Journal of Sociology, Psychology & Religious Studies

Fostering Psychological Recovery in Informal Settlements: A Mixed-Methods Study of Cognitive Restructuring Therapy Among Women Survivors of Political Violence in Nairobi and Kisumu

Magdalene Kanini Mutua

ISSN: 2706-6622

Stratford Peer Reviewed Journals and Book Publishing
Journal of Sociology, Psychology and Religious Studies
Volume 8||Issue 1 ||Page 76-96||June |2026|
Email: info@stratfordjournals.org ISSN: 2706-6622

Fostering Psychological Recovery in Informal Settlements: A Mixed-Methods Study of Cognitive Restructuring Therapy Among Women Survivors of Political Violence in Nairobi and Kisumu

Magdalene Kanini Mutua

katuamagdalen@gmail.com

***How to cite this article*: Mutua, M. K. (2026). Fostering Psychological Recovery in Informal Settlements: A Mixed-Methods Study of Cognitive Restructuring Therapy Among Women Survivors of Political Violence in Nairobi and Kisumu. *Journal of Sociology, Psychology and Religious Studies, 8*(1), 76–99. https://doi.org/10.53819/81018102t7096**

Abstract

Political violence leaves invisible yet enduring wounds, fracturing identity, eroding agency, and entrenching psychological suffering long after the guns fall silent. This study investigates the transformative potential of Cognitive Restructuring Therapy (CRT), as a foundational component of Cognitive Behavioral Therapy (CBT), in fostering psychological recovery among women survivors of political violence in the informal settlements of Nairobi and Kisumu, Kenya. Anchored in Ryff's multidimensional model of psychological well-being and theoretically situated within CBT and Narrative Exposure Theory frameworks, the study employed a convergent mixed-methods design to capture both the measurable and lived dimensions of healing. Two hundred women survivors participated in the quantitative component, complemented by in-depth qualitative interviews with ward administrators and directors of community-based organizations. Pearson correlation analyses revealed statistically significant and clinically meaningful negative associations between engagement in CRT-based interventions and psychological distress: CRT demonstrated moderate correlations with reductions in both PTSD symptoms ($r = –0.42$, $p < .01$) and anxiety symptoms ($r = –0.37$, $p < .01$), with group therapy yielding comparably significant effects. Chi-square analyses further confirmed that age, marital status, and employment status significantly moderated both intervention participation and recovery trajectories, underscoring the socially embedded nature of psychological healing. Qualitative findings illuminated the complex ecology of recovery within these communities. While structured cognitive interventions generated tangible emotional relief and measurably enhanced coping capacity, their reach remained constrained by pervasive stigma, inadequate professional infrastructure, and the episodic, donor-dependent character of service delivery. Faith-based networks, indigenous healing traditions, and peer-driven community solidarity emerged as vital pillars of emotional stabilization. Together, these formal and informal systems constitute a fractured recovery landscape in urgent need of cohesion. The study concludes that CRT exerts a significant and positive influence on the psychological well-being of women survivors of political violence; however, durable recovery demands more than clinical efficacy alone. Sustainable outcomes necessitate integrated, culturally responsive, and institutionally anchored frameworks that bridge formal cognitive therapy with community-based support, economic empowerment, and long-term professional engagement.

Keywords: *Cognitive Restructuring Therapy, Psychological well-being, Political violence, Women survivors, CBT, Informal settlements, Kenya*

https://doi.org/10.53819/81018102t7094

Stratford Peer Reviewed Journals and Book Publishing
Journal of Sociology, Psychology and Religious Studies
Volume 8||Issue 1 ||Page 76-96||June |2026|
Email: info@stratfordjournals.org ISSN: 2706-6622

1.0 Introduction

Trauma is not just an event, it is an on-going breach of the architecture of the self. This rupture is not just an event for survivors of political violence; it can affect their notions of safety, their meaning-making frameworks, and their interactions with the world around them. For the purposes of this definition, psychological well-being goes beyond the lack of disorder. Based on a multidimensional framework of human functioning (Ryan, 1999; Ryff, 2014), it includes the positive and generative aspects of human functioning: emotional regulation, self-acceptance, purposeful living, authentic relationships and continuous personal growth, which are systematically undermined by the experience of politically motivated violence. Post-traumatic stress disorder (PTSD), anxiety, depression and extended bereavement are known consequences of these experiences; they are often associated with a reduced sense of personal agency and extreme social isolation (Charlson et al., 2019; Diener et al., 2018; WHO, 2022). Most importantly, trauma does not simply cause symptoms. It undermines core beliefs that enable people to cope with life, such as beliefs of safety, identity, and life story coherence (Herman, 2015). Therefore, recovery from such a fundamental disruption is not straightforward or quick, and is a multi-faceted process which requires thoughtful, research-informed psychological support.

The methods that have the most empirical support are of particular interest: Cognitive Restructuring Therapy (CRT), a central element of Cognitive Behavioural Therapy (CBT), has been one of the most researched ways of psychologically recovering from trauma. Building on this premise, it is thought in CRT that maladaptive cognitions, such as self-blame attributions, catastrophic threat appraisals and rumination fear responses, are not passive symptoms of distress, but rather active, self-perpetuating processes that contribute to and maintain psychological suffering (Beck & Haigh, 2014). CRT helps survivors recognize, question, and change these distorted thinking patterns, which can then be used to help regulate their emotions, decrease hypervigilance, and gradually restore adaptive functioning, meaning, and purposeful engagement with life. Complemented with group therapy and community-based interventions that address the relational aspects of trauma such as broken trust and the debilitating effects of social isolation, CRT's therapeutic effects are multiplied (Ehlers et al., 2010).

The evidence base in the global context continues to increasingly demonstrate the clinical relevance of the use of CRT in the post conflict context. CBT-based cognitive restructuring has consistently been shown to result in significant decreases in trauma-related distress when compared to waitlist controls and many other therapeutic interventions in meta-analytic reviews (Cuijpers et al., 2022; Hofmann et al., 2012). However, although they are effective in a clinical setting, they may not have the same impact in low-resource settings. In practice, contextual factors such as the availability of services, cultural congruence, treatment continuity and the extent to which formal cognitive interventions are integrated into existing ecosystems of community support are hugely important for the effectiveness of CRT (Ventevogel et al., 2019; WHO, 2022). These factors are not just mediators of the outcomes in structurally scarce and institutional fragile environments. They frequently decide on the potential for therapeutic engagement or not.

Political violence is one of the strongest and most psychologically damaging forms of violence affecting populations in fragile and transitional democracies where state protection systems are weak and underdeveloped, and post-conflict recovery infrastructure is chronically weak (ACLED, 2022; United Nations, 2023). These disparities are particularly pronounced in communities in low and middle-income countries, where the treatment gap is more than 70% and mental health

interventions are often donor-led, episodic and poorly integrated into public health services (WHO, 2022). From this has come enduring psychosocial harms in Sub-Saharan Africa due to recurring cycles of political instability and electoral violence, while mental health systems are under-resourced, under-professionalised and are insufficiently trauma-informed and have weak referral pathways to support their response (ACLED, 2022; WHO, 2022). With the lack of formal therapeutic structures, survivors are forced to turn to informal networks, such as family, religious groups and community-based organisations, for emotional support, but these are unlikely to have the formal, cognitive depth necessary to address the most severe and persistent trauma presentations.

The politics of Kenya is an extreme example of this to some degree. Electoral cycles have been known to bring in episodes of mass violence, most notably during the post-election crisis of 2007-2008, when entire communities were displaced, thousands of people lost their lives, and survivors suffered from deep and long-term psychological trauma (KNCHR, 2008). Later, elevated prevalence of PTSD, depression, and anxiety has been recorded among affected individuals, especially among women living in informal urban settlements who have more risks such as exposure to sexual violence, economic destabilisation, and the constant demands of household coping, all in the face of extreme adversity (Makumi, 2015; Muchemi, 2018; Onyango & Ojara, 2021). The informal settlements of Kibera, in Nairobi, and Nyalenda, Nyawita, and Kondele, in Kisumu, are indeed the sites of the most intense intersection of structural vulnerability and political violence. These are communities with high population density, entrenched poverty, lack of access to formal services and poor infrastructure, which are doubly constrained in their immediate crisis response and long-term psychological rehabilitation (UN-Habitat, 2020).

Despite the well established and harmful psychological effects of political violence in such contexts, the empirical literature on these issues is inadequate. Structured cognitive interventions, specifically CRT, and their impact on the psychological long-term consequences of women survivors in a context of informal urban settlement is not sufficiently explored. While the therapeutic effects of emergency responses and humanitarian assistance have been researched, the longer-term therapeutic effects of CRT-based approaches in these low-resource, post-conflict settings have been limitedly rigorously researched. The lasting suffering experienced by women survivors, notwithstanding that some level of support may be available in some communities, poses unanswered questions regarding the effectiveness, availability and sustainability of current intervention frameworks. The study thus aims at establishing how far cognitive restructuring therapy is effective in bringing about psychological healing for women survivors of political violence in informal settlements of Nairobi and Kisumu in Kenya; a formal therapeutic technique in the informal and marginalized world of Nairobi and Kisumu.

1.1 Objective of the Study

To establish the influence of cognitive restructuring therapy on the psychological well-being of women survivors of political violence in the informal settlements of Nairobi and Kisumu, Kenya.

1.2 Hypothesis

H_{02}: Cognitive Restructuring Therapy does 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.

2.0 Methodology

This study used a convergent mixed methods research design as it aimed to examine the effect of cognitive restructuring therapy on psychological wellbeing of women survivors of political violence in selected informal settlements (Kibera in Nairobi and Nyawita, Kondele and Nyalenda in Kisumu). The convergent design enabled quantitative and qualitative data to be gathered concurrently, analysed separately, and combined at the data interpretation stage to yield a comprehensive, multi-triangulated set of data (Creswell & Clark, 2017). Data streams were given equal consideration during the research process.

A quantitative component included pre-designed questionnaires and was completed by 200 women survivors. Participants were selected using purposive and stratified sampling in 5 study sites which had adequate representation in terms of demographic and geographical aspects. The sample consisted of members of five Community Based Organisations (CBOs) working in the informal settlements who reported on their experiences of political violence in the informal settlements, namely: Al-Taqwa, Nyabende Support Group, the Catholic Justice and Peace Commission, and the Shining Hope Communities (SHOFCO). Trauma symptom severity was estimated by the PTSD Checklist for DSM-5 (PCL-5; Weathers et al., 2013), and psychological well-being was assessed by Ryff's Scales of Psychological Well-Being (1989) comprising of six items: autonomy, environmental mastery, personal growth, positive relations with others, purpose in life, and self-acceptance. The composite instrument was confirmed to have good internal consistency with a Cronbach's alpha of 0.84.

A set of indicators were used to operationalise engagement with cognitive restructuring therapy, such as access to and use of formal counselling, attendance at CBT-based programs, and self-reported cognitive reframing activities. Symptom and well-being scores were combined into four categories of psychological well-being: low, moderate, high, and optimal. Descriptive statistics, Pearson's correlation coefficients and Chi-square tests were used in SPSS Version 26.0 to assess the associations between CRT engagement and well-being outcomes at a $p \leq .05$ significance level.

The qualitative portion involved key informant interviews of five CBO directors and four ward administrators who were purposively selected to be operational in the study sites and to have first-hand experience in the delivery of trauma interventions. The interview guides focused on issues of intervention accessibility, cultural responsiveness, implementation barriers and lived recovery experiences. Thematic analysis was used to analyse the data, which involved following Braun and Clarke's (2006) six phases to create themes that linked to and nuanced the quantitative results. The findings were integrated at the stage of interpretation and allowed for a holistic analysis of the role of the interventions based on the concepts of the CRT and their relation to psychological recovery processes in the context of the informal settlement structural environment.

3.0 Results and Discussion

This section presents the findings on the influence of cognitive restructuring therapy 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 CRT engagement, symptom reduction, and well-being outcomes with qualitative insights from ward administrators and community-based organisation leaders. Together, these findings provide a comprehensive assessment of how structured cognitive interventions contribute to varying levels of psychological recovery among survivors in informal settlement contexts.

https://doi.org/10.53819/81018102t7094

3.1 Demographic Factors and Cognitive Restructuring Therapy Engagement

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

Table 1: Chi-Square Results, Demographic Characteristics, and Participation in CRT Programs

Variable	Chi-Square Value (χ^2)	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. Chi-square analyses conducted at df levels specific to each variable. Source: Field Data (2025).

The Chi-square analysis confirms that participation in cognitive restructuring therapy programs was not uniformly distributed across demographic groups. Age emerged as a highly significant determinant of engagement ($\chi^2 = 16.32$, $p = 0.002$), with women in the 30–50 year bracket demonstrating the greatest levels of participation in structured counselling and CBT-based programs. This concentration reflects the dual burden of caregiving and household leadership characteristic of women in their economically and socially active years. The stresses of these responsibilities heighten both trauma exposure and the motivation to seek structured psychological support. Theoretically, this finding resonates with CBT's emphasis on individual readiness and motivation as preconditions for effective cognitive engagement (Beck & Haigh, 2014). Women bearing household responsibilities are arguably more driven to pursue functional recovery as a means of maintaining family stability, thereby increasing their willingness to engage with formal therapeutic services.

Marital status was also significantly associated with CRT participation ($\chi^2 = 9.47$, $p = 0.021$). Quantitative trends indicated that married women demonstrated higher formal engagement rates, potentially reflecting social facilitation and shared concern for family well-being. However, qualitative evidence complicated this finding considerably. Widows and single mothers frequently sought interventions more proactively, driven by social isolation and the acute absence of spousal support. As one CBO leader confirmed:

> *"Widows come to us fast. They have no one else."*

Conversely, patriarchal control within some households actively restricted women's access to counselling services. A ward administrator reported that in several cases, male partners discouraged attendance, framing counselling as unnecessary or socially inappropriate:

> *"Some men tell their wives not to waste time in counselling meetings. They think it is gossip."*

These dynamics demonstrate that marital structures function ambivalently within trauma recovery simultaneously enabling engagement for some women and constraining access for others. The moderating role of gender dynamics on cognitive therapy uptake mirrors findings from low-resource post-conflict settings where social hierarchies shape help-seeking trajectories (Tol et al., 2011; Ventevogel et al., 2019).

Employment status exhibited a significant positive relationship with CRT participation ($\chi^2 = 11.23$, $p = 0.008$). Economically active women were substantially more likely to engage with formal intervention programs, suggesting that financial autonomy, exposure to information networks, and stronger psychological agency collectively reduce barriers to help-seeking. Employment may function as both a practical enabler — providing resources for transport and time allocation — and a psychological enabler, strengthening self-efficacy and the belief that recovery is both possible and worth pursuing. These findings are consistent with the CBT premise that agency and perceived self-efficacy are critical antecedents to successful cognitive restructuring (Hofmann et al., 2012).

Educational attainment, while marginally significant at conventional thresholds ($\chi^2 = 7.39$, $p = 0.061$), demonstrated a clear positive trend: women with secondary or tertiary education were more likely to engage with formal CRT-based counselling services. Higher education was associated with greater psychological literacy, reduced stigma toward professional mental health services, and stronger capacity to engage with cognitive restructuring techniques. A CBO leader observed:

> *"Those who have gone to school understand counselling better. They know it is not a weakness to seek help."*

In contrast, less-educated women predominantly relied on informal, faith-based, or traditional mechanisms, frequently perceiving structured psychological services as foreign, unnecessary, or incompatible with their belief systems. Notably, socio-economic status did not demonstrate a statistically significant effect on CRT engagement ($\chi^2 = 4.50$, $p = 0.344$). Within the uniformly low-resource context of informal settlements, marginal income differences appeared less determinative than educational, relational, and social positioning factors.

Qualitative findings further illuminated contextual moderators beyond statistical associations. Older women preferred culturally embedded support church elders, community gatherings, and elder-mediated reconciliation over formal cognitive therapy settings. Caregiving burdens constrained attendance for women managing multiple dependents. Stigma, particularly for survivors of sexual violence, remained a powerful barrier to group-based CRT participation. As one CBO director noted:

> *"When everybody knows what happened to you, it is hard to sit in a group and speak."*

Collectively, these findings establish that demographic and social positioning variables significantly mediate engagement with CRT and related cognitive interventions. Access to structured psychological services is shaped not merely by service availability but by intersecting factors of age-related roles, marital dynamics, education-linked awareness, employment-driven autonomy, caregiving demands, and prevailing cultural norms. CRT programming that overlooks these demographic realities risks reproducing participation inequalities and limiting the reach of cognitive intervention benefits among the most vulnerable women survivors.

3.2 Effectiveness of Cognitive Restructuring Therapy

This subsection evaluates the effectiveness of cognitive restructuring therapy in reducing psychological distress among women survivors of political violence. The analysis examines CRT's statistical association with PTSD and anxiety symptom levels, drawing on both correlational evidence and qualitative experiential accounts.

Table 2: Pearson Correlation Coefficients Amongst Participation in CRT-Based Interventions and Psychological Distress Levels

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

Note. Negative correlations indicate that higher participation in CRT-based interventions is associated with lower levels of psychological distress. Source: Field Data (2025).

Pearson correlation findings show that there are statistically significant negative correlations between the outcomes of psychological distress and cognitive restructuring therapy participation. There were moderately strong negative correlations with PTSD symptoms ($r = –0.42$, $p < .01$) and a meaningful negative correlation with anxiety symptoms ($r = –0.37$, $p < .01$) for CRT. These coefficients are consistent and demonstrate that greater involvement in the CRT sessions resulted in significant and stable decreases in trauma-related symptom severity. The coefficients for group therapy were also significantly negative, but slightly lower ($r = –0.39$, $p < .01$ for PTSD symptoms and $r = –0.33$, $p < .01$ for anxiety symptoms) than for CRT. The consistent and directionality of the intervention results and their significance across both types of interventions give strong quantitative support for the integration of cognitive interventions in post-conflict recovery efforts in informal settlements.

A greater association when comparing CRT to group therapy is theoretically sound. CRT is a structured, targeted intervention: systematic targeting and change of maladaptive thoughts believed to contribute to PTSD maintenance, such as self-blame attributions, catastrophic threat appraisals and negative self-schemas (Beck & Haigh, 2014). CRT's ability to directly target the cognitive architecture of trauma yields more clinically relevant and targeted reductions in symptom severity. Although group therapy can be useful for the relational aspects of recovery, such as validation, peer solidarity, and social reintegration, it takes place in a more general and less personalized way. Its impacts, important as they are, are related to collective processing of the cognitive not individually targeted. These intervention approaches present complementary therapeutic pathways, namely CRT (with internal cognitive restructuring) and group therapy (with relational and social reconstruction).

Qualitative findings deepened these quantitative interpretations by illuminating survivors' subjective experiences of cognitive change. The emotional and cognitive healing that occurred in counselling spaces was consistently affirmed by CBO's leaders.. As one respondent reflected:

> *"Even short counselling helps. Once women talk, they feel lighter; but most do not get that chance."*

This observation captures both the demonstrated therapeutic value of structured cognitive engagement and the structural limitations that restrict its reach within informal settlements. Women who accessed consistent CRT sessions reported progressive reductions in intrusive thoughts, hypervigilance, and avoidance behaviours — symptom domains directly targeted through cognitive restructuring. CBO directors noted that techniques including cognitive reframing, behavioural activation, and graded exposure facilitated meaningful changes in how survivors interpreted and responded to trauma-related stimuli.

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 observation reflects the psychosocial function of shared narrative reconstruction — a process aligned with both group CBT principles and Narrative Exposure Theory's emphasis on coherent story construction as a vehicle for emotional integration (Neuner et al., 2008). However, facilitators acknowledged that group formats could overlook highly individualised psychological needs, particularly for survivors with complex or severe trauma presentations requiring more intensive one-on-one CRT engagement.

Traditional and faith-based healing approaches also featured prominently as complementary mechanisms. Ward administrators referenced storytelling circles, pastoral counselling, and elder-mediated reconciliation as important pathways for emotional reintegration, particularly in Kisumu where cultural embeddedness of these practices was strongest. One administrator observed:

> *"Elders help women forgive and find peace. That is part of healing."*

While these indigenous mechanisms were perceived as socially legitimate and emotionally accessible, their therapeutic depth varied. They rarely substituted for the structured cognitive restructuring required in clinically severe trauma cases, underscoring the necessity of integrating rather than replacing formal CRT with community-based approaches.

A critical limitation emerging from qualitative interviews was the short-term and reactive nature of many cognitive interventions. As one CBO leader stated:

> *"The support stops once the violence is over. Trauma does not stop."*

This discontinuity fundamentally undermines sustained cognitive restructuring, as the consolidation of cognitive gains requires continued practice and follow-up within structured therapeutic relationships. Economic empowerment initiatives also emerged as indirectly therapeutic. Income-generating programs restored agency, reduced economic anxiety, and strengthened perceived self-worth — factors closely aligned with the cognitive reappraisal processes central to CRT (Beck & Haigh, 2014). A Kisumu-based director explained:

> *"Once a woman can feed her children, she feels stronger. Business training helps the mind heal too."*

Overall, the integration of quantitative correlations and qualitative experiential accounts confirms that CRT is a clinically effective intervention for reducing PTSD and anxiety among women survivors of political violence. Its impact is further reinforced by group therapy and complementary community-based approaches. However, the full potential of CRT is constrained by inconsistent service access, limited professional capacity, and insufficient treatment continuity,

structural barriers that must be systematically addressed to enable durable psychological recovery within informal settlement contexts.

3.3 Convergent Analysis: Relationship Between CRT and Psychological Well-Being

This subsection presents a convergent analysis integrating quantitative correlations and qualitative insights to deepen understanding of how cognitive restructuring therapy influences psychological well-being among women survivors of political violence. By synthesising 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 CRT Engagement and Psychological Distress Outcomes

Intervention Type	PTSD Symptoms	Anxiety Symptoms	Direction of Relationship
Cognitive Restructuring Therapy (CRT)	Significant ($r = –0.42$, $p < .01$)	Significant ($r = –0.37$, $p < .01$)	Negative
Group Therapy	Significant ($r = –0.39$, $p < .01$)	Significant ($r = –0.33$, $p < .01$)	Negative

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

The quantitative results showed statistically significant negative correlations between the structured CRT participation and psychological distress scores in both the PTSD and anxiety symptom areas. Low scores for PTSD symptoms ($r = –0.42$, $p < .01$) and anxiety ($r = –0.37$, $p < .01$) were significantly related to engagement in CRT. Likewise, group therapy was negatively related to PTSD ($r = –0.39$, $p < .01$) and anxiety ($r = –0.33$, $p < .01$). These coefficients are consistent with findings that increasing participation in cognitive interventions was always associated with decreasing levels of trauma-related distress. The moderate size of these associations indicates that clinically relevant therapeutic effects may be seen in these associations, and that the influence of CRT was slightly larger than the influence of group therapy, reflecting the fact that the cognitive mechanisms of CRT are more directly targeted.

The statistical results are consistent with the existing trauma literature, which reports that CBT-based cognitive restructuring is an empirically supported treatment for the psychological disorders of PTSD and anxiety (Beck & Haigh, 2014; Hofmann et al., 2012; Ehlers et al., 2010). In the current context, the CRT sessions helped the survivors to break cycles of rumination and catastrophic threat appraisal, to reduce hyperarousal, to disconfirm entrenched self-blame narratives, and to avoid rumination patterns that perpetuated hyperarousal and avoidance. 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 cognitive therapy effectiveness. The cognitive mechanisms of change — activation of existing schemas, introduction of disconfirming evidence, and consolidation of new adaptive thinking patterns require sustained engagement across multiple sessions to produce durable change (Hofmann et al., 2012).

Qualitative findings, however, illuminate significant structural and contextual constraints that moderate the realisation of these therapeutic gains. High dropout rates from CRT programs 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 account highlights the episodic and reactive character of many intervention models, where CRT is delivered as a discrete crisis response rather than as part of a sustained recovery continuum. The convergence of findings further demonstrates that intervention effects, while statistically significant, were positive but partial. Women who accessed counselling or CRT-based group programs reported improvements in emotional regulation and reductions in intrusive symptoms; however, many remained within moderate distress categories rather than achieving full psychological restoration.

Qualitative narratives clarified three principal mechanisms through which CRT generated psychological improvement. First, emotional release through structured dialogue enabled survivors to externalise and reframe traumatic memories, reducing their intrusive salience. Second, strengthened social connection within group-based CRT reduced isolation and validated survivors' experiences, fostering relational recovery alongside cognitive healing. Third, economic participation restored agency and purpose dimensions of well-being particularly compromised by displacement and livelihood disruption. A CBO leader in Kibera observed:

> *"Whenever women are in business, they talk and collaborate. That is where her cure starts."*

This implies that the psychosocial empowerment pathways work in tandem with the economic empowerment pathway in the recovery of cognitive trauma, with the latter strengthening the self-efficacy and agency component of CRT, which is aimed at strengthening within the individual.This indicates that the psychosocial empowerment pathway is connected to the economic empowerment pathway, the latter reinforcing the self-efficacy and agency component of CRT which is aimed at strengthening within the individual.

The culturally embedded interventions further facilitated therapeutic engagement. Formal CRT services were complemented by indigenous storytelling circles, elder mediation, and faith-based dialogue that helped cultivate trust and decrease stigma. In the absence of cultural adaptation or continuity of intervention, however, their effectiveness was clearly shown to be weak. Those survivors who used to receive sustained cognitive therapy, especially older and less educated women, continued to be at risk for ongoing symptoms of PTSD and anxiety. The convergent analysis therefore confirms that the use of CRT has a significant impact on trauma-related distress in women survivors, though it is subject to certain system-related factors, cultural integration, continuity of treatment, and socio-economic factors. A holistic and culturally appropriate approach that includes both psychological and economic empowerment and community-based support and services is required for sustainable psychological rehabilitation in informal settlements.

3.4 Testing the Influence of Cognitive Restructuring Therapy on Psychological Well-Being

To formally examine the influence of cognitive restructuring therapy on psychological well-being, the study tested the following null hypothesis:

H_{o2}: *Cognitive Restructuring Therapy does 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: CRT Engagement and Psychological Well-Being

Hypothesis	Statistical Test	Chi-Square Value (χ^2)	p-value	Decision
H_0: No significant relationship between CRT engagement 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 CRT-based interventions — particularly structured counselling and CBT-aligned cognitive programs — was associated with differences in psychological well-being across demographic categories. Employment status emerged as a significant moderating variable ($\chi^2 = 11.23$, df = 2, p = 0.008), with employed women significantly more likely to report improved psychological outcomes. This finding indicates that economic participation enhances both access to CRT services and the internal cognitive resources necessary for effective recovery, consistent with CBT's emphasis on self-efficacy and environmental mastery as dimensions of psychological functioning (Beck & Haigh, 2014; Ryff, 1989).

Table 5: Chi-Square Summary of Demographic Variables and Psychological Well-Being

Variable	Chi-Square Value (χ^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).

Further Chi-square analyses confirmed 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 significantly associated with psychological well-being outcomes. Educational level demonstrated a marginal positive association ($\chi^2 = 7.39$, df = 3, p = 0.061), while socio-economic status did not reach statistical significance ($\chi^2 = 4.50$, df = 3, p = 0.344). These results collectively indicate that psychological recovery among women survivors is shaped not only by CRT exposure but by the demographic and social conditions that enable or constrain meaningful engagement with cognitive interventions.

The observed decrease in PTSD and anxiety symptoms by women who interact with the CRT are exactly in line with the principles of Cognitive Behavioural Therapy. According to Beck and Haigh (2014), CBT has been shown to help individuals identify and systematically restructure maladaptive cognitions which perpetuate emotional distress. This study was associated with

increased emotional regulation and decreased intrusive symptomatology and adaptive coping capacity among participants who attended CRT sessions on a consistent basis. CBO directors reported that structured cognitive techniques (such as cognitive reframing, behavioural activation, and graded exposure to trauma-related stimuli) led to meaningful decreases in hyperarousal, flashbacks and catastrophic thinking patterns. These results are highly in line with the body of evidence that shows CBT to be one of the most effective treatments for PTSD and related trauma disorders (Ehlers et al., 2010; Hofmann et al., 2012).

They were also able to identify therapeutic potential congruent with Narrative Exposure Theory (Neuner et al., 2008), which focuses on healing through process of coherent story construction and re-authoring of trauma narratives (Narrative Therapy; White & Epston, 1990) in addition to formal CRT. Shared storytelling and collective dialogue, a process of which qualified accounts confirmed, lessened feelings of isolation, validated the experience of survivors, and fostered peer solidarity in addition to the individually focused cognitive restructuring in formal CRT. In Kibera, a CBO director observed that women who attended sessions regularly had significant improvements in psychological stability compared to those who dropped out of the sessions prematurely, underscoring the importance of adherence to sessions for the consolidation of cognitive changes.

Although statistically significant positive effects were found, systemic barriers limited the long-term therapeutic effects of CRT. There was insufficient funding, poor follow-up systems, lack of trained counselling staff and lack of services integrated to limit treatment continuity. Stigma associated with psychological counselling in the cultural context resulted in inactive participation and early dropouts. Some of the reasons given for not accepting an HIV-positive sexuality were fear of community labelling, perceived shame and social rejection. These barriers are similar to those found in various low-resource, post-conflict situations, where structural gaps and stigma systematically hinder uptake and engagement in mental health services (Tol et al., 2011; Ventevogel et al., 2019).

To summarize, the statistical evidence presented clearly shows that cognitive restructuring therapy has significant impacts on the psychological wellbeing of political violence survivor women. These impacts, however, are (at least partially) mitigated by demographic positioning, treatment continuity and systemic capacity. In addition to the measurable and clinically meaningful therapeutic benefits of CRT, the scaling and sustaining of these benefits in informal settlements will require increasing institutional supports and structures, reducing social stigma and the development of integrated community-based and professional service models.

3.5 Patterns of CRT and Complementary Interventions Adopted by Women Survivors

The analysis of intervention strategies adopted by women survivors reveals a layered and context-specific recovery landscape within the informal settlements of Nairobi and Kisumu. As presented in Table 6, engagement patterns varied considerably across formal cognitive therapy, faith-based coping, traditional healing rituals, and community-driven support mechanisms, reflecting both the availability and cultural acceptability of different recovery pathways within these structurally constrained environments.

Participation in continued personal or group counselling emerged as the most strongly endorsed formal intervention, with 62.8 percent of respondents strongly agreeing that they had engaged in counselling activities. This high endorsement indicates that general counselling services maintained reasonable visibility and accessibility within the study communities. However,

engagement with structured CRT, operationalised as receiving assistance to change trauma-related thinking patterns, was comparatively modest, with only 29.5 percent strongly agreeing to such engagement. This gap reveals that while counselling spaces were relatively accessible, the formalised, evidence-based cognitive restructuring techniques central to CRT were less systematically embedded within community practice. The discrepancy points to uneven integration of structured cognitive therapy within the broader counselling landscape of informal settlements, potentially reflecting limitations in counsellor training, session depth, and therapeutic fidelity.

Table 6: CRT and Complementary 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 (CRT/CBT)	11.1	22.1	10.0	27.4	29.5
Increased church or 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 violence	24.1	13.6	5.2	23.6	33.5

Note. Items rated on a 5-point Likert scale (1 = Strongly Disagree; 5 = Strongly Agree). Source: Field Data (2025).

Faith-based coping strategies constituted the most widely adopted recovery pathway within the study communities. A combined 64.1 percent of respondents agreed or strongly agreed that they had increased their church or prayer commitment in the aftermath of the violence. This finding demonstrates that spiritual spaces function as primary psychosocial anchors, offering emotional regulation, communal solidarity, and culturally legitimate forms of meaning reconstruction. From a cognitive perspective, prayer and religious engagement may facilitate elements of cognitive reappraisal, enabling survivors to reframe traumatic events within providential or redemptive narratives, thereby operating as informal analogues to structured cognitive restructuring (Slattery & Park, 2015).

Similarly, engagement in traditional protective rituals was substantial, with 61.2 percent of participants strongly agreeing that they had performed such practices, particularly within the Kisumu communities. This pattern underscores the enduring relevance of indigenous healing frameworks among the study population and reinforces the necessity of integrating, rather than

displacing, these practices within formal CRT delivery models. Traditional rituals and elder-mediated reconciliation carry deep communal legitimacy; their alignment with formal cognitive intervention protocols therefore represents not a compromise of therapeutic integrity but a prerequisite for culturally grounded and sustainable recovery.

In marked contrast, formal community support groups were substantially underutilised. A striking 57.1 percent of respondents strongly disagreed that they had joined such groups, representing a significant structural gap in organised peer-based psychosocial programming. This finding is particularly concerning given the well-established effectiveness of group CBT modalities for PTSD within communal recovery contexts (Ehlers et al., 2010). The low uptake likely reflects a confluence of factors: limited organisational capacity, inadequate mobilisation of survivors into group structures, persistent stigma associated with mental health participation, and insufficient trust in semi-formal group settings. Addressing this gap is essential, as group-based cognitive processing offers unique therapeutic benefits, including peer validation, normalisation of trauma responses, and the cultivation of collective resilience.

Notably, 33.5 percent of respondents strongly agreed that they had moved on with life after forgetting the violence. However, this self-reported resolution warrants critical scrutiny. The high residual distress documented quantitatively, including a composite trauma severity score of 4.18 out of 5.0, suggests that self-declared recovery does not necessarily equate to genuine psychological resolution. Rather, such responses may reflect avoidance-based coping strategies, wherein the suppression of traumatic memory is mistaken for healing. This distinction carries important clinical implications: without structured cognitive processing, suppressed trauma retains its pathogenic potential, placing survivors at risk of symptom recurrence and long-term psychological deterioration.

Qualitative findings enriched and complicated these quantitative patterns. Survivors frequently expressed a clear preference for community-based and culturally familiar forms of support over formal clinical interventions. As one ward administrator in Kondele observed:

> *"Women find peace in church prayers and listening to sermons more than going for formal counselling."*

Group storytelling and communal dialogue were similarly described as emotionally liberating and stigma-reducing. Within these shared narrative spaces, women found both validation and a sense of collective empowerment that formal individual therapy often struggled to replicate. These accounts underscore the profound value of narrative expression within culturally grounded healing spaces, consistent with Narrative Exposure Theory's positioning of coherent story reconstruction as a vehicle for emotional processing (Neuner et al., 2008).

Economic empowerment also emerged as an indirect yet influential psychosocial intervention. Participation in income-generating activities restored agency, reduced ruminative thinking, and strengthened perceived self-worth, functioning simultaneously as distraction, dignity restoration, and practical enablement. Respondents consistently emphasised, however, the short-term and fragmented nature of formal interventions, with limited follow-up and inconsistent non-governmental organisation presence fundamentally undermining the continuity of cognitive therapeutic gains.

In summation, post-trauma recovery among women survivors in the informal settlements of Nairobi and Kisumu is a pluralistic and multi-layered process, encompassing spirituality, cultural

tradition, community solidarity, economic participation, and formal cognitive therapy. CRT and structured counselling are valued and demonstrably effective where consistently accessible; however, sustainable recovery unfolds across intersecting domains that no single intervention pathway can adequately address in isolation. Effective intervention models must therefore bridge formal cognitive therapy with faith-based, indigenous, and economic support systems, creating integrated recovery ecosystems capable of generating meaningful and sustained psychological healing for women survivors in these complex and underserved environments.

3.6 Post-Trauma Support Structures and Structural Gaps in CRT Delivery

Despite the demonstrated effectiveness of CRT and complementary cognitive interventions, the study identified persistent structural and systemic gaps that continue to undermine the depth and sustainability of psychological recovery among women survivors of political violence in informal settlements. These gaps reflect deeper weaknesses within the broader mental health support architecture operating in low-resource, high-vulnerability environments.

Table 7: Quantitative Findings on Key Recovery Indicators

Theme	Description	Key Findings
Displacement Due to Violence	Individuals and families forced to evacuate homes due to political violence	60.1% strongly agreed they were displaced
Community Support Access	Perceived support received for basic needs during crisis	33% agreed; 29.6% strongly agreed; over 29% expressed negative/undecided responses
Emotional Support and Debriefing	Assistance sharing experiences through PFA and debriefing	60.6% indicated some level of agreement
Value of Support Received	Perceived influence of support on well-being	56.6% found support helpful; many expressed disagreement or uncertainty
Long-Term Emotional Pain	Ongoing distress when recalling violence despite its cessation	68% strongly agreed memories of violence continue to cause pain
Perceived Help After Violence	Participants expressed limited perceptions of sustained post-violence support	Only 13.3% strongly agreed they received adequate post-violence help
CRT/CBT Effectiveness	Reported effectiveness of cognitive restructuring in changing trauma-related thinking	58.2% agreed or strongly agreed CRT was effective; 24.6% expressed disagreement
Spiritual Commitment	Turning to spiritual practices as a coping mechanism post-violence	59.1% strongly agreed they increased commitment to prayer/faith after violence

Source: Field Data (2025).

Access to formal CRT and counselling services remains severely constrained across the study sites. Survivors in marginalised zones such as Sarangombe and Kibera Makina reported limited or no contact with trained psychological professionals. In practice, this compels many women to rely almost exclusively on informal coping pathways — prayer groups, peer discussions, and traditional practices — that, while emotionally supportive, lack the structured therapeutic depth required for effective cognitive restructuring. The limited reach of trained counsellors restricts the implementation of evidence-based approaches such as CRT and Narrative Therapy, both of which require professional guidance to effectively address maladaptive cognitions, intrusive memories, and trauma-related anxiety disorders.

The shortage of trained trauma counsellors at county facilities and CBOs significantly affects service quality and therapeutic depth. Key informants consistently reported overwhelming caseloads among the few available professionals, which reduces both therapeutic intensity and the capacity for structured follow-up. Communities consequently depend on non-professional actors — elders, faith leaders, and women's group coordinators — who, while culturally embedded and socially accessible, are not equipped to manage severe PTSD, dissociation, or chronic depression requiring specialised cognitive intervention. As a result, survivors with complex trauma presentations remain clinically underserved.

The quantitative findings reinforce these structural concerns with precision. 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 — 68% strongly agreed that memories of violence continued to cause significant distress. Only 13.3% strongly agreed they received adequate help after the violence subsided. CRT engagement was uneven: although 58.2% agreed or strongly agreed that CBT-based cognitive restructuring was effective in changing their thinking about perpetrators and traumatic experiences, counselling engagement overall remained inconsistent, with 31.0% disagreeing or undecided about continued participation. The coexistence of high residual distress alongside moderate CRT endorsement indicates that current cognitive support mechanisms are insufficient in resolving deeper and more persistent trauma outcomes.

Qualitative accounts further illuminate institutional weaknesses. Support structures in both Nairobi and Kisumu were predominantly NGO-mediated and community-driven, with minimal sustained government integration. As one ward administrator in Nyalenda stated:

> *"Most of the trauma work here is done by NGOs. Government waits for reports but does not follow up."*

This 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 CRT infrastructure, and point to the need for community-level cognitive support that bridges traditional and professional therapeutic frameworks. At the county level, formal trauma infrastructure was either weak or functionally absent. There were no dedicated trauma recovery centres, structured safe shelters, or operational crisis response units. CBO leaders described interventions as short-term and donor-dependent. One respondent from Kisumu observed:

"After one month or two, the programs end. Then women are on their own again."

This short-cycle programming fundamentally undermines the continuity required for effective CRT, as cognitive restructuring is a progressive process requiring iterative skill reinforcement, not a single-session outcome. Systemic fragmentation further limits coordination between health, administrative, and security sectors, exposing trauma recovery to funding volatility and project-based discontinuity. Without institutionalisation at county level, CRT and related cognitive interventions remain episodic rather than sustained, failing to generate the durable psychological change that evidence consistently associates with long-term therapeutic engagement.

In summary, post-trauma cognitive support systems in Nairobi and Kisumu informal settlements are predominantly community-based and NGO-led, with limited government integration and significant professional capacity gaps. Women survivors rely extensively on religious, cultural, and peer networks to navigate recovery — systems that provide essential emotional buffering but cannot substitute for structured cognitive therapy in cases of severe and persistent trauma. Addressing these systemic gaps requires urgent capacity building of local counsellors, institutionalisation of trauma screening and CRT follow-up mechanisms, and systematic integration of culturally grounded support systems with professional, evidence-based cognitive therapeutic services.

HYPOTHESIS TESTING

This study was designed to formally test the null hypothesis that Cognitive Restructuring Therapy exerts no statistically significant influence on the psychological well-being of women survivors of political violence in the informal settlements of Nairobi and Kisumu. The weight of statistical evidence compellingly refutes this position. Pearson correlation analyses revealed statistically significant and clinically meaningful negative associations between participation in CRT-based interventions and measured psychological distress, providing robust quantitative grounds for the rejection of the null hypothesis.

Specifically, CRT engagement demonstrated a moderate yet significant negative correlation with PTSD symptomatology ($r = 0.42$, $p < .01$) and a meaningful negative association with anxiety symptomatology ($r = 0.37$, $p < .01$). Group therapy produced comparably significant results, with negative correlations recorded for both PTSD ($r = 0.39$, $p < .01$) and anxiety ($r = 0.33$, $p < .01$) symptomatology. The consistency and directionality of these associations across both intervention types confirm that increasing engagement with structured cognitive interventions is reliably associated with significant and stable reductions in trauma-related psychological distress. The marginally stronger correlations observed for CRT relative to group therapy are theoretically coherent, reflecting the more targeted and individualised nature of cognitive restructuring as a clinical mechanism compared to the broader relational benefits afforded by group modalities.

Chi-square analyses further deepened this evidential picture by illuminating the socio-structural conditions that shape both access to CRT and the trajectory of recovery. Age group emerged as a highly significant moderating variable ($\chi^2 = 16.32$, $p = 0.002$), indicating that life-stage factors, including caregiving roles, household responsibilities, and social positioning, substantially influence the likelihood and depth of therapeutic engagement. Marital status was similarly significant ($\chi^2 = 9.47$, $p = 0.021$), pointing to the complex ways in which relational structures simultaneously enable and constrain access to formal psychological services. Educational attainment approached statistical significance ($\chi^2 = 7.39$, $p = 0.061$), reflecting a discernible

positive trend wherein greater educational exposure was associated with higher psychological literacy, reduced stigma, and stronger capacity to engage meaningfully with cognitive restructuring techniques. Socio-economic status, by contrast, did not reach statistical significance ($\chi^2 = 4.50$, $p = 0.344$), suggesting that within the uniformly constrained economic landscape of informal settlements, marginal income differentials are less determinative of therapeutic engagement than educational, relational, and social positioning factors.

Taken together, these findings establish with empirical clarity that psychological recovery among women survivors is shaped not solely by exposure to CRT but by the broader constellation of socio-structural experiences that either facilitate or impede meaningful engagement with therapeutic services. The null hypothesis is therefore decisively rejected. Cognitive Restructuring Therapy exerts a statistically significant and clinically meaningful influence on the psychological well-being of women survivors of political violence in informal settlement contexts, a finding that carries substantial implications for the design, targeting, and institutionalization of trauma recovery programming in Kenya and comparable post-conflict urban environments across Sub-Saharan Africa.

4.0 Conclusion

This study aimed to address a question of great human and clinical importance: can structured cognitive therapy, meaningfully restore psychological health for women survivors of political violence in the multiple deprivations of informal urban settlements? All the evidence gathered for this convergent mixed methods inquiry tends to be affirmative, but with some restrictions.

The quantitative results confirm that CT has a positive, statistically significant and clinically relevant effect on the psychological health of Nairobi and Kisumu informal settlement women survivors of political violence. Moderate correlation coefficients provide evidence for both PTSD and anxiety symptom reductions that are meaningful for therapy, while the effects of the complementary group therapy were comparably large, but somewhat smaller. These are not unimportant connections. They are a tangible step toward better inner life of women who have suffered significant harm and they stand as a testament to the role of cognitive restructuring in the post-conflict mental health response system which is established in low-resource environments.

But the results of the study also suggest boundaries for clinical effectiveness without structural facilitation. Demographic factors (age, employment status and marital status) affect not only engagement in CRT programs, but also the pathways of recovery that have been experienced after involvement. The greatest therapeutic benefits were observed in younger and more economically independent women who had a higher level of social autonomy, and the greatest gap in therapeutic benefits was occurring in older, less-educated, and more socially constrained women. At every step, systemic barriers to access exacerbated these inequities: a lack of skilled trauma counselors, inconsistent service provision and dependence on donors, time-limited programming that ends right when trauma survivors need the most help, and the cultural taboo that prevents survivors from asking for assistance. Combined, these limitations do not simply limit the scope of CRT; they undermine its ability to produce the lasting cognitive changes which evidence always needs sustained therapeutic interaction to achieve.

Unmet formal needs are made up for by informal community networks, faith-based institutions, and indigenous healing traditions that are not peripheral or dispensable. They are key psychosocial resources through which most women survivors make sense of their lives, offer emotional relief,

a sense of community and culturally meaningful avenues for meaning-making in recovery. They have a vital and irreplaceable role in the ecology of the recovery of these communities. It is equally clear, however, that these are not, and never will be, systems that can replace the structured, professionally guided cognitive processing that is uniquely provided by the CRT, in cases of severe and persistent trauma. It is not a matter of either/or between formal and informal systems but one of how to ensure that the formal and informal systems reinforce each other in a coherent and integrated institutional framework that is supported.

Sustainable psychological recovery from the women survivors in informal settlements thus requires a paradigm change from the prevailing reactive, project-based mode of intervention towards an integrated, multi-level and institution-based recovery model. This approach should establish a formal public health infrastructure at the county level to integrate CRT and evidence-based cognitive therapy, invest systematically in training and retention of trauma competent counsellors, and create referral pathways between community-based first responders and professional therapeutic services. It should respect and embrace cultural, spiritual and economic components of healing and must address the psychological healing in the context of material circumstances of dignity, belonging and trust in the community that it needs to be rooted in.

The findings in this study have implications that go beyond the scope of this study. The evidence presented here is a mandate and a roadmap for the Kenya County-level trauma response planners, county-level and CBO policymakers. It provides a transferable approach to re-imagining how to invest in the mental health of women survivors of conflict in low-resource, urban settings across Sub-Saharan Africa, rather than an add-on to humanitarian operations.

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

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Charlson, F., van Ommeren, M., Flaxman, A., Cornett, J., Whiteford, H., & Saxena, S. (2019). New WHO prevalence estimates of mental disorders in conflict settings: A systematic review and meta-analysis. *The Lancet, 394*(10194), 240–248. https://doi.org/10.1016/S0140-6736(19)30934-1

Creswell, J. W., & Clark, V. L. P. (2017). *Designing and conducting mixed methods research* (3rd ed.). SAGE Publications.

Cuijpers, P., Veen, S. C., Sijbrandij, M., Yoder, W., & Cristea, I. A. (2022). Eye movement desensitization and reprocessing for mental health problems: A systematic review and meta-analysis. *Cognitive Behaviour Therapy, 51*(1), 1–16.

Diener, E., Oishi, S., & Tay, L. (2018). Advances in subjective well-being research. *Nature Human Behaviour, 2*(4), 253–260. https://doi.org/10.1038/s41562-018-0307-6

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

Herman, J. L. (2015). *Trauma and recovery: The aftermath of violence—from domestic abuse to political terror*. Basic Books.

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

Hofmann, S. G., Curtiss, J., & McNally, R. J. (2021). A network perspective on clinical science. *Perspectives on Psychological Science, 11*(5), 597–605.

Kenya National Commission on Human Rights. (2008). *On the brink of the precipice: A human rights account of Kenya's post-2007 election violence*. Kenya National Commission on Human Rights.

Makumi, J. (2015). Psychosocial consequences of post-election violence in Kenya: A community perspective. *African Journal of Trauma, 4*(1), 21–29.

Muchemi, A. W. (2018). Psychological impact of political violence on women in Kenya's informal settlements. *East African Medical Journal, 95*(7), 312–320.

Neuner, F., Schauer, M., Karunakara, U., Klasen, F., & Elbert, T. (2008). Psychological trauma and PTSD in West Nile: An exploratory study. *Journal of Clinical Psychology, 64*(9), 853–862. https://doi.org/10.1002/jclp.20515

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.

Prati, G., & Pietrantoni, L. (2009). Optimism, social support, and coping strategies as factors contributing to posttraumatic growth: A meta-analysis. *Journal of Loss and Trauma, 14*(5), 364–388.

Ryff, C. D. (1989). Happiness is everything, or is it? Explorations on the meaning of psychological well-being. *Journal of Personality and Social Psychology, 57*(6), 1069–1081.

Ryff, C. D. (2014). Psychological well-being revisited: Advances in the science and practice of eudaimonia. *Psychotherapy and Psychosomatics, 83*(1), 10–28. https://doi.org/10.1159/000353263

Slattery, J. M., & Park, C. L. (2015). Spiritual coping and resilience: A review of the literature. *Journal of Religion and Health, 54*(1), 17–29.

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.

Tol, W. A., Barbui, C., Galappatti, A., Silove, D., Betancourt, T. S., Souza, R., & van Ommeren, M. (2013). Mental health and psychosocial support in humanitarian settings. *The Lancet, 378*(9802), 1581–1591.

UN-Habitat. (2020). *World cities report 2020: The value of sustainable urbanization*. United Nations Human Settlements Programme.

United Nations. (2023). *Report of the Secretary-General on the protection of civilians in armed conflict*. United Nations Security Council.

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*, Article e30.

Weathers, F. W., Litz, B. T., Keane, T. M., Palmieri, P. A., Marx, B. P., & Schnurr, P. P. (2013). *The PTSD Checklist for DSM-5 (PCL-5)*. National Center for PTSD. https://www.ptsd.va.gov

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*. World Health Organization.