-trauma interventions are associated with moderate but significant improvements in psychological well-being. Nonetheless, their impact remains partial and highly dependent on accessibility, continuity of care, and integration with culturally grounded support systems. Sustainable recovery therefore requires institutionalized, tiered, and context-responsive trauma care frameworks within informal settlement settings.

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

1.1 Background to The Study

Political violence is one of the most disruptive social phenomena in weak and transitional democracies and it can have lasting psychological effects that do not end with observable physical damages. In Kenya, incidences of election-related violence have disproportionately impacted people living in informal settlements, including Kibera in Nairobi and Nyalenda, Nyawita, and Kondele in Kisumu, where residents are vulnerable due to extreme poverty, overcrowding, and lack of institutional protection. In these environments, women are often displaced, sexually assaulted, bereaved, and financially disrupted, which are closely linked to increased post-traumatic stress disorder (PTSD) and anxiety, depression, and ongoing emotional distress (Mollica et al., 2017; WHO, 2022).

Although emergency responses tend to focus on physical protection and humanitarian aid, formalized post-trauma treatments (including Cognitive Behavioral Therapy (CBT), group therapy and culturally informed healing rituals) are not uniformly provided. Trauma-oriented interventions are proven to have a significant beneficial effect on reducing PTSD and anxiety symptoms (Hofmann et al., 2012; Beck and Haigh, 2014), but their application in low-resource, violence-affected informal settlements is still scattered and mainly delivered by NGOs (Ventevogel et al., 2019). This disparity between evidence-based therapies and actual service delivery models requires a direct analysis of the impact of post-trauma intervention strategies on the psychological health of women survivors in these contexts.

1.1.1 Trauma Recovery as a Long-Term Psychological Process

Trauma is not resolved at the moment of physical safety; it unfolds as a prolonged psychological process that may persist long after the violent event has ceased. While immediate interventions such as Psychological First Aid stabilize acute distress, enduring recovery requires structured post-trauma support systems capable of addressing cognitive distortions, emotional dysregulation, relational rupture, and identity fragmentation (Herman, 2015; WHO, 2022). In post-conflict settings, unresolved trauma often transitions from acute stress reactions into chronic conditions including Post-Traumatic Stress Disorder (PTSD), depression, anxiety disorders, and somatic symptom disorders (APA, 2022; Charlson et al., 2019). Without sustained therapeutic engagement, trauma may become embedded in daily functioning, affecting parenting, livelihood, social trust, and community participation.

Recovery therefore extends beyond symptom reduction. It involves restoring agency, rebuilding social connections, reconstructing meaning, and re-establishing a coherent self-concept (Herman, 2015; White & Epston, 1990). Contemporary trauma literature emphasizes that healing is multidimensional, requiring psychological, relational, social, and structural interventions delivered over time (IASC, 2021; Tol et al., 2011). In fragile urban settlements where formal mental health systems are weak, the absence of sustained post-trauma care increases the risk of prolonged psychological impairment among survivors of violence.

1.1.2 Post-Trauma Intervention Strategies: Scope and Typologies

Post-trauma interventions refer to structured psychological, psychosocial, and community-based programs delivered after the immediate crisis phase to facilitate long-term recovery. These include individual psychotherapy (such as Cognitive Behavioral Therapy), group therapy, trauma-focused counselling, narrative therapy, community resilience programs, social reintegration initiatives, economic empowerment linked to psychosocial recovery, and culturally grounded healing

approaches (Hofmann et al., 2021; Cuijpers et al., 2022; WHO, 2018). Unlike emergency responses, post-trauma interventions aim at cognitive restructuring, emotional processing, trauma narrative integration, and restoration of psychological well-being over sustained periods.

Globally, trauma-informed care frameworks increasingly advocate tiered systems of care, where survivors with moderate symptoms receive community-based psychosocial support, while those with severe trauma are referred to specialized mental health professionals (WHO, 2022; IASC, 2021). Evidence shows that sustained therapeutic engagement significantly reduces relapse, chronicity of symptoms, and intergenerational transmission of trauma (Bolton et al., 2003; Bryant et al., 2017). Nonetheless, in low-resource contexts, continuity of care remains inconsistent, often dependent on non-governmental organizations and short-term funding cycles rather than institutionalized public systems.

1.1.3 Psychological Well-Being in the Context of Post-Trauma Recovery

Psychological well-being represents more than the absence of distress; it reflects positive functioning across emotional, relational, and existential domains. Ryff (2014) conceptualizes psychological well-being as comprising autonomy, environmental mastery, personal growth, positive relations with others, purpose in life, and self-acceptance. In trauma recovery contexts, these dimensions are often compromised, as survivors experience diminished trust, impaired self-worth, loss of life direction, and restricted social participation (Diener et al., 2018; Kashdan & Rottenberg, 2010).

Post-trauma interventions therefore aim not only to reduce PTSD symptoms but also to rebuild these broader well-being domains. Sustained counselling and psychosocial programming support survivors in regaining emotional regulation, restoring interpersonal relationships, and reconstructing meaning after violence (Herman, 2015; WHO, 2022). In contexts of political violence, psychological well-being becomes a marker of both individual recovery and community resilience, particularly for women who often carry caregiving and economic responsibilities.

1.1.4. Political Violence and Gendered Psychological Vulnerability

Political violence remains a persistent global phenomenon, particularly in fragile democracies and post-conflict societies. Electoral unrest, state repression, militia activity, and communal clashes frequently produce widespread displacement, injury, and psychological trauma (United Nations, 2023; ACLED, 2022). Beyond physical destruction, politically motivated violence fractures social cohesion, erodes trust in institutions, and destabilizes community safety structures. Research consistently shows that exposure to political violence significantly increases the risk of PTSD, depression, anxiety, and prolonged grief disorders (Charlson et al., 2019; WHO, 2022).

Women are disproportionately affected, not only as direct victims of physical assault and sexual violence but also as indirect bearers of economic disruption, caregiving burden, and social fragmentation (UN Women, 2022; Betancourt et al., 2013). Gendered trauma often manifests in layered forms—combining physical harm, psychological terror, loss of livelihood, displacement, and stigma. In many contexts, women experience violence within both public and private spheres during political crises, amplifying cumulative trauma exposure (Herman, 2015; Tol et al., 2011). Such compounded exposure increases vulnerability to chronic psychological distress and complicates recovery trajectories.

1.1.5. From Global Patterns to the Kenyan Context

Globally, post-election violence has been identified as a recurring trigger of community-level trauma in emerging democracies (United Nations, 2023). In Sub-Saharan Africa, electoral cycles are frequently accompanied by heightened tensions, communal clashes, and politically incited violence, with lasting psychosocial consequences (ACLED, 2022). Mental health systems across the region remain under-resourced, with significant treatment gaps exceeding 75% in some countries (WHO, 2022). As a result, many survivors receive minimal follow-up psychological care after acute crises.

Kenya presents a well-documented case of politically triggered violence, particularly during electioneering periods such as 2007/2008 and subsequent electoral cycles. The 2007/2008 post-election violence resulted in over 1,000 deaths and displaced hundreds of thousands, leaving enduring psychological scars among affected communities (Kenya National Commission on Human Rights [KNCHR], 2008). Studies conducted in the aftermath documented high prevalence of trauma-related symptoms among women in urban informal settlements, including intrusive memories, hypervigilance, depression, and emotional withdrawal (Makumi, 2015; Muchemi, 2018). Although humanitarian responses addressed immediate displacement and physical safety, long-term psychological follow-up remained inconsistent.

1.1. 6. Informal Settlements as Sites of Prolonged Trauma Exposure

Urban informal settlements such as Kibera in Nairobi and Nyawita, Kondele, and Nyalenda in Kisumu are characterized by high population density, economic precarity, limited formal service delivery, and fragile infrastructure (UN-Habitat, 2020). These structural vulnerabilities intensify the psychological impact of political violence. When violence erupts in such settings, escape options are limited, property loss is immediate, and social fragmentation spreads rapidly.

Post-crisis recovery in informal settlements is further constrained by limited access to professional psychological services. County-level mental health facilities are few, referral systems are weak, and structured trauma-informed care is rarely institutionalized at the ward level (WHO, 2022). Consequently, survivors often depend on NGOs, faith-based organizations, or informal support systems for continued recovery. While such networks provide valuable psychosocial support, they frequently lack sustained therapeutic depth, structured monitoring, and differentiated care pathways for severe trauma cases.

Women in these settlements face intersecting vulnerabilities: poverty, caregiving responsibilities, exposure to domestic and political violence, and limited autonomy in seeking professional care. In the absence of structured post-trauma intervention systems, unresolved trauma may evolve into chronic psychological impairment, affecting not only individual well-being but also family stability and community cohesion.

1.1.7. The Continuity Gap in Post-Trauma Care

Despite recognition of the importance of sustained psychosocial support, evidence from low-resource settings indicates a persistent gap between immediate crisis response and long-term trauma recovery (IASC, 2021; WHO, 2022). While emergency interventions are often mobilized during violent outbreaks, continuity of counselling, structured therapy, and reintegration support frequently declines once immediate humanitarian attention subsides.

This discontinuity is particularly consequential for women survivors of political violence, whose trauma experiences are often layered and prolonged. Without ongoing counselling, narrative

processing, social reintegration, and economic stabilization support, early gains from immediate interventions may erode. Persistent flashbacks, avoidance behaviors, emotional numbing, and depressive symptoms may become chronic (Charlson et al., 2019; Herman, 2015).

1.2 Statement of The Problem

Psychological well-being among women survivors of political violence in Kenya's informal settlements remains a major public health and social policy concern. Empirical evidence from post-election violence contexts demonstrates elevated prevalence of post-traumatic stress disorder (PTSD), depression, anxiety, and prolonged grief among women exposed to politically motivated violence (Charlson et al., 2019; WHO, 2022). In Kenya, studies following the 2007/2008 post-election violence documented sustained trauma symptoms among women in urban informal settlements, including intrusive memories, hypervigilance, emotional withdrawal, and sleep disturbances years after the events (Makumi, 2015; Muchemi, 2018; KNCHR, 2008). Despite the passage of time, many survivors continue to report unresolved psychological distress, suggesting that recovery mechanisms may be inadequate or inconsistently implemented.

While immediate crisis interventions such as Psychological First Aid (PFA), emergency shelter, and material support provide short-term stabilization, they do not necessarily guarantee sustained psychological recovery. Global mental health frameworks emphasize the importance of post-trauma interventions—including structured counselling, cognitive-behavioral therapies, group therapy, follow-up systems, and community reintegration programs—in preventing chronic psychological impairment (IASC, 2021; WHO, 2022; Cuijpers et al., 2022). Nonetheless, in low-resource urban settings, continuity of trauma care is often fragmented, underfunded, and NGO-dependent. County-level mental health infrastructure in Kenya remains limited, and formal referral pathways linking informal settlements to specialised psychological services are weak.

In Kibera (Nairobi) and Nyawita, Kondele, and Nyalenda (Kisumu), anecdotal and qualitative evidence suggests that women survivors frequently rely on informal social networks, faith-based organizations, and community-based organizations for ongoing support. However, the extent to which structured post-trauma interventions influence long-term psychological well-being outcomes remains insufficiently examined. Existing literature has largely focused on trauma prevalence and immediate humanitarian responses, leaving a gap in understanding how sustained, structured post-trauma strategies shape recovery trajectories among women survivors in informal settlements.

Therefore, the problem this study addresses is the limited empirical understanding of how post-trauma intervention strategies influence the psychological well-being of women survivors of political violence in Nairobi and Kisumu informal settlements. Without such evidence, policy responses risk remaining reactive, short-term, and insufficiently aligned with the long-term psychological needs of survivors.

1.3 **Scope of the Study**

This study focused on women survivors of political violence residing in selected informal settlements of Nairobi (Kibera) and Kisumu (Nyawita, Kondele, and Nyalenda). It examined structured post-trauma intervention strategies—including counselling, follow-up psychosocial support, group therapy, and referral systems—and their influence on key dimensions of psychological well-being such as emotional regulation, resilience, purpose in life, and social

functioning. The study was confined to community-level interventions implemented after the immediate crisis phase and did not evaluate emergency or acute trauma responses.

1.4 Purpose of the Study

The purpose of this study was to examine the influence of post-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 structured, sustained interventions contribute to improved long-term psychological recovery outcomes.

2.0 Theoretical Framework

2.1.1 Post-Traumatic Growth (PTG) Theory

The Post-Traumatic Growth (PTG) Theory originated with Richard Tedeschi and Lawrence Calhoun (1996, 2004) as a way of explaining the positive psychological change one may experience following severely upsetting life events. Instead of focusing on trauma as a cause of pathology, the theory suggests that people can also undergo deep personal growth having struggled with misfortune. Tadeschi and Calhoun (2004) categorized growth in terms of five domain: heightened sense of the worthiness of life, better relations with other people, greater personal strength, the sense of new possibilities, and spiritual or existential growth. PTG makes no claim about the exclusion of the existence of distress; however, it claims that growth arises during the process of conscious intellectualization of the trauma. Subsequent empirical findings have supported PTG in conflict, disaster, and violence settings (Joseph and Linley, 2008; Shakespeare-Finch and Lurie-Beck,2014) and it is thus most applicable in post-conflict societies.

In PTG Theory there are a number of assumptions. To begin with, traumatic experiences upset the basic assumptions regarding the security, personal identity as well as predictability of life (Tadeschi and Calhoun, 2004). Second, psychological development is not a natural process and it is a consequence of mental activity, contemplation and sense making. Third, it is asserted that supportive environments can support beneficial rumination and narrative reconstruction which are necessary to grow (Joseph and Linley, 2008). Fourth, social support has the catalytic effect of converting distress into developmental benefits. It presumes that using structured psychosocial interventions, such counselling and guided storytelling, can assist survivors to reinterpret trauma in a manner that recreates a sense of coherence and agency. Notably, PTG does not occur without distress; survivors can still report symptoms but also report growth.

One of the key strengths of the PTG Theory is that it is a balanced theory that takes into consideration suffering, but it also emphasizes human resilience and transformation. It is not a deficit-based approach to trauma but offers a strengths-based view that can be used in empowerment-based interventions (Tadeschi and Calhoun, 2004). The theory empirically holds in a variety of cultural backgrounds, including conflict and displacement environments (Shakespeare-Finch and Lurie-Beck, 2014). It is more consistent with multidimensional models of psychological well-being, including Ryffs model specifically in areas of purpose in life, personal growth, and relational connectedness (Ryff, 2014). Moreover, PTG Theory offers a realistic solution to intervention formulation, focusing on cognitive processing, existential reconstruction of meanings, and facilitating relational environments.

PTG Theory has its weaknesses in spite of its strengths. Critics claim that perceived growth can also indicate illusion of coping or self-enhancing bias as opposed to actual change (Zoellner and

Maercker, 2006). There are also measurement difficulties, because growth is often self-reports, and can change over time. Also, the structural barriers, including poverty, gender inequality, and lack of professional help, are not addressed adequately by the PTG Theory, which is of particular interest in informal settlements. Cognitive processing capacities can also be overwhelmed by severe trauma resulting in restricted growth potential unless substantive therapeutic support is provided. Therefore, PTG can be less effective when the exposure to the trauma is extreme or extended without organized clinical care.

This study is directly related to PTG Theory as it examines the effect of post-trauma intervention strategies on the psychological well-being of survivors of political violence in informal settlements in Nairobi and Kisumu who are women. The theory offers a framework of the influence of counselling, group therapy, psychosocial support and narrative engagement in meaning-making and identity reconstruction after violence. It is also useful in understanding why structured interventions can aid not only in symptom management, but also in the re-establishment of meaning, interpersonal trust, and personal resilience. In situations where women have suffered political violence, displacement, and socio-economic vulnerability, PTG Theory sheds light on the avenues through which long-term post-trauma support can enable long-term psychological reconstruction. Consequently, it provides a theoretical and a practical perspective through which to understand the results of the study.

2.1.2 Empirical Literature Review

Empirical evidence is growing to show that there is no consistent deterioration in long-term psychological health following exposure to trauma; instead, individuals may be helped to recover through structured mechanisms that can enable post-traumatic growth (PTG). Tadeschi and Calhoun (2004) confirmed that people having experience of severe adversity can report on higher personal strength, better relationship, new life priorities, and spiritual change. Survive war, displacement, and political instability are some populations experiencing conflict that have been found to have PTG in populations affected by conflict (Shakespeare-Finch and Lurie-Beck, 2014). Wu et al. (2019) conducted a meta-analysis that established moderate positive correlations between exposure to trauma and growth outcomes in cases when survivors could obtain social and psychological support. These results indicate that growth does not occur spontaneously and is mediated by facilitating environments and cognitive processing systems.

Women survivors in politically unstable areas tend to go through distress and developmental change at the same time. As an example, a series of research with refugee women in post-conflict areas indicated that women participating in formal psychosocial interventions demonstrated greater reconstruction of meaning and restoration of relationships despite continued suffering (Sleijpen et al., 2016). Such a twin existence of distress and growth is consistent with PTG theory, which also acknowledges that positive change may co-exist with trauma symptoms.

Empirical data supports the claim that structured post-trauma counselling is associated with positive changes in the psychological well-being and signs of growth. Cognitive-behavioral therapy, trauma-focused therapy, and narrative exposure therapy have been linked to the decrease in PTSD symptoms and, in the same breath, the increase in perceived personal strength and purpose (Hofmann et al., 2021; Cuijpers et al., 2022). These interventions also contribute to planned rumination and cognitive restructuring, which is key to the development of PTG (Joseph and Linley, 2008).

Community-based counselling models have demonstrated good results in low-resource and post-conflict settings. According to Tol et al. (2013) psychosocial interventions, specifically structured in the humanitarian setting, were associated with enhanced emotional regulation, social functioning, and resilience in women survivors of violence. In the same way, in a systematic review of mental health interventions in humanitarian emergencies, Bangpan et al. (2017) identified that psychosocial support programs led to increased coping ability and less emotional distress, particularly in the case of culturally sensitive practices. This evidence strengthens the thesis that systematic post-trauma intervention can be used as the triggering mechanism of psychological reconstruction instead of symptom management.

As it turns out, social support is always one of the most powerful predictors of post-traumatic growth. Studies conducted among conflict-affected groups indicate that survivors incorporated into supportive family, faith-based, or peer groups are more likely to have higher levels of PTG compared to those who are socially isolated (Prati & Pietrantoni, 2009). Specifically, women who attend support groups and shared healing areas exhibit greater relational trust and emotional processing (Sleijpen et al., 2016). These results can be aligned with the PTG argument that relational connectedness is a field and a source of development.

Communal coping has been observed to be a protective and transformative factor in sub-Saharan African settings. In a study of war-displaced populations, Ainamani et al. (2020) found that individuals who participated in organized social networks recorded better psychological adaptation, in spite of their high level of exposure to trauma. Social support helps to mitigate emotional distress, supports meaning-making, and enhances perceived agency. However, research also evidence that informal support is not enough in severe cases of trauma that require professional intervention (WHO, 2018). This implies that community-based and professional service models should be integrated to bring about long-term well-being.

Empirical sources highlight that woman in war zones are particularly vulnerable, with gender-based violence, displacement, economic insecurity, and caregiving being the most frequent vulnerabilities (UN Women, 2024). These accumulated stressors make people vulnerable to stress but can also deepen transformative processes provided one receives sufficient support. Tolin and Foa (2016) have discovered that women who experienced trauma note more prevalence of PTSD compared to men, yet, structured psychosocial interventions proved to be very effective in enhancing relational growth and coping in female survivors.

Onyut et al. (2009) and Roberts et al. (2011) showed high levels of trauma symptom prevalence among survivors in Kenyan post-election violence situations. Nevertheless, later community-based recovery programs were shown to have better social cohesion and emotional stability in areas that had structured support. The implications of these findings are that although women survivors are very susceptible to trauma-related disorders, they can also experience as much as possible growth when it comes to offering them some regular post-trauma interventions that are culturally-based.

Despite the global literature that establishes the relationship between post-trauma interventions and growth outcomes, scanty research has been done that specifically analyzes the same relationship in informal settlements of Nairobi and Kisumu. The Kenyan literature on the topic is mostly based on prevalence of PTSD and anguish after political violence (Onyut et al., 2009; Wachira et al., 2020), but little on the mechanisms of structured growth or restoration of well-being over time. Moreover, there is a paucity of studies that combine both quantitative severity

measures and qualitative experiential reports to investigate the effects of post-trauma interventions on multidimensional psychological well-being.

A contextual and empirical gap in the literature is thus found: there is not enough evidence of how organized post-trauma strategies can play a role in post-traumatic growth and well-being reconstruction among women survivors of political violence in informal urban settlements. The gap in this study is that the focus will be not only on symptom reduction but also on recovery pathways of development in conjunction with the theory of PTG.

2.2 Conceptual Framework

This study conceptualizes post-trauma response strategies as the primary explanatory variable influencing the psychological well-being of women survivors of political violence in informal settlements of Nairobi and Kisumu. Post-trauma response strategies encompass structured counselling services, indigenous counselling practices, and trauma coping mechanisms adopted during the recovery phase. These strategies represent sustained psychosocial interventions aimed at facilitating emotional processing, cognitive restructuring, and adaptive behavioral adjustment following traumatic exposure.

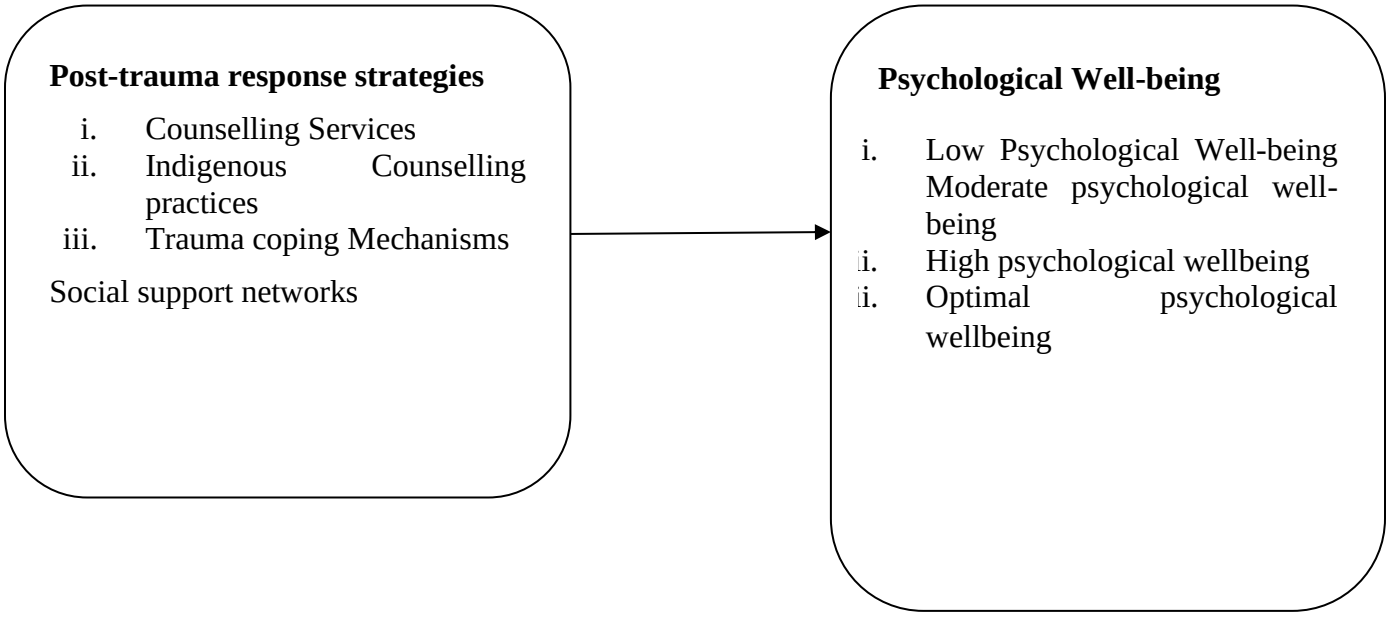

Figure 1: Conceptual Framework

Counselling services refer to formal therapeutic interventions delivered by trained professionals or organized community-based structures. These include individual therapy, group counselling, and structured trauma recovery sessions designed to reduce distress and promote meaning-making. Indigenous counselling practices incorporate culturally grounded healing approaches such as community mediation, faith-based dialogue, traditional rituals, and elder-guided reconciliation forums. Trauma coping mechanisms reflect the survivor's adaptive behavioral and emotional strategies, including social engagement, spiritual participation, peer support, and constructive self-regulation practices. Collectively, these post-trauma responses are expected to influence recovery trajectories by either facilitating psychological rebuilding or, if absent or inadequate, allowing distress to persist.

Psychological well-being is the dependent variable and is operationalized across four levels: low, moderate, high, and optimal functioning. These levels reflect the survivor's emotional stability, sense of purpose, relational connectedness, and perceived personal growth. Low psychological well-being is characterized by persistent distress, emotional dysregulation, and impaired functioning. Moderate well-being reflects partial recovery with residual symptoms. High and optimal well-being indicate substantial emotional restoration, resilience, and evidence of post-traumatic growth.

The framework further acknowledges the influence of extraneous variables that may condition or alter the relationship between post-trauma strategies and psychological well-being outcomes. Age may shape coping maturity and life experience; educational attainment may enhance access to information and professional services; socioeconomic status influences resource availability; and cultural beliefs and customs shape help-seeking behavior and interpretation of trauma. These variables are not the primary focus of the study but are recognized as contextual factors that may strengthen or weaken intervention effectiveness.

Overall, the conceptual framework posits that structured and culturally responsive post-trauma response strategies positively influence psychological well-being among women survivors of political violence, while the strength of this relationship may vary depending on demographic and socio-cultural conditions.

3.0 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 interpretation stage to enhance validity and provide a comprehensive understanding of how structured post-trauma strategies influence psychological rebuilding within low-resource urban settings.

4.0 Findings

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 organization leaders. Together, the findings provide a

comprehensive assessment of how sustained post-trauma interventions contribute to varying levels of psychological well-being among survivors.

4.1.1 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

Note. Source: Field Data (2025).

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 (χ^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 (χ^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 utilization 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.

4.1.2 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 behavioral 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

Intervention Type	PTSD Symptoms (r)	p-Value	Anxiety Symptoms (r)	p-Value
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 normalize trauma responses. As described by a Kibera-based facilitator, *"They heal by listening to each other. They realize 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 individualized 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.

4.1.3 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 behavioral 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 behavioral 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 recognizes 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.

4.1.4 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_{o2}: *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 Behavioural 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.

4.1.5 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.

4.1.6 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. FirstFirst, 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 Behavioural 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 affect 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 non-existent. There was no dedicated trauma recovery centres, 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.

5.0 Discussion

This study examined the relationship between post-trauma intervention strategies and psychological well-being among women survivors of political violence in informal settlements in Nairobi and Kisumu. The findings indicate statistically significant associations between participation in structured interventions and reduced psychological distress. Specifically, Cognitive behavioral Therapy (CBT) and group therapy were moderately associated with lower levels of PTSD and anxiety symptoms ($r = –0.42$; $r = –0.39$). These results align with existing trauma literature that identifies structured psychosocial interventions as beneficial in supporting emotional regulation and cognitive restructuring. Nonetheless, the magnitude of these associations remains moderate, indicating partial rather than comprehensive psychological recovery.

Importantly, the findings should be interpreted within the limitations of the analytical approach. The reliance on correlation analysis restricts causal inference, meaning that while participation in interventions is associated with improved outcomes, it cannot be conclusively established that the interventions directly caused these improvements. It is plausible that women who accessed interventions differed systematically from those who did not, particularly in terms of motivation, social support, or baseline psychological functioning. As such, the observed relationships may reflect both intervention effects and underlying selection dynamics.

Similarly, Chi-square results revealed statistically significant associations between demographic variables—such as age, marital status, and employment status—and psychological well-being outcomes. However, these tests capture distributional differences rather than predictive or explanatory relationships. Without multivariate modelling to control for confounding variables, the independent influence of these factors remains uncertain. Variables such as prior trauma severity, duration and intensity of intervention exposure, and consistency of access to services were not accounted for, raising the likelihood of omitted variable bias. This limits the internal validity of the findings and necessitates cautious interpretation.

The persistence of moderate distress levels among a substantial proportion of participants further reinforces the conclusion that intervention effects are incomplete. While structured therapies contribute to symptom reduction, they do not fully resolve trauma-related conditions in the studied context. This outcome reflects both the complexity of trauma recovery and the structural constraints within informal settlement environments. Qualitative findings provide critical context, revealing that interventions are often short-term, inconsistently delivered, and constrained by limited professional capacity, stigma, and economic pressures that disrupt sustained participation.

The findings also highlight the interplay between formal and informal support systems. Faith-based and community-driven coping mechanisms were widely utilized and provided accessible emotional support. Nonetheless, these systems lack the structured therapeutic components

necessary for addressing severe or chronic trauma. This dual reliance on formal and informal mechanisms underscores the need for integrated models that combine culturally grounded support with evidence-based clinical interventions.

Overall, the study contributes to the literature by providing context-specific evidence on the relationship between post-trauma interventions and psychological well-being in low-resource urban settings. However, the results should be understood as indicative rather than definitive. Future research should employ longitudinal designs and multivariate analytical techniques to better isolate causal pathways and account for confounding influences. Strengthening methodological rigor in this area is essential for developing more precise and actionable evidence on trauma recovery in informal settlement contexts.

6.0 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.

7.0 Recommendation

First, county governments should institutionalize structured trauma response frameworks within ward-level systems, including trained trauma counsellors, crisis response teams, and safe recovery spaces. Second, structured psychological interventions such as CBT should be scaled through capacity-building programs that train community-based facilitators under professional supervision to expand reach without compromising quality. Third, referral pathways linking informal community systems, faith-based organizations, health facilities, and specialized trauma centers must be formalized to ensure continuity of care. Fourth, intervention models should integrate economic empowerment and social support strengthening as complementary components of trauma recovery. Finally, long-term monitoring and follow-up mechanisms must be embedded within intervention programs to prevent relapse and ensure sustained psychological well-being among women survivors in informal settlements.

References

Beck, A. T., & Haigh, E. A. P. (2014). Advances in cognitive theory and therapy: The generic cognitive model. *Annual Review of Clinical Psychology*, *10*, 1–24. https://doi.org/10.1146/annurev-clinpsy-032813-153734

Ehlers, A., Bisson, J. I., Clark, D. M., Creamer, M., Pilling, S., Richards, D., & Yule, W. (2010). Do all psychological treatments really work the same in posttraumatic stress disorder? *Clinical Psychology Review, 30*(2), 269–276. https://doi.org/10.1016/j.cpr.2009.12.001

Hofmann, S. G., Asnaani, A., Vonk, I. J., Sawyer, A. T., & Fang, A. (2012). The efficacy of cognitive behavioral therapy: A review of meta-analyses. *Cognitive Therapy and Research, 36*(5), 427–440. https://doi.org/10.1007/s10608-012-9476-1

Johnson, D. M., & Zlotnick, C. (2020). A cognitive-behavioral treatment for battered women with PTSD in shelters: Findings from a pilot study. *Journal of Traumatic Stress, 33*(1), 45–56.

Kohrt, B. A., & Mendenhall, E. (2015). Global mental health: Anthropological perspectives. *Left Coast Press*.

Mollica, R. F., Brooks, R., Tor, S., Lopes-Cardozo, B., & Silove, D. (2017). The enduring mental health impact of mass violence: A community comparison study. *Journal of Nervous and Mental Disease, 205*(2), 132–139.

Onyango, M. A., & Ojara, S. (2021). Psychological effects of political violence on women in Kenya's informal settlements. *African Journal of Psychology, 11*(3), 45–58.

Tedeschi, R. G., & Calhoun, L. G. (1996). The Posttraumatic Growth Inventory: Measuring the positive legacy of trauma. *Journal of Traumatic Stress, 9*(3), 455–471.

Tedeschi, R. G., & Calhoun, L. G. (2004). Posttraumatic growth: Conceptual foundations and empirical evidence. *Psychological Inquiry, 15*(1), 1–18.

Tol, W. A., Barbui, C., & Jordans, M. J. D. (2011). Resilience in children affected by armed conflict: A systematic review of protective factors. *Journal of Child Psychology and Psychiatry, 52*(3), 237–249.

Ventevogel, P., Jordans, M., Reis, R., & De Jong, J. (2019). Madness or sadness? Local concepts of mental illness in conflict-affected settings. *Global Mental Health, 6*, e30.

White, M., & Epston, D. (1990). *Narrative means to therapeutic ends*. W. W. Norton.

World Health Organization (2018). *Psychological first aid: Guide for field workers*. WHO Press.

World Health Organization (2022). *World mental health report: Transforming mental health for all*. WHO.