

**PSYCHOLOGICAL DISTRESS AND POST TRAUMATIC GROWTH AMONG
REFUGEES IN NAIROBI COUNTY, KENYA**

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DECLARATION

I, the undersigned declare that this thesis is my original work and has never been submitted to any other University for academic credit. Information from other sources has been duly acknowledged.

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DEDICATION

This work is dedicated first and foremost to Almighty God, the giver of every good gift and especially to Sr. Dr. Henrietta Ebosiogwe Alokha, SSH and Sr. Goretti Iwu SSH both of blessed memory.

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ABSTRACT

The psychological distress caused by social and environmental factors like political violence, terrorism, war, sexual abuse, natural and human disaster is alarming and disheartening, resulting to root causes of severe psychological problems such as trauma, depression, anxiety, stress, shattering people's sense of security, creating separation of family members from their homestead and forcing them into migration from their home of origin; rendering them hopeless and helpless. The main objective of this study is to assess the influence of psychological distress on posttraumatic growth among refugees in Nairobi County, Kenya. This study adopted the Posttraumatic Growth Theory (PTG) and Cognitive Behavioural Theory of Trauma. The study used embedded mixed method research design, adopting correlational and phenomenological research design. The study target population was male and female refugees from 18-59 years of age. Total sample size of 133 from which 120 participants was selected using simple random sampling for the quantitative strand; and 13 respondents (5 officials and 8 refugees) using convenience/purposive sampling for the qualitative strand. The Posttraumatic Growth Inventory (PTGI), Depression, Anxiety, and Stress Scale (DASS), and Posttraumatic Stress Disorder Checklist (PTSD Checklist- PCL-5) were used to collect quantitative data, while an interview guide was used to collect qualitative data from the participants. The researcher used the Statistical Package for Social Sciences (SPSS) specifically the simple bivariate statistics and Pearson correlation analysis, to analyze quantitative data. Qualitative data was analysed using thematic analysis where by themes were extracted. The study found a weak negative relationship between the level of anxiety, depression, PTSD and posttraumatic growth. Finally, intervention used by Jesuits Refugee Service implies that continuous psychological and psychosocial assistance are considered as coping skills that facilitate posttraumatic growth.

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ABBREVIATIONS / ACRONYMS

BDI	Beck Depression Inventory
CBTT	Cognitive Behavioural Theory of Trauma
DASS	Depression, Anxiety and Stress Scale
DSM	Diagnostic and Statistical Manual for Mental Disorders
DRC	Democratic Republic of Congo
HHI	Hearth Hope Index
HSCL	Hopkins symptom checklist
IDA	International development agencies
M.I.N.I	Mini-international Neuropsychiatric interview
NACOSTI	National Commission for Science, Technology and Innovation
NGO	Non-Governmental Organization
NLE	Negative life event
PCL-5	Posttraumatic Stress Disorder Checklist
PTG	Posttraumatic Growth theory
PTGI	Posttraumatic Growth Inventory
PTSD	Posttraumatic Stress Disorder
SCID	Structured clinical interview for DSM
SPSS	Statistical Package for Social Sciences
SPLM	Sudan People's Liberation Movement
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations International Children's Emergency Fund
WHOQOL	World Health Organization Quality of Life Scale

OPERATIONAL DEFINITION OF KEY TERMS

Anxiety – In this study, anxiety refers to a condition whereby the refugees experience enduring fear, worry and uncertainty about life, due to their sudden loss of property and displacement from their country of origin.

Depression – This is a condition that is experienced by the refugees after being displaced from their home country. It is a feeling of loss of sense of meaning, purpose and hope for living or recovery.

Government Policy - According to this study, these are legislations or guidelines propounded by the government for the thriving and smooth running of the state, which could either be beneficial or distressing to the refugees.

Posttraumatic Growth –Posttraumatic growth is used to refer to the positive growth or transformation experienced by the refugees.

Posttraumatic Stress Disorder - In this study, PTSD is a consistent feeling of an intense stress and anxiety experienced by the refugees for loss of their home, livelihood and what they have always known to be normal.

Psychological Distress –Psychological distress in this study is used to refer to the emotional problem faced by the refugees in terms of anxiety, depression and PTSD.

Refugees –These are people, who seek basic needs in life outside their homestead, land or country due to war, famine, disease, pestilence or other natural or human disasters.

CHAPTER ONE

INTRODUCTION

1.1 Introduction

This chapter consists of the background of the study, the statement of the problem, the objectives and research questions, the significance / justification of the study, theoretical framework, scope and delimitations of the study, and assumption of the study.

1.2 Background of the Study

Life-threatening incidents such as wars, terrorism, conflicts, and other violent related experiences have caused displacement of several persons from their country of origin to seek refuge in another country perceived as peaceful (UN Refugee Agency 2016). These realities of seeking refuge in another country have different impacts on the social living conditions and psychological well-being of the individuals. For instance, it renders so many people helpless and hopeless as the experience comes with variety of challenges such as psychological distress, emotional instability, insecurity, financial difficulties, restriction of freedom, hostility, deprivations (Digidiki & Bhabha, 2017; International Medical Corps (IMC) & United Nations International Children's Emergency Fund (UNICEF), 2014; Sim, Saunders, Waterfield, & Kingstone 2018). These incidents have always been discussed in terms of the psychological distress and negative outcomes that it brings on the individuals (Digidiki & Bhabha, 2017; Kimondo, 2013; Im, 2011; Mels, Derluyn, Broekaert, & Rosseel, 2010). Recent studies however have shown that there is a paradigm shift from the negative to positive outcomes. Some scholars such as Tedeschi, Shakespeare-finch, Taku, and Calhoun (2018), documented that there is a positive side to every overwhelming or psychological distress incident. This study acknowledges that, although the experiences of the refugees could cause psychological distress, it however

recognized that the negative outcomes could ignite positive psychological transformation among the refugees.

The psychological distress caused by social and environmental factors like political violence, terrorism, war, sexual abuse, natural and human disasters, is alarming and disheartening. These factors often become the root causes of severe psychological problems such as trauma, depression, anxiety, stress, and social, familial and existential insecurity such as migration, homelessness, unemployment and misery (Zimmerman, Kiss, & Hossain, 2011; Barbara, 2013; Mels, Derluyn, Broekaert, & Rosseel, 2010). According to the global report of the United Nations Refugee Agency, the number of people displaced from their home countries due to war, armed conflict, political violence, and related threats is growing. Indeed, if current trends continue, one in every 100 persons will soon be a refugee (UN Refugee Agency, 2016).

These social and environmental phenomena have left so many questions in the heart of citizens and humanitarians within and outside the shores of Europe and Africa. This lives a lasting impact on the victim's mental and emotional stability (Barbara, 2013). Consequently, these phenomena have continued to increase the number of refugees and displaced persons. Alemi, James, Cruz, Zepeda & Racadio, (2013) affirms that some empirical studies with refugees expressed their high vulnerability to psychological distress (depression, anxiety, and PTSD). Various studies across the world have reported high prevalence of mental illnesses in refugees (Norredam, Garcia-Lopez, Keiding & Krasnik 2009; Sherin & Nameoff, 2011; Digidiki & Bhabha, 2017; Malejko, Abler, Plener & Straub, 2017; Kimondo, 2013; Imana, 2011; Mels, Derluyn, Broekaert, & Rosseel, 2010). Moreover, the experience of individuals who have been forced out of their countries, and their subsequent exposure to events before, during and after migration is

recorded as an indicator of psychological distresses (depression, anxiety, and PTSD), that influences their mental health to a great extent (Zimmerman, Kiss, & Hossain, 2011).

Globally, the world is presently experiencing unparalleled refugee influx which is as a result of political instability, economic, and religious conflicts and wars (Ali, Imana, & Ocha, 2017). According to the United Nations High commissioner for refugees' report, (UNHCR, 2017), Syrian crisis is caused by political and religious misunderstanding forcing many to flee Syria. Furthermore, climate change is causing unreliable rainfall in many parts of the world, as well as prolonged droughts that make farming, which is the traditional way of life, nearly impossible to practise. People in such areas are forced to migrate to areas or countries where they can find work or even practise farming. This, in turn, causes tension and conflict. Over 65.6 million people are estimated to be forcibly exiled around the world, with 22.5 million of them being refugees. There are over 10 million stateless people worldwide, with an estimated 189,300 resettled in 2016. Surprisingly, 55 percent of all refugees worldwide came from three countries: Syria (5.5 million), Afghanistan (2.5 million), and South Sudan (1.4 million). The latest statistics of UNHCR (2019) stated that the world's refugee population as at the end of 2018 was a record of 25.9 million.

In Southeast Asia, for example, the UNHCR reported that 99,930 refugees were residing in nine camps in Thailand as of September 2017. The majority of these refugees, according to the same report, are ethnic minorities from Myanmar who have been fleeing turmoil in their homeland for nearly 30 years (UNHCR, 2017). The political unrest in Northern African countries such as Libya, Tunisia, and Egypt is forcing refugees to flood into Europe via the Mediterranean Sea. Europe has seen the largest influx of refugees, with the majority coming from Syria, Somalia, Libya, Tunisia, and Egypt. As a result of the refugee crisis, some European countries have built border walls, fences, and implemented severe border controls to prevent refugees from accessing

their country (UNHCR, 2015). The most affected countries in Europe currently includes; Germany, Italy, Spain, Turkey and Greece (UNHCR, 2015).

In Eastern Africa, Kenya has a long history of hosting refugees, which began in the early 1970s, when Kenya accommodated Ugandans displaced by the time of political coups and tribal regimes. The regional political and economic crises that occurred in the 1990s, both in the Horn of Africa and in Central African nations, drastically altered the condition of refugees in Kenya (UNHCR, 2015). Kenya took in refugees from Somalia, Ethiopia, South Sudan, and the Democratic Republic of the Congo during this time. Ethiopian refugees arrived in Kenya following the fall of the Derg regime in 1991, which failed to prevent political persecution. Following the fall of President Siad Barre's government in 1992 and the entry of 40,000 boys from South Sudan known as the "Lost Boys" into Kenya in 1992 due to religious war problems between the government of Khartoum in the north and the rebels - the Sudan People's Liberation Movement (SPLM) in the south, refugees from Somalia and South Sudan (then Sudan) arrived in large numbers in Kenya. The number of refugees increased further when Rwandans arrived in Kenya following the 1994 Rwandan genocide, and Kenya also hosted refugees from the Democratic Republic of the Congo (DRC), who were victims of a decade-long conflict between the Kinshasa government and Congolese rebel factions (UNHCR, 2015).

Kenya's refugees and asylum seekers come from a diverse range of countries, including the following: Somalia, Rwanda, South Sudan, Ethiopia, Burundi, DRC, Sudan, Eritrea, Uganda, and other nationalities (UNHCR, 2015).

In addition, the government of Kenya has accepted some refugees who have resources to live in urban cities such as Nairobi, Ruiru and Eldoret. As a result, Kenya is home to over 584,989 registered refugees and asylum seekers. According to the statistics from UNHCR Kenya (2015),

there are four refugee camps in Kenya with the following statistics, Dadaab camp with 38%, Kakuma camp with 31% Alinjugu camp with 22% and Nairobi Urban refugee camp with 9% respectively. The majority of refugees and asylum seekers in Kenya are from Somalia (53.9%), South Sudanese (24.7%), Congolese (9 %), and Ethiopians (5.8%). Other nationalities, including Sudan, Rwanda, Burundi, Eritrea, Uganda, and others, account for 6.6% of the total population as of the end of July 2020, with a total of 494,289. Almost half of Kenya's refugees (44%) live in Dadaab, (40%) in Kakuma, and (16%) in urban areas (primarily Nairobi), with an additional 18,500 stateless people (UNHCR 2020).

Some studies with refugees showed high vulnerability to psychological distress (Alemi et al., 2013). Again, Lindert, Ehrenstein, Priebe, Mielck and Brahler (2009), hold that different studies have described psychological distress such as mood and anxiety disorders including depressive and posttraumatic symptomatology among the refugees. They also confirmed that three meta-analyses of data from research with refugees from various countries resettling in Western and non-Western nations found that refugee populations have disproportionately lower mental health status than economic migrants and the general populations in their host countries. Consequently, Barbara (2013) opines that poor mental health outcomes have been linked to a host of pre-migration traumas (imprisonment, physical and emotional torture, loss of family members due to displacement and death) and post-migration stressors (cultural adjustment difficulties and the loss of social support), which create psychological distress for the refugees.

Furthermore, Turrini, Purgato, Ballette, Nose, Ostuzzi and Barbui (2017) indicated that, about one out of three asylum seekers and refugees experience high rates of depression, anxiety, and post-traumatic stress disorders (PTSD). However, systematic reviews show that prevalence estimates of mental health disorders for this population vary widely from 20% to 80% (Bogic,

Njoku & Priebe 2015). A breakdown of this figure indicated specifically, 4 to 40% for anxiety, 5 to 44% for depression, and 9 to 36% for PTSD (Steel, Chey, Silove, Marnane, Bryant, & van Ommeren (2009); Lindert et al., (2009); Slewa-Younan, Uribe Guajardo, Heriseanu, & Hasan (2015). Moreover, most refugees and asylum seekers with PTSD and depression show a reduction over time, particularly if there are low resettlement stressors (Oppedal, & Idsoe, 2015; Betancourt, Borisova, Williams, Meyers-Ohki, Rubin-Smith, Annan & Kohrt 2013). Furthermore, Morina, et al (2018), Turrini, et al. (2017), and Lindert, et al (2018) opine that depression and anxiety are at least as common as PTSD among refugees and suggest that one or a combination of these conditions affects at least one in three refugees. Hence, most traumatic events jeopardize the physical and psychological equilibrium of the victim, giving rise to a wide range of physical and mental health complications. Dekel, Ein-dor and Solomon (2012) supported this in a substantial body of longitudinal research stating that there is an elevated rate of posttraumatic stress disorder (PTSD), depression, anxiety, somatization and alcoholism amongst other mental health complications.

Various studies have conceptualized a negative aspect of people who undergo psychological distress but this study will examine both the negative and the positive aspect. An alternative perspective proposes that trauma has a salutogenic effect (Dekel, Ein-Dor & Solomon, 2012). That is, individuals can develop a positive outlook and further experience positive psychological changes in the wake of psychological distress (Tedeschi, Shakespeare-finch, Taku, & Calhoun, 2018). In line with currently prevalent positive psychology theory (Seligman & Csikszentmihalyi, 2000; Tedeschi, Shakespeare-finch, Taku, & Calhoun, 2018) and earlier salutogenic models (Antonovsky, 1979), survivors may gain psychological benefits. The commonly held term, posttraumatic growth (PTG), (Tedeschi & Calhoun, 1996) signifies that the

individual has transformed in new ways that go beyond his or her pre-trauma or distressing level of psychological functioning. It is a positive and transformative mental change in emotions, cognitions, and behaviours that occurs as a result of coping with major life events that challenge the individual's presumptive world, core beliefs, and future prospects (Tedeschi & Calhoun, 2004; Tedeschi, Shakespeare-Finch, Taku, & Calhoun, 2018). This entails increase in personal strength, relational intimacy, sense of spirituality, appreciation of life, and life possibilities (Tedeschi & Calhoun, 1996). Not undermining the pathogenic impact of psychological distress, recently, a growing body of studies has consistently revealed PTG reported by survivors, following various physical and psychological traumas (Calhoun & Tedeschi, 2006; Linley & Joseph, 2004). Thus, while both salutogenic and pathogenic trauma outcomes have been documented, an imperative issue is how they relate in the individual survivor.

There have been a growing body of literature in recent decades supporting positive psychological transformation as a result of people experiencing distressing life events (Siqueland, Hafstad & Tedeschi, 2012; Kilmer, Cann & Tedeschi, 2012; Tedeschi, Shakespeare-Finch, Taku, & Calhoun, 2018). According to Calhoun and Tedeschi (2013), people who have distressing experiences are more likely to have fundamental changes in their worldview and to develop beyond their previous level of adaptation, psychological functioning, and life awareness. Heidarzadeh et al., (2018) conceptualized a positive dimension to PTG as inner peace, finding meaning in life, being a role model, performing health, promoting behaviour and other positive personal attributes. In Uy and Okubo's (2018) study, 'Gratitude' also emerged as positive personal attribute. Janoff-Bulman (2004), proposed that there are three distinct models in explaining PTG. These include: Strength through suffering, psychological preparedness and Existential re-evaluation. Furthermore, Janoff-Bulman stated that while a person may experience changes in all models, PTG

might be observed within each model. People become stronger when they struggle through terrible life circumstances. This is known as "strength through suffering." Psychological preparedness model suggests that individuals are better prepared to cope with traumatic experiences after successful treatment. This in some ways is a kind of protector for the individual. Lastly, existential re-evaluation tends to be less obvious and unexpected. Once a person has worked through a distressing event, he or she may indicate a greater appreciation for life or meaning finding related to the event. This model has several striking similarities with the five domains of Tedeschi and Calhoun (1996).

Hence, this study seeks to explore the gap on dimensionality of trauma by focusing on growth after distress, which will generate new knowledge that may complement the existing trauma counselling interventions. As a result, this study seeks to investigate the positive transformation that survivors have undergone, as opposed to the common approach of focusing only on the negative outcomes of their experience, with a focus on refugees in Nairobi County.

1.3 Statement of the Problem

The influx of refugees in the 21st century is on the rise due to overwhelming experiences brought by political, social, economic and environmental factors, which have left those affected psychologically distressed and traumatized. In Eastern Africa for instance, political violence, tribal conflict, terrorism and environmental factors such as natural disaster have continued to increase the number of traumatized and psychological distressed people, giving rise to a wide range of physical and mental health complications among victims. Researchers and psychologists on the other hand have attempted to address the psychological distress of refugees. However, their focus has been on the pathological dimension. This study conceptualized psychological distress as a two-dimensional phenomenon with pathological and transformative aspects (PTG). This

transformative side often has been neglected by some researchers. This study will explore the instances of psychological distress (depression, anxiety and PTSD), with emphasis on posttraumatic growth among refugees in Nairobi County, Kenya. The study assumes that this population is highly distressed. The focus of this study is to investigate post-traumatic growth in refugees who have experienced psychological distress (depression, anxiety and PTSD), as well as factors that promote PTG among refugees in Nairobi County. This will provide knowledge that will guide therapists in the design of transformation focused interventions to complement the existing treatment interventions that focus on the pathological aspects.

1.4 Objectives of the study

This study will be guided by main and specific objectives.

1.4.1 Main objective

The main objective of this study will be to assess the influence of psychological distress on posttraumatic growth among refugees in Nairobi County, Kenya.

1.4.2 Specific Objectives

- i. To determine the relationship between depression and PTG among refugees in Nairobi County, Kenya.
- ii. To establish the association between anxiety and PTG among refugees in Nairobi County, Kenya.
- iii. To examine the influence of PTSD on PTG among refugees in Nairobi County, Kenya.
- iv. To identify the existing interventions used in addressing psychological distress among refugees in Nairobi County, Kenya.

1.5 Research Questions

- i. What is the relationship between depression and PTG among refugees in Nairobi County, Kenya?
- ii. What is the association between anxiety and PTG among refugees in Nairobi County, Kenya?
- iii. What is the influence of PTSD on PTG among refugees in Nairobi County, Kenya?
- iv. What are the existing interventions used to address psychological distress among refugees in Nairobi County, Kenya?

1.6 Significance/ Justification of the Study

As the influx of Refugees continues to increase daily, the mental health needs among refugees remain a pressing challenge worldwide. Since the issue of refugees involves the society at large, this study therefore will be beneficial to the following categories:

This study will create awareness and help the refugees to make serious commitment to the programmes offered them by the government and NGOs in order to be able to cope in the camps and grow from their distressing situation into psychologically fit citizens and face life challenges with hope and optimism.

The findings of this research will be of immense benefit to the Kenya government and its policy maker in developing policy that enhance and adequately address the needs of refugees and asylum seekers in Kenya. The findings will as well be useful to government agency implementing refugee welfare programs.

The study will be of great assistance to counselling psychologist to incorporate posttraumatic growth as a solution-based intervention approach instead of concentrating on the problem focused critical incident debriefing alone. In other words, it will provide knowledge to

guide therapists in the design of transformation-focused interventions to supplement existing pathological-focused treatment interventions.

The study may also help non-governmental organisations (NGO), international development agencies (IDA), and others who may wish to use the findings from the research to improve their programs in their various organizations.

This study will be of immense benefit to the researcher, academicians, researchers and future researchers, who may want to conduct further research(s) on the subject matter.

1.7 Theoretical Framework

A theoretical framework denotes an appropriate theory which is used to explain the empirical observations made in the study (Mvumbi & Ngumbi, 2015). This study will adopt the Posttraumatic Growth Theory (PTG) and Cognitive Behavioural Theory of Trauma.

1.7.1 Post-Traumatic Growth Theory (PGT)

This theory conceptualizes that apart from the distress people undergo during trauma, they also develop some positive growth. According to Tedeschi and Calhoun (2004), the post traumatic growth theory has five tenets that explain how posttraumatic growth is attained. These tenets include: an enhanced sense of personal power and spiritual change, as well as a greater appreciation for life and more meaningful interpersonal relationships with others. A detailed explanation of the tenets of PTG theory, its strengths and weaknesses, and application to this study is presented in chapter two of this thesis.

1.7.2 Cognitive Behavioral Theory of Trauma (CBTT)

This existing model that people's prior thinking habits, also known as cognitive processing, have a significant impact on how they approach future life situations (Ehlers & Clark, 2000; Gonzalez-Prendes & Resko, 2012; Ringel & Brandell, 2012). This theory is attributed to George Kelly's developed hypothesis (Kelly, 1963) which holds that, an individual's conduct is reliant on mental constructs made from encounters.

A further discussion of the key concepts of Cognitive behavioural theory of trauma (CBTT), its strengths and weaknesses, and application to this study is presented in chapter two of this thesis.

1.8 Scope and Delimitations of the Study

This study will be restricted to just examining how psychological distress relates to Post traumatic Growth among refugees in Nairobi County. Thus, this study will be an empirical investigation of the relationship between psychological distress and PTG. Recent statistics indicated that in Nairobi County there are 80,760 registered urban refugees (UNHCR, June 2020). In the same vein, the study will include only adult male and female refugees between the ages of 18 to 59 years. This choice was influenced by the available statistics which showed that in Nairobi County, among registered urban refugees, this age group has the largest population of 22,797 females with 28% and 25,219 males with 31% and a total of 48,016 (59%) of both sexes. This will help the researcher establish whether there are age and gender differences in psychological distress and PTG among the refugees. Furthermore, this study will be restricted only to Nairobi County, which accommodates most of the urban refugees in Kenya (UNHCR, 2020). The urban refugees in Nairobi are from eight countries. These refugees are not resident in any displaced camp. Official and anecdotal information indicates that the Somali population is the largest followed by

Ethiopians, Congolese, Sudanese, Ugandan and Rwandese, while smaller refugee groups residing in Nairobi include those from Eritrea and Burundi. The various refugee nationalities live throughout the city; those from Somalia, Ethiopia and Eritrea mainly live in Eastleigh and those from other communities are dispersed throughout many of the lower income areas like Eastleigh, Mithonge, Waithaka, Makadara, Embakasi, Kangware, Kibera, Kangemi, Dagoretti and Ruaraka respectively. (Pavanello, Elhawary & Pantuliano, 2010).

1.9 Assumptions of the study

Based on the mantra that: “what does not kill a person makes him/her stronger” is echoes by many people. Therefore, the study assumed that, the refugees were a psychologically distressed population due to their experiences and after they had processed their experiences. It also assumes that the refugees live in Nairobi County and they were available at the time this research was carried out. Furthermore, the study assumes that the refugees had recalled their initial state and how they have changed over time. The questionnaires and interview guide questions had disposed the population to share their experiences. Finally, the researcher assumed that the sample size of 133 respondents provide adequate and sufficient data for the study. This assumption is in line with Mugenda and Mugenda (2012), which states that a sample of 10% -30% of the accessible population for a population of less than 10,000 is sufficient to generalize the results of the study and to represent the entire population.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter describes the theories on which the study is based. It highlights the underpinning tenets of the theories, the strengths and weaknesses of the theories and its utilization in peer reviewed literature and application to this study. It also presents the review of relevant literature according to the objectives of the study, critiques of the literature, research gap, conceptual framework and summary of the reviewed literature.

2.2 Theoretical Framework

A theoretical framework denotes an appropriate theory, which is used to explain the empirical observations made in the study (Mvumbi & Ngumbi, 2015). This study adopted the post-traumatic growth theory (PTG) and Cognitive behavioural theory of Trauma (CBTT).

2.2.1 Post-Traumatic Growth Theory (PTG)

This theory was propounded by psychologists Richard Tedeschi and Lawrence Calhoun in the mid-1990s. This theory conceptualizes the presence of growth in spite of the misery individuals go through during any distressing events. “Post-traumatic growth” was conceptualized by Tedeschi and Calhoun as an approach in understanding the positive mental changes people may experience following the aftermath of challenging life circumstances or conditions (Tedeschi & Calhoun, 2004). Indicators of PTG include: the capacity to utilize social supports, the ability to make importance out of life occasions or events, the accessibility and utilization of an assortment of adapting aptitudes (Benetato, 2011). A few different variables can add to PTG including, however not restricted to, character attributes, religious beliefs, strict convictions, and severity of the distressing event (Calhoun & Tedeschi, 2004, 2006; Taku, Tedeschi, & Cann, 2015). Within

the post-traumatic development field, specialists have agreed that PTG happens following an assorted scope of horrendous accidents and in a scope of various populaces. PTG has been accounted for among kids (Meyerson, Grant, Carter, & Kilmer, 2011), youths and grown-ups from various societies (Splevins, Cohen, Bowley, & Joseph, 2010). post-traumatic development has been recognized after assorted encounters that incorporate hazardous sicknesses (Hefferon, Grealy, & Mutrie, 2009), overcomers of bone marrow transfers (Tallman, Shaw, Schultz, & Altmaier, 2010), deprivation (Cadell & Sullivan, 2006), rape (Frazier, Conlon, & Glaser, 2001), quake survivors (Karanci & Acaturk, 2005), fear-based oppressor assaults (Peterson & Seligman, 2003) and war (Powell, Rosner, Butollo, Tedeschi, & Calhoun, 2003). An audit led by Linley and Joseph (2004) showed that 30–70% of overcomers of a scope of horrible mishaps including clinical issues, attacks and catastrophic events experienced positive change following an awful accident. The audit found that individuals who kept up PTG over the long haul were additionally less troubled or distressed. According to Tedeschi and Calhoun (2004), the post-traumatic growth theory has five tenets that explain how posttraumatic growth is attained. These tenets include a greater appreciation for life, deeper interpersonal relationships with others, new life possibilities, a greater sense of personal strength, and spiritual change. Vázquez, Pérez-Sales, and Ochoa (2014) affirmed these tenets, nevertheless stated them as becoming more aware of one's own strengths, appreciating new possibilities in life, experiencing greater social cohesion, establishing more positive philosophies of life, among others.

2.2.1.1 Appreciation of Life

A person experiencing PTG may report an increased appreciation for life, as trauma brings people face to face with their mortality. According to Tedeschi and Calhoun (2004), when people are faced with an overwhelming or life-threatening events, they start to value what they were not

valuing before the experience. For example, in the case of refugees, they start valuing life having experienced the death of their loved ones; it reminds them of the shortness of life. While routines are still important in daily life, persons who have a greater appreciation for life are more willing to live life on the spur of the moment (Calhoun et al., 2010).

2.2.1.2 Relationship with others

For Tedeschi and Calhoun (2004), a person experiencing PTG may report improved relationships with others. Most frequently, this refers to friends and close family members, as they can provide support to one another during a terrible occurrence. However, the feeling of being more connected to others can extend beyond close family and friends (Calhoun et al., 2010). For example, some refugees who were very individualistic before the experience, may join a support group in the refugee camp and are involved with other people rather than stay on their own.

2.2.1.3 New Possibilities in Life

A person experiencing PTG may report coming up with new possibilities in life. Tedeschi and Calhoun (2004) noted that, trauma comes with an organic shift in perspective. Some of the things people have never tried in life are now their priority. The grieving person is left to figure out new methods to fill those responsibilities, which offers up new connection possibilities (Calhoun et al., 2010). For example, a person who has never loved physical exercising may find joining yoga exercise and staying fit in the camp very fulfilling.

2.2.1.4 Personal Strength

Personal strength refers to the recognition and acknowledgment of living through the distressing experience. Tedeschi and Calhoun (2004) opined that, people who have gone through a distressing event report having more strength thereafter. They find some strength that was not

there before the experience. By persevering, a person can acknowledge the power and courage they have shown, which can lead to increased self-confidence in all situations (Tedeschi & Calhoun, 1996). Personal strength does not shield a person from the consequences of their loss. Sadness, shock, and other distressing symptoms can occur simultaneously with the development of confidence and strength (Calhoun et al., 2010).

2.2.1.5 Spiritual Change

Tedeschi and Calhoun (2004) affirmed that, a person experiencing PTG may report spiritual change or transformation; however, after a traumatic event, people often seek meaning for their existence. People who have been through a traumatic event or have lost a loved one may want to reconsider their lives and how they are living (Calhoun et al., 2010). For example, a refugee who was never serious with going to church or worshipping God may become a staunch Christian after such experience.

2.2.1.6 Strength of Post-traumatic Growth Theory

This theory explains the kind of transformation following a distressing event. This theory envisages within itself its limitation in the sense that it cannot capture the universal reality of the human person (Collier, 2016). In the same line of humble disposition, it upholds that the growth process is not automatic but a process. The individual after going through the psychological distress and having had his or her core belief systems challenged would gradually grow in resilience and then would experience a growth beyond telling. PTG is not stereotyped according to Tedeschi and Calhoun (2004), various personality types would respond to posttraumatic growth differently. There are those that possess openness to the process, then those with an attitude of extraversion. Some experience post-traumatic growth faster than others due to their personality type. This is seen here as strength of this theory. Tedeschi and Calhoun went beyond the fifth force

upheld by Abraham Maslow, which is transpersonal psychology, to a more integrative psychology which is called the sixth force. Tedeschi and Calhoun (2004) would submit the five components necessary for the post traumatic growth of individuals. Therefore, it is an all-encompassing theory that reaches out to the human person at various levels. It is a theory for transformation and wisdom. It has a great social impact on the family, the community and the society at large for those recovering from the loss of a significant other, war veterans or refugees. This theory proposes a sense of hope in managing distressed patients or individuals. This theory sees the individual as capable of experiencing growth in spite of distressing events in life. The theory helps in the measurable of PTG in distressed individuals. Moreover, PTGI as an instrument proposed by Tedeschi and Calhoun for measuring PTG justifies this theory as reliable, objective and valid since it is scientifically measurable.

2.2.1.7 Weakness of Post-Traumatic Growth Theory

This theory is not universal and it discriminates amongst personality types. In its promise for growth, it mentions that people that are extroverted would experience greater growth than those who are introverted. The introverted may experience slow growth due to their inability to relate with others. The question is what happens to those who are introverted? What is their hope? This theory was propounded within a context that does not take into cognisance other cultures and backgrounds. In its attempt to be all inclusive, it conveniently left out cultural and environmental elements amongst the five elements or tenets for post traumatic growth.

In the last decade, psychologists are encouraged to be eclectic, holistic, all encompassing, and use an integral instrument that attempts to address the issues of the human person for healing and help from psychological distress (Micozzi, 2015). The post-traumatic growth theory has a limitation to capture the total composite nature of the human person that is physiological,

intellectual, emotional, cultural, social, psychological and spiritual. There is no much emphasis on the cognitive aspect of the human person.

2.2.1.8 Justification for Use of the PTG Theory

The integral nature of the theory though not exhaustive would help in the attempt to examine the influence of psychological distress (anxiety, depression and PTSD) on the posttraumatic growth experienced by distressed refugees. It would aid the researcher to examine the place and role of support systems and resources that promotes PTG among distressed refugees.

This theory as posited by Tedeschi and Calhoun would aid the researcher in examining how the intervening variables such as age and gender, influence the experiences of psychological distress and post-traumatic growth among the urban refugees in Nairobi.

2.2.2 The Cognitive Behavioural Theory of Trauma

The cognitive behavioral theory of trauma (CBTT) has been utilized as a theoretical lens for research on traumatized individuals (Shirk, DePrince, Cristostomo, & Labus, 2014; Marquett et al., 2013; Webb, Hayes, Grasso, Laurenceau, & Deblinger, 2014). The cognitive behavioural theory of trauma is a theory that is designed to eradicate irrational thoughts patterns and replace them with more productive, positive and enhancing ones. It affirms that individuals past occasions and encounters influences the way they approach future life circumstances. The CBTT is attributed to George Kelly's developed hypothesis (Kelly, 1963) which holds that an individual's conduct is reliant on mental constructs made from encounters.

The individuals' constructions help him or her figure out the world he or she lives in. The CBTT assists the individual to foresee and control occasions however much as could reasonably be expected. Besides, the CBTT conjectures that individuals respond to awful mishaps as though those occasions actually hold dangers for them (Ehlers & Clark, 2000; Kelly, 1963). At the point

when individuals experience awful encounters (for example war and torment), their perspectives about the world become broken (Tedeschi & Calhoun, 2004). Cognitive handling gets indispensable in individuals' endeavour to figure out the horrible experience, modify their perspective, and develop after an awful encounter (Calhoun, Cann, Tedeschi, & McMillan, 2000). The CBTT explores the relationships between feelings, thoughts and behaviour. An essential part of cognitive handling is rumination, which incorporates both negative and positive intellectual preparing of the occasion (Calhoun & Tedeschi, 1998). The CBTT recommends that the psychological cycles that lead to a feeling of current danger are ordinarily joined by interruptions, avoidance and other re-experiencing manifestations like flashbacks, repetitive beating of heart, and hyper vigilance (American Psychiatric Association, 2013).

2.2.2.1 Strength of Cognitive Behavioural Theory of Trauma

The cognitive behavioural theory of trauma is from two schools of thought (Cognitive and Behavioural) that give its strength, credibility and relevance for this study. It focuses on the restructuring of the individual's thought pattern and it aids the individual to overcome the symptoms of issues experienced, and also equips the individual with new coping skills and strategies. The CBTT addresses the root cause of the problem in an individual: The thoughts of a person are the reason for both psychological distress and tranquillity accomplishments and problems, especially behaviour problems.

CBTT is tested and trusted, it is evidence-based. CBT has been established to be effective in treating depression, anxiety, and post-traumatic stress disorder (PTSD). It helps the client challenge his or her irrational thinking and thus reduce the anxiety levels.

2.2.2.2 Weakness of Cognitive Behavioural Theory of Trauma

The cognitive model or theories are very narrow in scope. How much of thinking is conscious and unconscious? Among the weakness of CBTT is the denial or exclusion of unconscious influence in human feelings. Mahoney (1980), affirms this by suggesting that cognitive behavioral approaches are restricted in that they view emotions ‘as something to be controlled rather than experienced’ and add that therapists overemphasize rationality and neglect the potential importance of unconscious processes. The refugees could be influenced by unconscious factors. A lot of unconscious beliefs, facts and ideas that one is not aware of can influence behavior. Our thoughts are just one part of being human – there are more issues that need to be addressed in the holistic nature of the human person.

The CBTT is classified as a directive therapy that is sometimes done in a more forceful way hence (McLeod, 2015) would opine that this method can be unethical. The CBTT is a complex methodology that has various models which can be used in therapeutic practice.

2.2.2.3 Justification for Use of Cognitive Behavioural Theory of Trauma (CBTT)

The cognitive behavioural theory of trauma is from two schools of thought (Cognitive and Behavioural) this gives its strength and credibility and relevance for this study. It helps the client in restructuring their irrational thought pattern. It looks specifically at the cognitive abilities of the distressed refugee with the aim to influence the post traumatic growth from the experience of anxiety, depression and PTSD. The use of this theory provides a cognitive dimension to the understanding of the experience of PTG among urban refugees in Nairobi with psychological distress

2.3 Review of Empirical Studies

Empirical studies as described by Rebecca (2017) are those studies which are published in scholarly or peer reviewed journals based on objective and actual observation or experimentation and descriptions on a specific topic.

Numerous scholars have conducted research on post-traumatic growth globally with focus on different objectives. The current study will concentrate on determining the relationship between depression and PTG; association between anxiety and PTG; influence of PTSD on PTG; and evaluate the interventions used in addressing psychological distress among refugees.

2.3. 1 Relationship between depression and PTG among Refugees

Most refugees have frequently been subjected to a variety of potentially traumatic events, which have a wide range of negative consequences for their mental health and quality of life. However, some also report positive personal changes, post-traumatic growth, related to these potentially distressing events. In this section, literature on depression and PTG will be reviewed.

Teodorescu et al. (2012) conducted a study in Norway that looked at post-traumatic growth, post-traumatic stress symptoms, depressive symptoms, post-migration stressors, and their association with quality of life in a refugee outpatient psychiatry population. Fifty five psychiatric outpatients with a refugee background participated in a cross-sectional study using structured clinical interviews for DSM (SCID-PTSD) and Mini-international Neuropsychiatric interview (MINI) to measure psychopathology and four self-report instruments measuring posttraumatic growth, posttraumatic stress symptoms, depressive symptoms, and quality of life (Post-traumatic growth inventory- short form (PTGI-SF), Impact of events scale-revised (IES-R), Hopkins symptom checklist -25-depression scale (HSCL), and World Health Organization quality of life scale (WHOQOL-Bref) as well as measures of social integration, social network and employment

status. According to the findings, all patients reported some level of post-traumatic growth, with only 31% reporting greater levels of growth. Once again, 80% of the patients exhibited post-traumatic stress symptoms that were over the cut-off threshold, and 93% had clinical levels of depressive symptoms. While at first glance, this study may appear to be in line with the objective of this study, which seeks to explore the relationship between depression and PTG among refugees. On closer examination, it is probably not. The reviewed study is different from this research based on the design, data source, and the location of study.

Furthermore, in Iran, Heidarzadeh, Dadkhah and Gholchin (2016), conducted a study on Post-traumatic growth (PTG), depression, and hope among elderly cancer patients living in Middle East countries. Here, a descriptive correlational study was used to examine PTG, depression, and hope among Iranian elderly patients with cancer. The study included a sample of 142 elderly Iranians of Azari ethnic origin (55 women, 87 men), with a mean age of 68.4 years diagnosed with cancer and admitted to oncology departments of hospitals and oncology clinics. A demographic questionnaire, Beck's Depression Inventory (BDI), Herth's Hope Index (HHI) and Posttraumatic growth inventory were tools used in collecting data. The data were analysed with the SPSS-22 software. The standard deviations and mean of the PTG, BDI, and HHI scores for all participants were 70.27 ± 12.43 , 12.1 ± 6.5 , and 34.63 ± 3.13 , respectively. The findings showed that PTG was negatively correlated with depression ($r = -0.60$, $p < 0.001$) and positively correlated with hope ($r = 0.50$, $p < 0.001$). All PTG dimensions were significantly correlated with the BDI and HHI total scores. Depression and hope correlated with some of the variance of PTG in the Iranian elderly patients with cancer. Offering counselling programmes and providing appropriate levels of nursing care may help patients feel less depressed and more hopeful. The majority of population-based research on PTG suggests that the young are more likely to experience post-traumatic growth

following a distressing event. Surprisingly the result of the research under review distances itself from this assumption. This research was conducted among the elderly and these clients from the result seem active, optimistic about the future and filled with positive emotions. Despite the differences based on the sample, design, data source, and the location of study, this study under review is related to this study, which seeks to explore the relationship between depression and PTG among urban refugees in Nairobi.

In Liberia, Acquaye (2016) conducted an empirical study on the relationship between post-traumatic growth, religious commitment, and optimism among adult Liberian ex- refugees and war-torn internally displaced persons who were traumatized by war. The study used cognitive theory of trauma which broadens and builds theory of positive emotions. Purposeful and snowball sampling methods were used in the study, and 500 participants were selected for the sample. Participants were 8th grade literate adult Liberian former refugees and IDPs living in Monrovia. A demographic survey, the Religious Commitment Inventory, the Posttraumatic Growth Inventory, the War Trauma Screening Index, the Revised Life Orientation Test, and the Posttraumatic Stress Disorder Checklist for DSM-5 were all completed by the participants. The findings revealed a statistically significant link between war-related events and post-traumatic stress disorder, with the strongest link being alterations in arousal and reactivity. However, several scholars have openly questioned the dimensionality of the scale of intervention used, it is unclear and it is seldom specified, whether the reported growth is directly related to a traumatic event. Also, the measured growth may lead to some extent an illusory. These problems make it highly problematic to compare results across studies (Christiansen, Iversen, Ambrosi & Elklit, 2015). Moreover, the reviewed study differs from this study based on the samples who were ex-refugees, sampling techniques,

instruments and the location of study. Nevertheless, this research under review adds voice to this study, which seeks to explore the relationship between depression and PTG among refugees.

Some scholars in Japan, Nishikawa, Fujisawa, Kojima and Tomoda (2018) conducted a research on the type and timing of negative life events (NLE) associated with adolescent depression. The primary objective of this study was to assess the direct and indirect effects of negative life events/stabilization on PTG and depression in non-clinical teenagers, as well as the timing and intensity impacts of NLE on current depressed symptoms. During their first and second years, data were collected from 1,038 high school students in seven high schools in Fukui, Japan (648 boys and 390 girls, mean age = 15.71, SD = 0.524). Participants completed a series of questions designed to assess the type and timing of NLE, depressive and traumatic symptoms, and PTG. Cluster analysis was used to divide respondents into three groups based on the results: "Group 1" (n = 631), whose depression scores were significantly lower than the other two groups ($p < 0.05$, for both); "Group 2" (n = 52), whose current and past stress levels appeared to be associated with NLE were higher than those of the other two groups ($p < 0.05$, for both); "Group 3" (n = 374), whose stress detected during NLE was higher than that of group 1 participants ($p < 0.05$), but not group 2. Their results showed that exposure to NLE at a younger age resulted in worse results and that the intensity of NLE timing were associated with PTG and current depressive symptoms. In addition, trajectory analysis showed that the associations between the stress experienced during NLE were direct and indirect predictors of current depression through PTG and that symptoms of post-traumatic stress and PTG mediate relationship between negative life event, resilience and depression. In conclusion, the results show that the magnitude of the events, the time of the NLE and the gender may play a role in the emotional turmoil during adolescence. The result of this study nevertheless provokes questions concerning the theory of

PTG. Tedeschi and Calhoun submit that younger clients are more disposed to experience PTG and that it is more personality based than gender based. Usually adolescents would be more open to experience, curious, open to novelty and ready to explore. These are qualities that characterize adolescents. Despite differences in the sample, design, theories, data source, and the location of study between this study and the research under review were areas of agreement. This work under review is related to this study which attempts to explore the relationship between depression and PTG among refugees.

In Kenya, Lang'at, (2018) conducted a study on post-traumatic Growth: Survivors of Kenyan skirmishes, post-election violence in 2007, and a national-level oil tanker fire explosion in 2009. Van Manen's (1990) construct of lived existential was used to conceptually frame the study. The study used in-depth interviews (both focus group and individual), demographic data, written journals, video/audio tape, surveillance strategies, and secondary data/different resources were used to collect data. Themes and concepts derived from the participants' scripts, based on activities, actions, and meanings were inductively analysed and interpreted. The results revealed that extensive research on PTG has been conducted in the Americas, Europe, and Asia, but not so much on the African continent, and how trauma survivors experience their survival experience may not be the same worldwide. This universal phenomenon can also be interpreted differently depending on the frequency, intensity, and scope of the traumata, as well as the survivors' socioeconomic status (SES) and other benefits and risk factors. Furthermore, anticipating high-risk factors may facilitate growth. The findings of this study filled a global research knowledge-gap on the experience of PTG among recurrent trauma survivors as influenced by their socioeconomic status. This research finding is methodologically sound and produces reliable data. The issue here is that they're relying on statistics that cannot address the difficulties raised by the

participants. They did however mention two crucial facts about this study. First, extensive research on PTG has been conducted on the American, European, and Asian continents, but little on the African continent; second, this universal phenomenon may be interpreted differently depending on the frequency, intensity, and scope of the traumata, as well as the survivors' socioeconomic status (SES) and other benefits and risk factors.

A number of scholars would raise doubts regarding their position about how survivors of trauma make meaning out of their lived experience may not be the same globally. Tedeschi and Calhoun would emphasize that it is a human experience that research is not done to generate data as evidence does not negate PTG as a global phenomenon. In addition, SES is a factor for PTG but in the research conducted by Tedeschi and Calhoun (2004) after interviewing so many people SES did not stand out among the top five factors for PTG. However, this study under review is relevant to this present study, which seeks to explore the relationship between depression and PTG among urban refugees in Nairobi; Although it differs from the current study in terms of the population, which includes persons who have lived through recurring and multiple trauma as a result of Kenyan skirmishes, post-election violence in 2007, and a national level oil tanker fire explosion in 2009. Similarly, the methodology used was qualitative method as against this present study which intends to use mixed method research design.

In a study conducted by Bamonti et.al (2016), a cross sectional study that examined whether spirituality moderates the association between depression symptoms severity and meaning in life among treatment-seeking adults. The study sampled 55 adults (60years of age) outpatient seeking mental health treatment for mood, anxiety, or adjustment disorder. The findings revealed that there is a significant negative association between depression symptom severity and meaning in life. The reviewed literature adopted a cross sectional method to explore the spirituality

attenuates the association between depression symptom severity and meaning in life. However, the current study explores psychological distress and posttraumatic growth among refugees in Nairobi County adopting an embedded mixed method approach.

2.3.2 Association between Anxiety and PTG among Refugees

The circumstances under which most refugees have to flee from their homes and homelands can be extremely distressing. According to the United Nations Educational, Scientific and Cultural Organization's report, most of the refugees crossed the Mediterranean in an overcrowded and unsafe boat, being barricaded in a Syrian basement for protection from shelling, being chased away from a burning village in Myanmar or being chased away by terrorists attack or other environmental factors; these events of their departures and their journeys can leave scars on those affected (UNESCO, 2019). Most refugees face problems of loss of their basic needs, loss of a job, education, alienation from the community, and limited access to health services which indirectly cause mental health problems for refugees and most times creates anxiety among refugees. In this section, literature on anxiety and PTG will be reviewed.

In Indonesia, Prasetya, Muhdi, and Atika (2020) conducted a multifaceted review of studies on the relationship between previous traumatic experiences, post-traumatic growth, and coping strategy to mental health state on refugees in Sidoarjo Camp. This study employed a cross sectional study design with a total of 97 refugees in Sidoarjo camp, which were chosen with simple random sampling. This study found that there was no significant relationship between coping strategy and post-traumatic experience with mental disorders and there was no significant relationship between previous traumatic experiences, with post-traumatic growth. But there is significant relationship between coping strategy and post-traumatic growth. The research under review is based upon cross-sectional survey data of refugees in Sidoarjo Camp at the time of the surveys. This allows

them to investigate generational differences among refugees, which is an important analytical concern.. However, this methodology systematically ignores the main claim of PTG theory. By design, it is blind to the submission by Tedeschi and Calhoun that there is significant relationship between previous traumatic experiences, with post-traumatic growth when they concluded that there was no significant relationship between previous traumatic experiences, with post-traumatic growth. However the reviewed study is relevant to this study even though it is different based on the design, data source, and the location of study.

Another study conducted in Poland by Tomaszek and Muchacka-Cymerman (2020), examined the mediating effect of existential anxiety activated by Covid-19 and life satisfaction (SWLS) on the relationship between PTSD symptoms and PTG. During the peak of the Covid-19 outbreak, an online poll was undertaken. The methods employed were the existential anxiety scale (SNE), life satisfaction scale (SWLS), IES-R scale for measuring PTSD symptoms, and post-traumatic growth inventory (PTGI). Existential anxiety and life satisfaction mediated the effect of PTSD on PTG, according to the findings. The findings also showed that a high level of PTSD was linked to a decreased PTG, but low and full PTSD stress symptoms improved PTG. As a result, the study concludes that the degree of traumatic experiences can influence the association between life satisfaction and post-traumatic growth. This study under review raised doubts regarding the objectivity of its findings especially in the case of PTG. In the case of PTSD yes; but that of PTG, it would be premature to say, since growth is a process that crystalizes over time. This research under review is related to this study which seeks to explore the association between anxiety and PTG among refugees. However, the reviewed study is different from this study based on the design, population, data source, and the location of study.

Additionally, in New York, Schneider et al., (2019), studied post-traumatic growth and mental health difficulties in the aftermath of Hurricane Sandy. The study included 1,356 participants recruited from the New York metropolitan area, who completed questionnaires regarding their experiences of the hurricane, demographics, MHD, and PTG. The findings indicated that all MHD were crudely associated with greater PTG. After adjustment, PTSD score was significantly associated with a 0.20unit increase in PTG ($t=6.05$, $p<0.01$). This does not apply to symptoms of depression or anxiety. Higher PTG was associated with being non-white ($B=5.90$, $t=6.49$, $p<.001$), Hispanic ($B=3.38$, $t=2.89$, $p=.004$), smoker ($B=3.18$, $t=3.28$, $p=.001$), and the largest hurricane exposed sandy ($t=7.11$, $p<.001$). The positive relationship between PTSD symptoms and PTG was weaker among participants who were likely depressed. Participants with more PTSD symptoms were more likely to grow from the storm's impact, suggesting resilience, according to the findings. Participants who had been exposed to a lot of things were more likely to get PTG. PTG levels were shown to be lower in people with PTSD and depression symptoms.

Tedeschi and Calhoun would distance themselves from the position that the participants with higher PTSD symptoms were more likely to grow from the impact of the storm, indicating resilience. It is clear that resilience would mean bouncing back, while PTG on the other hand means a growth beyond where one was before the impact of the distressing circumstance. However, this study under review is related to this study which seeks to explore the association between anxiety and PTG among refugees. Nevertheless, the reviewed study is different from this study based on the design, population, data source, and the location of study.

In the Middle East, Thabet and Sultan (2016) conducted a research on War Trauma, Anxiety, and Resilience among University Students in the Gaza Strip. The purpose of the study was to identify the types of traumatic experiences, to identify the types of resilience, anxiety

behaviour and outcomes, and to determine the relationship between exposure to traumatic experiences, resilience and behaviour traits central to university students. The method used was descriptive analytical study; In the second semester of the academic year 2012-2013, 399 randomly selected university students from four universities in Gaza (Al-Aqsa, Al-Quds Open, Al-Azhar, and Islamic University) were included in the sample. Data was collected using five questionnaires: a predesign socio-demographic paper, a checklist of Gaza traumatic events, an anxiety trait inventory, and the resilience scale of Connor-Davidson. The study found that the most frequently reported traumatic events were seeing bodies cut off on television (92.7%), witnessing a bomb blast and the destruction of another person's house (47.37%) witnessing tank and heavy firearms on the streets. Neighbor housing (47.12%)), and forced to move from home to a safer place during the war (42.86%). The overall mean of trauma cases was 4.72%. The mean state of anxiety was 46.62% and the mean behavior of anxiety was 36.22%. The most common concepts of bravery (most of the time / all the time) were: God can help (91.7%), things happen for a reason (90.3%) and I am proud of my success (85.2%).

Male students were generally more confident, more self-motivated, and more generally confident than female students. In the second semester of the academic year 2012-2013, 399 randomly selected university students from four universities in Gaza (Al-Aqsa, Al-Quds Open, Al-Azhar, and Islamic University) were included in the sample. Data was collected using five questionnaires: On the other hand, there was a strong connection between completely traumatic events and spiritual competence. There was a strong connection between the state of anxiety and the general stability and its support except in a spiritual sense. The researchers' conclusion was that the disclosure cited the traumatic events that preceded the Gaza war, which had a devastating effect on Palestinian university students, and exacerbated their mental health problems. The study

recommends that those responsible for student affairs should provide therapeutic interventions for university students who suffer from anxiety. The relevance of this study cannot be overemphasized. The result that male students had significantly more total resilience, more personal competence and more trust in one's instincts than female students may not be generalized but not divorced from the Palestinian culture. Exposure to previous traumatic events due to Gaza war had long-term negative effects on Palestinian university students and these distressing events break the process of PTG, since the anxiety trigger is intermittent. Therapy is truly the way to go for sustained PTG. This is related to this study which seeks to explore the association between anxiety and PTG among refugees. However the reviewed study is different from this study based on the design, population, data source, and the location of study.

In Knoxville, Tekie (2018) conducted a study that examined the Role of Meaning-Making in Post-traumatic Growth among Eritrean Refugees with post-traumatic Stress Disorder. The purpose of this study was to look at the moderating effects of meaning, meaning making, and social support on the association between negative life experiences and PTSD, anxiety, and depression, as well as the facilitating effects of these moderating variables on post-traumatic growth (PTG). The study enlisted the help of 135 Eritrean refugees living in Europe to conduct a quantitative survey. The findings revealed a link between post-migration living issues and bad consequences. Furthermore, social support attenuated the association between the amount of traumatic life experiences and anxiety symptoms, according to the findings. However, neither the number of traumatic life events nor social support were significant mediators of the association between PTSD and depression, nor the relationship between bad outcomes and PTG. The result of the reviewed literature does not appear to be in agreement with Tedeschi and Calhoun's assertion that social support is important for PTG. However, according to the study under consideration,

meaning created and social support were not significant moderators of the association between the number of traumatic life events and PTSD, depression, or poor outcomes, as well as the relationship between negative outcomes and PTG. However, the finding of this research is relevant to this study which seeks to explore the association between anxiety and PTG among refugees. Nevertheless, the reviewed study is different from this study based on the design, population, data source, and the location of study.

2.3.3 Influence of PTSD on PTG among Refugees

Studies on PTSD and PTG have indicated that those who experience traumatic events are capable of positive transformation resulting in growth. Post-traumatic growth (PTG) is a phrase used to describe beneficial reactions to stressful circumstances (Tedeschi & Calhoun, 1996). After a traumatic event, the phrase is described as beneficial social, psychological, or spiritual progress. Individual parts include personal growth, shifted priorities, enhanced relationships, and finding meaning in life, according to Tedeschi and Calhoun (2004). PTG has been documented as a side effect of cancer treatment (Soo & Sherman, 2015), natural disasters; (Holgersen, Boe & Holen, 2010), abuse, (Vloet et al., 2014) and military deployment, (Wooten, 2012). As discussed above, PTG is possible among different samples. Therefore, there is need to examine the influence of PTSD on PTG among refugees. In this section, literature on PTSD and PTG will be reviewed.

A recent study examining the prevalence of youth trauma using a representative sample in England and Wales (United Kingdom) showed that 31% of the general population experienced trauma by the age of 18 and almost 8% experienced post-traumatic stress disorder (Lewis et al., 2019). In Germany, about 40% of refugee adults and 20% of refugee children suffered from PTSD (BPTK, 2017). In the Netherlands, between 13% and 25% of refugees and asylum seekers suffer from post-traumatic stress disorder and/or depression (BPTK, 2017). Over 40% of children who

resettled in Europe after experiencing the war in former Yugoslavia had mood and anxiety disorders, while one-third suffered from post-traumatic stress disorder. Stressful experiences after resettlement also contributed to these effects (Bogic et al., 2015). These statistics shows the global relevance of this study which seeks to explore the influence of PTSD and PTG among refugees.

In the United Kingdom, Mark, Stevelink, Choi, and Fear (2018) conducted a review of studies on PTG among military and ex-military personnel from 2001 to 2017. The intent of the study was to establish evidence of PTG and possible factors promoting PTG among the sample. Secondary data from electronic data base such as PsycInfo, OVID medline and Embase were searched for studies published between 2001 and 2017. The study's suitability criteria and participant documents were kept if they involved military or former military personnel, some of whom had been deployed to Iraq or Afghanistan. A quality assessment was performed on all the study. Results indicated moderate growth among the sample. Higher levels of social support, spirituality, and rumination, as well as minority ethnicity, were all linked to increased post-traumatic growth. The finding of this study is supported by the PTG theory that positive outcome is possible from negative experiences such as PTSD among military and ex-military personnel. This is related to this study which seeks to explore the influence of PTSD and PTG among refugees. However, the reviewed study is different from this study based on the sample, design, data source, and the location of study.

In Australia, a meta-analysis study was piloted by Shakespeare-Finch and Lurie-Beck (2014), examining the strength and balance between the symptoms of post-traumatic stress disorder (PTSD) and post-traumatic stress disorder (PTG) as well as identifying roles that can control trauma and age. Literature research in all languages was conducted using Pro-Quest, Wiley Inter-science, Science-Direct, Informa-world and Web Database. Linear and quadratic

(curvilinear) r s as well as s were analysed. Forty-two studies ($N = 11,469$) examining PTG and PTSD symptoms were included in the meta-analysis calculations. The combined studies showed a significant association between PTG and PTSD symptoms ($r = 0.315$, $CI = 0.299, 0.331$), but also a stronger (as tested by Fisher mutation) curly ratio ($r = 0.372$, $CI = 0.353, 0.391$). The strength and balance of this relationship varied according to the type of trauma and age. The results remind those working with the distressed that positive and negative post-traumatic outcome can co-occur. Just focusing on the symptoms of PTSD can slow recovery and hide the possibility of growth. This is related to this study that seeks to investigate the impact of PSTD on PTG among refugees. However, the study differs from this study based on the sample, the research design, the data source and the location of the study.

In Norway, Siqueland et al., (2015) conducted a longitudinal research on Post-traumatic growth, depression and post-traumatic stress in relation to quality of life among tsunami survivors. This paper found how post-traumatic stress disorder (PTG), depression and post-traumatic stress disorder interact and freely predict Quality of Life (QoL) in a long-term study of disaster survivors. A total of 58 Norwegian adults who were present in Khao Lak, Thailand during the 2004 South-East Asian Tsunami completed private report questionnaire 2 and 6 years after the tragedy. Participants reported depressive and post-traumatic stress disorder symptoms as well as PTG and QoL. The independent effects of PTG, depression and post-traumatic stress on QoL measurement 2 and 6 years after the epidemic were determined by analysing the multiple effects of the combination used. The results revealed that post-traumatic stress and depression were negatively correlated with QoL. PTG was not significantly associated with QoL in the bivariate analysis. However, significant interaction effects were obtained. Six years after the tsunami, high levels of PTSD were associated with lower quality of life in those participants with lower levels of PTG,

while lower levels of depression were associated with higher quality of life in those participants with higher levels of PTG. PTG, Post-traumatic stress disorder and depression are negatively associated with quality of life after a natural disaster. PTG can be used as a reason to manage this relationship. This is related to this study which seeks to investigate the influence of PTSD on PTG among refugees. However the research review is different from this study in terms of sample, structure, theory, data source, and research area.

In Uganda, Bapolisi et al., (2020) conducted a study on post-traumatic stress disorder, mental illness and related causes among refugees in the Nakivale camp in southwestern Uganda. The purpose of the study was to determine the prevalence of post-traumatic stress disorder, its main psychological problems and psychological needs among refugees in the Nakivale refugee camp. A cross-sectional study of refugee camp residents ($n = 387$) from nine different countries of origin was conducted. Mental disorders were assessed using the MINI international Neuropsychiatric Interview (MINI) and the needs identified by the Humanitarian Emerging Settings Perceived Needs Scale (HESPER). The results show that the prevalence of dementia was as high among refugees as it was at the level of perceived demand. The most common mental disorders were generalized anxiety disorders (73%), post-traumatic stress disorder (PTSD) (67%), severe depression (58%) and substance use disorder (30%). There was a high level of comorbidity between PTSD and substance abuse ($OR = 5.13$), major depression ($OR = 4.04$) and generalized anxiety disorder ($OR = 3.27$). In multivariate analysis, PTSD was positively associated with stress perceptions such as high stress ($OR = 6.52$; $P\text{-value} = 0.003$), safety and protection for women in society ($OR = 2.35$; $P\text{-value} = 0.011$), family care $OR = 2.00$; $P\text{-value} = 0.035$) and Location ($OR = 1.83$; $P\text{-value} = 0.04$). After applying the Bonferroni revision, depression perceptions remained strongly associated with PTSD. The results show a strong association between PTSD, its main

comorbidities and basic needs in the Nakivale refugee camps. This is related to this study, which seeks to explore the influence of PTSD on PTG among refugees. However the reviewed study is different from this study based on the sample, design, data source, and the location of study.

In another study conducted by Ainamani, et al (2020) in south-western Uganda among Congolese refugees in Nakivale refugee settlement, to investigate gender differences in response to war- related trauma and posttraumatic stress disorder. The study sampled 325 Congolese refugees who lived in Nakivale camp. The findings showed that refugees were highly exposed to war-related traumatic events; the overall high prevalence of PTSD differed among women (94%) and men (84%). The reviewed literature is related to this study which seeks to determine the influence of PTSD on PTG among refugees. However, the methodology used is not clear as compared to this current study which adopted the embedded mixed method design.

In Kenya, Asatsa (2018) examined strategies for processing trauma and post-traumatic growth among survivors of a terrorist attack at Garissa University. The study was based on the organismic theory, and it adopted the explanatory sequential design of the mixed method. The target audience was 650 survivors of the Garissa University terrorist attack, who were transferred to the main campus of Moi University, where a sample of 257 participants was selected using simple random sampling, extreme case sampling and automatic integration techniques. The Posttraumatic Growth Inventory, the Cognitive Processing Trauma Scale, and the Primary Traumatic Processing Scale, as validated by the PTSD checklist, were used to collect quantitative data. Qualitative data were collected using two interview guidelines for victims and their parents. The findings established a positive relationship between post-traumatic growth and early trauma processing strategies, severity of traumatic events, traumatic recovery strategies and the number of counselling sessions attended after the terrorist attack. The study again elicited higher post-

traumatic growth in the victims of the Garissa University terrorist attack compared to other global studies. The results further showed that there was no significant population difference in post-traumatic growth. This is related to this study which seeks to investigate the influence of PTSD on PTG among refugees. However, this reviewed study examined terrorist attack survivors using a research method and theories different from this present study.

2.3.4 Interventions used in Addressing Psychological Distress among Refugees

Various international organisations have identified the development of programmes that mitigate the negative impact that forced displacement has on refugees' mental health as a priority intervention area. In this section, literature on the different interventions used in addressing psychological distress among refugees will be reviewed. Social and emotional learning programmes are one of the facets used in addressing psychological distress (UNESCO, 2019). They address the social, emotional and cognitive facets of the human development (Aspen Institute, 2017). An effective social and emotional learning programmes tend to use active forms of learning, such as project-based learning, role play or group discussions, and, in some cases, form part of a coordinated, school-wide, whole-child approach (CASEL, 2013). Other effective programme characteristics include appropriate sequencing, focus and explicitness of the activities (Durlak et al., 2011). It helps build resilience in the face of adversity and avoids treating children and youth who have had traumatic experiences primarily as victims. It targets skills related to self-awareness, self-management, social awareness, relationship building and responsible decision-making, all areas that can be particularly damaged by the uncertainty and dangers of migration or displacement. Developing these skills can provide children with the tools to successfully negotiate their environments: for instance, self-management training can help build skills needed to manage stress, control emotions, and set and achieve goals (INEE, 2016).

In Spain, Paloma, de la Morena, and López-Torres (2018) conducted a study on promoting post-traumatic growth among the refugee population in Spain and a community-based pilot intervention. The purpose of the study was to provide military support for community-based interventions aimed at promoting post-traumatic stress disorder (PTG) among adult refugees arriving in Seville, the capital of Andalucía (southern Spain). Forty-seven participants which includes males and females from several countries in conflict participated in the intervention over 15 weeks (March–June 2017). The implementation process comprised of two phases: (a) training a group of displaced refugees as peer counselors; and (b) hold peer support groups consisting of newly arrived refugees led by counselors. Following the collection of quantitative and qualitative data (using the 'Post-traumatic Growth Inventory' (PTGI) calculation and assessments written by participants, and the subject), and adopting a post-test evaluation framework, significant improvements were made in four factors. five PTGs: 'value for life', 'personal power', 'related to others' and 'new possibilities'. However, no significant difference was seen in 'spiritual transformation'. The study documented the implementation results that revealed interventions, accuracy and feasibility. This study highlights how PTG expression and refugee populations can be effectively improved through community-based interventions, particularly by creating community-based interventions that support peer counselling and mentoring approach. This is related to this study which seeks to explore the various interventions used in addressing psychological distress among refugees. However, the reviewed literature examined refugee population in Spain, using a community-based pilot intervention in the study which is different from the method and location of the population being studied in this present research.

In addition, Kane and Greene, (2018) in their desk review on Alcohol and Drug Abuse Intervention in Refugees in Low- and Medium Income Countries (LMIC) would indicate that alcohol abuse and other drug use it is a common but often overlooked problem that affects many refugee communities around the world. The purpose of their research is to compile evidence on measures to prevent and treat substance abuse in refugees in low- and middle-income countries (LMIC). To achieve this goal, they conducted a comprehensive review of professional and unpublished literature on drug use measures that target refugees and vulnerable people at LMIC. They identified six measures of substance use in the refugee population and twenty-nine relevant measures administered to other distressed individuals at LMIC. Three of these measures were implemented in the context of a refugee camp in Thailand. The remaining interventions included one treatment program for women with substance abuse problems in Kabul, Afghanistan or in a refugee camp in Pakistan, short interventions for male refugees who are chewing khat in Kenya, and community outreach interventions for refugees smuggling drugs. in Afghanistan.

In addition, they focused on five universal preventive measures, three selective measures, ten short preventive measures, psychological treatment of outpatients, six community outreach programs, two community outreach (i.e., harm reduction) and two programs. to build capacity across systems in sub-Saharan Africa, South and Southeast Asia, Eastern Europe and Central Asia, and Latin America. There was preliminary evidence of the effectiveness of selective preventive measures and cognitive behavioral therapy on reducing substance use in non-refugees. In conclusion, Kane and Greene, (2018) found that there is a lack of special attention in the technical literature and that has not been published on ways to prevent the use of refugee drugs. Many prevention and treatment strategies focus on treating low threshold or mild cases of alcohol abuse problems. Social programs, peer-led programs and training of health care workers in drug

treatment are possible in poor resource and refugee environments and can reduce the stigma associated with use and help seek. This is related to this study which seeks to explore the various measures used to address psychological distress among refugees. However the study review is different from this study depending on the sample, structure, data source, and area of the study.

Recent research in Kenya, by Asatsa, Mutisya, and Owuor (2018), has tended to show the predictable relationship between counselling and post-traumatic growth among survivors of terrorist attacks from Garissa University. The study was rooted in the organismic valuation theory after adversity, and it adopted the explanatory sequential research design by mixed method. The study used a two-phase approach, beginning with quantitative data collecting and analysis and then moving on to qualitative data gathering and analysis. Simple random sampling and extreme case sampling approaches were used to pick a total of 210 participants. A validated questionnaire, the 21-post Posttraumatic Growth Inventory, was used to obtain quantitative data (PTGI). Interview guidelines were used to acquire qualitative data. Multiple regression analysis was used to examine quantitative data using univariate analysis. Themes and narratives from the participants were used to assess qualitative data. The study found a positive significant correlation between the number of counselling sessions present and post-traumatic growth among the survivors of Garissa University terrorist attacks. The study also discovered that those who attended between 5 and 10 therapy sessions following the attack saw the most post-traumatic growth, while those who took part in critical incident debriefing experienced the least. Participants who did not get any type of counseling saw more post-traumatic growth than those who simply received critical incident debriefing. The findings piqued people's interest in the efficacy of critical incident debriefing as a trauma intervention technique. This is related to this study which seeks to explore the various interventions used in addressing psychological distress among refugees. However, the reviewed

study is different based on the method used, the study also examined a population that is different from the present study.

In another current study conducted by Osborn et al., (2020), entitled "The Shamiri Group's intervention for adolescent anxiety and depression: study protocol for a randomized controlled trial of a play-delivered, school-based intervention in Kenya". The purpose of the study was to evaluate intervention for teenage depression and anxiety in Kenya. The intervention is called Shamiri (a Swahili word for "thrive"), It uses evidence-based components of brief therapies based on non-clinical concepts rather than psychopathology treatment (e.g., mindset for growth, gratitude, and virtues). The study encouraged four hundred and twenty Kenyan teenagers (aged 13-18) with clinically elevated depression and / or anxiety symptoms will be randomized to either a 4-week Shamiri group intervention or a group study of skill control intervention of the same duration and dose.

Participating young people meet in groups of 8-15 led by a high school graduate who is trained to provide Shamiri as a medical provider. Adolescents will self-report primary outcome measures (depression measured by PHQ-8 and anxiety symptoms measured by GAD-7) and secondary outcome measures (perceived social support, perceived academic control, self-reported optimism and happiness, loneliness and academic grades) at 2-week intervention center, 4 -week end point after intervention and 2-week follow-up after intervention. The results revealed that a short school-based intervention from a medical manufacturer can reduce depression and anxiety symptoms in adolescents with clinically elevated symptoms, thereby improving the academic and other psychosocial outcomes of adolescents in sub-Saharan Africa. This reviewed literature is related to this study which seeks to explore the various interventions used in addressing psychological distress among urban refugees. However, the reviewed study is different from this

study based on the sample which was mainly adolescent with clinically elevated anxiety and depression symptoms in Kenya, while this current study is researching on the interventions used in addressing psychological distress among refugees in Nairobi County.

In a study conducted by Jemutai et al (2021), to assess the Situation Analysis of access to refugee health services in Kenya: Gaps and recommendations, the findings revealed that the existing mental health intervention includes counselling and psychotherapies. Furthermore, Mutiso et al 2018; Silove, Ventevogel, & Rees 2017; The Center for Victims of Torture 2013; & Sannoh (2015), reported that the current Mental health and psychosocial support intervention (MHPSS) in Kenyan refugee camps include psychosocial support, psychotherapy and clinical services, community sensitization on MHPSS issues, local advocacy strategies and local mental health capacity building. These reviewed literatures are different from the study based on the sample which was mainly those in the camp unlike the current study that investigates those refugees in Nairobi County who neither leave in camps.

2.4 Research Gaps

The reviewed literature has been done globally, regionally, and locally showing the influence of psychological distress on Post-traumatic growth among refugees. However, none of the reviewed literature focused on urban refugees in Nairobi County. Thus, this study will examine psychological distress and PTG among urban refugees in Nairobi County, Kenya.

This chapter has shown the different empirical studies and has discussed the methods and designs used in the reviewed literatures. Cross-sectional study, descriptive correlational study; purposeful and snowball sampling methods, qualitative method, multifaceted review and cross sectional study design; an online survey, a descriptive analytical study, a quantitative survey design, a meta-analysis research; a longitudinal research; a cross-sectional survey and the mini

International Neuropsychiatric interview (MINI), a desk review and an explanatory sequential mixed method design. From the reviewed literatures, the researcher has found the knowledge gaps, both in methods, instruments, theories and location. Previous studies have utilized any of the various methods above but none has utilized the embedded mixed method research design adopted for this study. The researcher discovered that much has been done globally and few researchers conducted their studies in African countries on the influence of psychological distress on Post-traumatic growth among refugees, but very few studies have been conducted either in East Africa or Kenya (Nairobi County). This is why the current study focuses on Nairobi County.

2.5 Conceptual Framework

A concept is a word or phrase that symbolizes several interrelated ideas (Kombo & Tromp, 2006), and it is self-explicit needing no further explanation. It presents schematically the assumed interactions between the variables of study. According to Creswell (2013), a conceptual framework is a theoretical structure that illustrates, either graphically or narratively, the main items to be examined, the key causes, concepts or variables, and the supposed relationship between them.

This study has psychological distress as the independent variables; counselling, demographic (gender, religion, age) and government policies as the intervening variables, and post-traumatic growth as the dependent variables. Figure 1 depicts the conceptual framework of this study, and the path analysis of the conceptual framework is as follows:

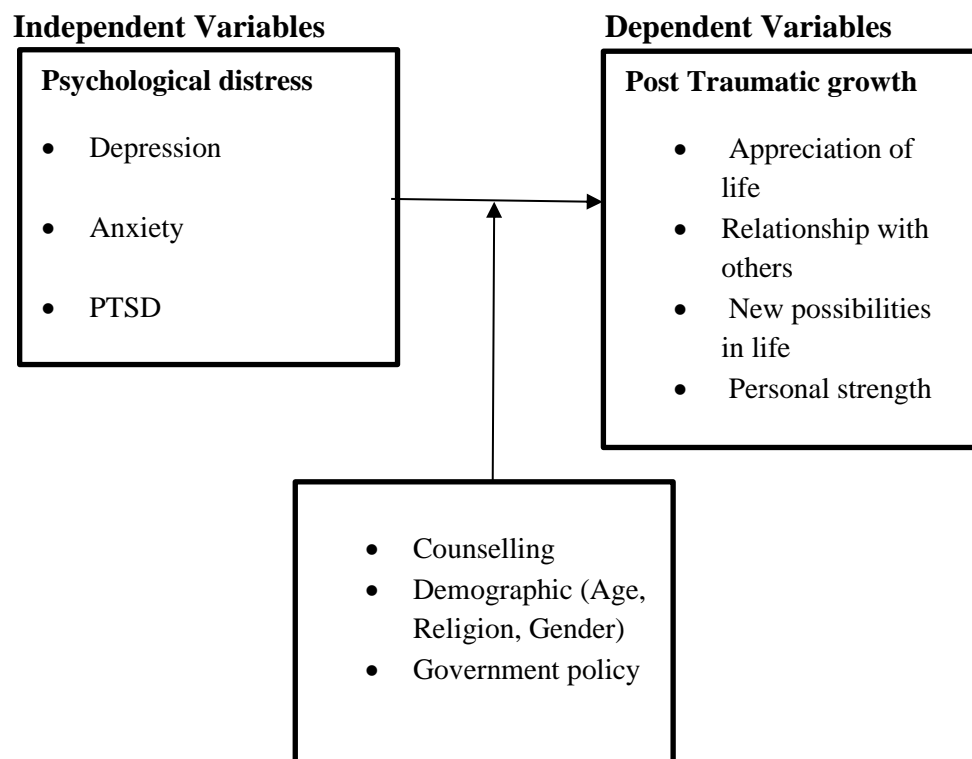


Figure 1: Conceptual Framework

2.5.1 Independent Variables

The independent variable in a non-experimental study is the variable which is being assumed to be the antecedent of the dependent variable (Kothari, 2006). The independent variable of this study is Psychological distress. This study argues that the combination of Depression, Anxiety and PTSD are factors that influence or cause distress to the individual.

2.5.2 Intervening Variables

The intervening variables affect the relationship between the independent and dependent variable by enhancing the effect of the independent variables (Kothari, 2006). The intervening variables of this study include counselling, demographic characteristics (gender, age, religion) and government policies for refugees. This study argues that, gender, age, religion and existing government policies for refugees, could further influence the post traumatic growth of refugees in Nairobi County.

2.5.3 Dependent Variable

The dependent variable in a study is the variable whose variation depends on the variation in the independent variable (Kothari, 2006). Therefore, the dependent variable of this study is post traumatic growth (PTG). According to this study, there is a greater respect for life, more meaningful interpersonal relationships with others, new life possibilities, a greater sense of personal strength, and spiritual change.

2.6 Chapter Summary

Although we might assume that post-traumatic growth and psychological distress are opposite ends of a continuum, this is not the case (Tedeschi et al. 2018). They are orthogonal constructs, and psychological distress is a prerequisite for post-traumatic growth, given that experiencing trauma is extremely distressing and growth comes through struggle.

From the reviewed literature, the researcher discovered that psychological distress and PTG is possible among different populations, Refugees/ former refugees, Military and ex-military personnel, trauma survivors, hurricane victims, terrorist attack survivors amongst others. The PTG theory conceptualizes that apart from the misery individuals go through during any distressing events; they likewise build up some sure growth. While the cognitive behavioural theory of trauma (CBTT) proposes that people's prior thinking patterns, also known as cognitive processing, play a significant impact in how they approach future life situations. The rationale for the use of these two theories in this study is the absence of total explanatory capability in each of the theories. The cognitive mind-set must be developed before one can attain PTG. More so, PTG without a structured cognitive thought pattern would mean unstructured PTG.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter describes the research design and methodology that will be used in the study to ensure that the study's objectives are met and the research questions are answered. Thus, this chapter consists of the research design of the study, the locale of the study, study population, the sample size and sampling procedures, the research instruments, the reliability and validity of the instruments, data collection procedure, data analysis procedures and ethical considerations.

3.2 Research Design

According to Creswell (2014), the design of a research is the arrangement and construction of how the researcher will explore data in order to find answers to the research questions, the setting of the conditions for data collections and analysis in a manner that aims to syndicate relevance to the research objective.

This study adopted the embedded mixed methods research design by combining correlational and phenomenological research design. Creswell (2017) argued that mixed method research offers more detailed evidence to study research issues than either qualitative or quantitative research alone. The two models allow the researcher to obtain both statistical and in-depth data from the different respondent categories. Each methodology has its limitations that help to compensate and complement each other and achieve more satisfactory outcomes than using one form of research design. In this study, the researcher embeds qualitative design into quantitative design which is the primary design. The goal of this mixed method approach is to promote understanding of both the overall research problem and the relationship between variables. Hence, the two designs complemented one another in this study. Through this design, quantitative data,

and qualitative data were collected separately, analysed separately and the results mixed during interpretation to answer the research questions.

3.3 Study Area

This study was restricted only to Nairobi County, which is the capital and the largest city of Kenya. It accommodates most of the urban refugees in Kenya (UNHCR, 2020). The choice was influenced by the available statistics which indicated that Nairobi County had 80,760 registered urban refugees (UNHCR, June 2020). The urban refugees in Nairobi County mainly dispersed throughout many of the lower income areas like Eastleigh, Satellite, Kawangware, Kayole, Ruiru, Githurai, Kangemi, Mithonge, Waithaka, Makadara, Embakasi, Kangware, Kibera, Dagoretti and Ruaraka respectively. (Pavanello, Elhawary & Pantuliano, 2010).

3.4 Study Population

The study comprised of only adult male and female refugees between the ages of 18 to 59 years to help establish if there are age and gender differences in psychological distress and PTG among the refugees. This choice was influenced by the available statistics which indicated that in Nairobi County among the registered urban refugees, this age bracket of the research population has the largest number of about 22,797 female with 28% and 25,219 male with 31% and with a total of 48,016 (59%) of both gender (UNHCR, June 2020).

According to the UNHCR, June 2020 demographic records of refugees and asylum seekers in Nairobi County, the total population group stands at 80,760. Out of which 6,205 were between the ages of 0 – 4 years (3,002 females and 3,203 males); 12,466 were between the ages of 5 - 11 years (5,977 females and 6,489 males); 11,878 were between the ages of 12 – 17 years (5,930 females and 5,948 males); 48,016 were between the ages of 18 – 59 years, (25,219 males and

22,797 females); while 2,195 were between the ages of 60 years and above (1,244 females and 951 males). In this study, the focus was on urban refugees in Jesuit refugee service facilities (JRS) with the age bracket of 18-59 years (male and female). These categories of the population were of interest to the researcher because this age bracket was the highest among the population and also the researcher reduced the study to a manageable and also accessible population. This helped the study to focus on urban refugees within the time frame of this study. Moreover, it was not every centre that was accessible.

3.5 Sampling Procedure and Sample Size

Sampling is a process of selecting or recruiting a number of individuals, items, or cases from the general population of interest, in such a way that those selected represent the characteristics of the larger population (Bordens & Abbott, 2018). Mugenda and Mugenda (2012), also maintained that sampling involves the researcher securing a representative group that will enable him/her obtain information about the entire population. It also allows sample is a key feature of any research undertaking.

A sample of 10% -30% of the accessible population for a population of less than 10,000 was sufficient to generalize the results of the study and to represent the entire population. The study therefore acquired a representative sample from the target population as the sample size for this study (Mugenda & Mugenda 2012).

The total population of refugees in the Jesuits refugee service in Kenya were about twelve thousand three hundred and forty-nine (12,349) living in three areas (Kakuma, Kalobeyi and Nairobi) and in Nairobi, there were 200 refugees within the county (18-59) age bracket. The researcher used Yamane (1973) sample size formula. The calculation formula is presented as follows.

$$n = \frac{N}{1 + (e)^2 N}$$

$$1 + (e)^2 N$$

Where:

n = sample size required

N = number of people in the population

e = allowable error (%) or the level of precision.

$$n = \frac{200}{1 + 0.05^2 (200)}$$

$$1 + 0.05^2 (200)$$

$$n = 133$$

This gives a sample size of 133 respondents.

3.5.1 Sampling Techniques

The study used a simple random sampling technique to select 120 participants for the quantitative strand and purposive/convenience sampling technique to select 13 respondents (5 officials and 8 refugees) for the qualitative strand. According to Mugenda (2012), simple random sampling is performed when each member of the target population is assigned a successive number and then is selected randomly according to an assigned number by having a complete list of the target population.

In this study for the quantitative strand, from the population, people between the ages of 18-59 years had an equal chance of inclusion in the sample (Kothari, 2014); while for the qualitative sample, the researcher used purposive sampling to select refugee's participants and convenient sampling technique to select staff of the refugees.

Convenience sampling is a non-random sampling whereby the research subject or participants of the target population that meets certain practical criteria, such as geographical proximity, easy accessibility, willingness to participate and available at a given time are included for the purpose of the study (Dörnyei, 2007); while the purposive sampling is also a non-random sampling technique used in qualitative strand whereby a deliberate choice of a research subject is selected by the researcher due to the qualities the participant possesses, such as who can and are willing to provide the information by virtue of knowledge or experience (Bernard, 2002).

3.6 Data Collection Instruments

In this study, data was collected using standardized questionnaires and an interview guide. The standardized questionnaires which were used for the quantitative strand include: Posttraumatic Growth Inventory (PTGI), Posttraumatic Stress Disorder check list (PTSD Checklist- PCL-5), and Depression, Anxiety and Stress Scale (DASS-21); while for the qualitative strand, data was collected using an interview guide.

3.6.1 Posttraumatic Growth Inventory (PTGI)

The posttraumatic growth inventory (PTGI), is a 21 Likert scale tool developed by Tedeschi and Calhoun (1996). PTGI is used to evaluate or measure the level of post-traumatic growth among respondent. PTGI measures growth across five domains. The first is relating to others, which addresses the interpersonal relationships of the respondents following a traumatic event experienced. The second is new possibilities which address the ability of respondents to see post-traumatic possibilities that they would not normally have seen. The third is personal strength, which addresses the strength acquired despite the traumatic event experienced by the respondents. The fourth is the spiritual change, which addresses either an increase or a decrease in spirituality

of the respondents due to the traumatic event experienced and the final factor is the appreciation for life, which addresses the gratitude for life by the respondents.

The PTGI is a self-report scale with a six-point scale ranging from 0 (I did not experience this change as a consequence of my crisis) to 5 (I experienced this change as a result of my crisis) (I experienced this change to a very great degree as a result of my crisis). According to Tedeschi and Calhoun (1996), an exploratory factor analysis with a sample of American university students (Tedeschi & Calhoun, 1996) identified five areas of potential growth following stressful events (i.e. relating to others, personal strength, new possibilities, spiritual change, and appreciation of life) and validated by confirmatory factor analysis with another university sample (Taku, Cann, Calhoun & Tedeschi, 2008). The Inventory has five scales, and the initial validation found it to be reliable. The scales include: new possibilities (reliability of 0.84), relating to others (reliability of 0.85), personal strength (reliability of 0.72), spiritual change (reliability of 0.85), and appreciation of life (reliability of 0.67). Tedeschi and Calhoun (1996) reported an overall inventory reliability of 0.90. Some of the items in the inventory sampled included: 'I have a greater sense of self-reliance,' 'I shifted my priorities in terms of what is important in life,' 'I feel more connected to others,' and 'I developed new interests.'

3.6.2 Post-traumatic Stress Disorder check list (PCL-5)

The PCL-5 is a 20-item Likert scale questionnaire developed in 2013 by the US National Center for Post-Traumatic Stress Disorder (Weathers, Litz, Keane, Palmieri, Witte & Domino, 2015). The items in the Diagnostic Statistical Manual of Mental Disorders (Fifth Edition) are designed to respond to PTSD symptoms (American Psychiatric Association, 2013).

In the past, many instruments were used to assess the level of PTSD of respondents (for example, PTSD Scale (Davidson, Smith & Kudler, 1989) and PTSD symptom scale-self report (Foa Riggs, Dancu & Rothbaum, 1993). However, due to the latest re-classification of the diagnostic and statistical manual of mental disorders (DSM 5; APA 2013), the post-traumatic stress disorder checklist for DSM-5(PCL-5; Weathers et al., 2015) was selected for this study on the basis of its alignment with current literature on trauma and PTSD, particularly in the treatment of non-western populations.

PCL-5 is a 20-item Likert-type measure used in evaluating the degree to which an individual has been disturbed by post-traumatic stress symptoms linked to his or her most distressing event in the past month (Weathers et al., 2015). The initial internal consistency is 0.94 and test retest reliability is 0.82 (Blevins et al., 2015). As a result, the PCL-5 is a psychometrically sound tool for assessing or screening PTSD severity. It contains four characteristics that match the DSM-5 PTSD symptoms criteria. Intrusion is the first factor, as evidenced by persistent, involuntary, and intrusive distressing memories of the traumatic experience. The second aspect is avoidance, which is manifested by efforts to avoid painful memories, thoughts, or sensations related to the event. Negative changes in cognition and mood are the third factor, which are characterized by dissociative amnesia (the inability to remember important aspects of the event), feelings of detachment, persistent and distorted patterns of thinking about the event's causes and/or consequences, and persistent and exaggerated negative beliefs about oneself or others. The fourth factor is alterations in arousal and reactivity, which is characterized by hyper vigilance, concentration problems, imprudent or self-destructive behaviour, and sleep disturbances. Subscales severity scores were calculated by summing up items in each of the four DSM-5 PTSD symptom clusters: intrusions (items 1-5), avoidance (items 6-7), negative changes in cognition and

mood (items 8-14), and changes in arousal and reactivity (items 15-20), items are rated from 1(not at all) to 4(extremely) and are summed to the total severity score.

Items on the scale have been revised to make them relevant to the experience of war. Examples of the scale included: avoid any memories, feelings or thoughts, related to the wartime experience. avoid memories, suddenly feeling or acting as if the experience of war was actually going to happen again (as if you were actually back there to relive it) PCL-5 scores ranges from 0 to 8 (M= 42.41, SD= 15.06) with psychometric properties that indicate strong Cronbach alpha ($\alpha = .91$; test-retest reliability, 5-007=.95; Wortmann et al.,2016). Inter-item correlation for the PCL-5 fell in the recommended range of .15 to .50, with a .10 to .74 range (Clark & Watson, 1995).

3.6.3 Depression, Anxiety and stress Scale (DASS-21)

The depression, anxiety and stress scale (DASS-21) is a short version with 21 Likert scale item developed by Lovibond and Lovibond (1995). Both proponents of this scale intended to create a tool that could both measure and discriminate symptoms linked with depression and anxiety. During instrument development, the authors incorporated clinical and diagnostic signs of depression and anxiety while excluding symptoms that could be present in both disorder, such as changes in appetite. However, in their initial validations, factorial analyses revealed a third factor (stress), which, according to the authors, combines symptoms associated with difficulty relaxing, nervous tension, irritability, and agitation (Lovibond & Lovibond, 1995). The literature on the instrument's factorial structure is extensive and diverse, demonstrating that factorial structures can change over time and also depending on the population and the sociocultural context the instrument is being administered. For example, in Latin American countries, DASS-21 has shown to fit well with a three-factor structure (Antunez, Vinet, Escalas & Ansiedad, 2012; Gurrola-Pena, Balcázar-Nava, Bonilla-Muños, & Virseda-Heras, 2006; Ruiz, García Martín, Suárez Falcón, &

Odriozola González, 2017). This is in line with data from 2,630 Asian participants from Malaysia, Indonesia, Singapore, Taiwan, and Thailand, who identified a three-factor structure (DASS-18) after deleting three items. Oei, Sawang, Goh, & Mukhtar (2013). According to the authors of these studies, the original DASS-21 may not be appropriate in Asian groups, hence the tool should be presented differently. A three-factor model was also best suited to a sample of non-clinical Greeks in eastern regions such as China, Iran, and Greece, according to Chan et al (2012); Jafari, Nozari, Ahrari, and Bagheri (2020); Kyriazos, Stalikas, Prasa, and Yotside (2018). Furthermore, a four-factor structure was discovered in a study of American adolescents, including a new factor called negative emotion (Szabó) (2010). This is consistent with findings in the Portuguese community (Vasconcelos-Raposo, Fernandes, Teixeira 2013) and a sample of Vietnamese adolescents (Le et al., 2017), where an additional factor for psychological distress was discovered (negative emotion). In addition, a sample of patients with brain trauma discovered a four-factor structure, with distress serving as a fourth factor in most cases (Randall, Thomas, Whiting, and McGrath, 2017). According to the authors of these studies, stress is an underlying factor in depression, anxiety, and stress. Other studies with clinical and non-clinical samples have been conducted in the United States (Osman et al., 2012), Brazil (Silva et al., 2016), and Italy (Bottesi et al., 2015) found two factor models in the DASS-21. Indeed, a recent systematic review, supports the possibility of an overall factor underlying depression and anxiety (Yeung, Yuliawati, & Cheung, 2019). In addition, the authors believe that a two-factor model could be useful. As previously documented, DASS's factorial structure has evolved into a variety of structures depending on the context. Examples of this are DASS-14 Wise, Harris, and Oliver (2017), and DASS-9 Kyriazos, Stalikas, Prassa, & Yotsidi, (2018).

The DASS-21 instrument consists of three scales: The depression scale is used to assess hopelessness, low self-esteem, and low positive affect; the anxiety scale is used to assess autonomous arousal, musculoskeletal symptoms, situational anxiety, and the subjective experience of anxious arousal; and the stress scale is used to assess tension, agitation, and negative affect. The instrument contains seven selected items from each of the scales.

3.6.4 Interview Guide

An Interview guide was used to collect qualitative data on the interventions used in addressing psychological distress among refugees in Nairobi County. In the interview guide for the staff, there was one broad question with five sub-questions exploring the intervention – see Appendix III, while for the refugees, there was one broad question with five sub-questions exploring the intervention - see Appendix IV. The goal of the interview was to elicit subjective experiences and report the interventions used to address psychological distress, which may differ from those captured in the questionnaire. This brought about more dimensions of the interventions used by allowing the respondents to report their experiences subjectively.

3.7 Pre-Testing of the Research Instruments

A pre-test was carried out to judge the suitability of the research instruments. This was conducted in a camp that was not part of the actual study outside Nairobi County. The research instruments were pre-tested on a small representative sample identical to but not including, the group that was part of the actual study. This helped the researcher to detect any flaws in the instrument and to refine the errors prior to the actual study. These inaccuracies include mechanical problems, correct misunderstandings, check the level of the language/ unclear wordings, and

eliminate ambiguity at the right time. For the pretesting of the research instruments, 20 respondents were selected which is an equivalent of 10% of the main study population.

3.8 Data Quality Control

The data quality control refers to the reliability and validity of instruments for quantitative data tools and trustworthiness and credibility for qualitative data tools which will be discussed below.

3.8.1 Reliability and Validity of Instruments

In research, the issue of reliability and validity applies to quantitative study. The reliability of the instrument is consistency, accuracy or trustworthiness of a test (Kothari, 2007). Validity alludes to the degree of certainty that the instrument estimates what it was intended to gauge or measure (Selvam, 2017). Validity is generally used as a quantitative exploration instrument. Notwithstanding, since the current investigation is a blended techniques plan (a mixed method design), the study talked briefly about both the validity and reliability of the instruments (Creswell, 2013). With the expertise of the supervisor, the researcher constructed the interview questions in a way that it measured what they set out to measure among the respondents of this study.

3.8.1.1 Reliability of PTGI

In the original sample of university students, the psychometric properties for the PTGI indicate a high or strong internal consistency with a total scale of 0.90 Cronbach's alpha. Each of the five criteria had significant internal consistency: new opportunities ($\alpha = .84$), relating to others ($\alpha = .85$), personal strength ($\alpha = .72$), spiritual change ($\alpha = .85$), life appreciation ($\alpha = .67$), and test-retest reliability was .71 over a two-month period (Tedeschi & Calhoun, 1996). However, in a different sample, Chinese cancer survivors, using a translated PTG, a Cronbach's alpha of .76, .79,

.63, .37, .63 for the subscales of interpersonal relationships, new opportunities, personal strength, spiritual growth, and life appreciation were recorded (Ho, Chan, and Ho, 2004). The initial factor structure of the PTGI did not apply to cancer patients, according to the authors. As a result, they suggested dichotomous variables for PTGI and discovered $\alpha = .70$ (Interpersonal) and $\alpha = .80$ (Intrapersonal). PTG was found to be strongly associated to Meaning in Life-Presence ($r = .27$) in a sample of undergraduate students (Triplett, Tedeschi, Cann, Calhoun, & Reeve, 2011). PTG was also found to be strongly related to PTSD ($r = .22$) in a study of Iraqi students who had suffered war-related adversity, as measured by the Traumatic Stress Symptom Checklist (Magruder, Klic, & Koryurek, 2015).

3.8.1.2 Reliability of PCL-5

The Post Traumatic Stress Disorder (PCL-5) Checklist is a commonly used self-report measure of PTSD symptoms that is based on the DSM. The PCL-5 was recently updated in the DSM-5 to reflect the PTSD criterion modifications. According to Blevins et al., (2015), the development and initial psychometric examination of the PCL for the DSM-5 were explored in two different studies involving college students who were exposed to trauma, and further revealed that: In Study 1 ($N = 278$), PCL-5 scores exhibited strong internal consistency ($\alpha = .94$), convergent ($r_s = .74$ to $.85$), test-retest reliability ($r = .82$) and discriminant ($r_s = .31$ to $.60$) validity. Furthermore, confirmatory factor analysis indicated an adequate fit with the DSM-5 4-factor model, $\chi^2 (164) = 455.83$, $p < .001$, residual standardized root mean square (SRMR) = $.07$, root mean square error of approximation (RMSEA) = $.08$, comparative fit index (CFI) = $.86$ and Tucker-Lewis index (TLI) = $.84$, and superior fit with the recently proposed factor 6, $\chi^2 (164) = 318.37$, $p < .001$, SRMR = $.05$, RMSEA = $.06$, CFI = $.92$ and TLI = $.90$, and factor 7, $\chi^2 (164) = 291.32$, $p < .001$, SRMR = $.05$, RMSEA = $.06$, CFI = $.93$ and TLI = $.91$, models. In Study 2 ($N =$

558), PCL-5 scores demonstrated equally strong reliability and validity. Overall, the results indicate that the PCL-5 is a psychometrically robust measure of PTSD symptoms.

3.8.1.3 Reliability of DASS-21

DASS has been translated into Spanish and validated into Hispanic populations, revealing adequate psychometric properties (Antúnez, & Vinet, (2012); Daza, Novy, Stanley, Averill, (2002); Román, Santibáñez, Vinet, (2016); Román, Vinet, & Alarcón, (2014).

In a study Antunez, Vinet, Escalas & Ansiedad, (2012) reported that this short version has shown adequate psychometric properties in validation studies of adults, the general-population, and in clinical samples. Similarly, previous research showed that, when compared to other existing measures, the DASS-21 has a high level of internal consistency and can distinguish between anxiety and depression adequately (Antunez, Vinet, Escalas & Ansiedad, 2012). The scales demonstrated adequate convergent and discriminatory validity, according to Lovibond and Lovibond (1995), who were the main proponents of this instrument.

The instrument was tested in a pilot intervention study with 32 adults, and the total scale received a Cronbach's alpha of 0.94 for internal consistency (Rosselló, Zayas, & Lora, 2016). In non-experimental investigations conducted in Puerto Rico, DASS demonstrated an internal consistency of 0.87 to 0.90 (González-Rivera, 2018; Pagán-Torres, González-Rivera, 2019; González-Rivera, et al., 2018; González-Rivera, Segura, & Urbistondo, 2018). Another study found that the reliability has excellent cronbach's alpha values of = 0.81, 0.89, and 0.78 for the depressive, anxiety, and stress subscales, respectively. Internal consistency, discriminative, concurrent, and convergent validities were also discovered. It is dependable, valid, and simple to use (Coker, Coker & Sanni, 2018).

3.8.2 Trustworthiness and Credibility

Trustworthiness of the Research Instrument - The researcher ensures that the study instrument was trustworthy and credible. For the qualitative strand, following due guidance from her supervisors, the researcher developed the interview questions.

3.9 Data Collection Procedures

The researcher first of all obtained an introductory letter from the Catholic university of Eastern Africa. The researcher was able to conduct the study after obtaining a research permit from the National Commission for Science, Technology, and Innovation (NACOSTI) and a memorandum of understanding signed between JRS and the researcher. The letter of identification from the university, memorandum of understanding and National Commission for Science, Technology, and Innovation (NACOSTI), helped to eliminate speculation or suspicion of any kind. While in the field, the researcher introduced herself and the research assistance to the participants of the study, thereafter, she briefed the respondents about the purpose of her visit.

The researcher then seeks the consent of the respondents. As soon as they granted her their consent, the researcher then explained the importance of conducting the study to the respondents. Data were collected through coded questionnaires and interview guides respectively. Research instruments were then administered to the respondents with the help of the research assistants. After the respondents have completed the questionnaire and the interview had been carried out, the researcher appreciates the respondents for their active participation in the research.

3.10 Data Analysis and Presentation

In analysing the data, the researcher was guided by research questions. Quantitative data was input and coded using the Statistical Package for Social Sciences (SPSS) and then analysed using specifically the simple bivariate statistics and Pearson correlation analysis. Qualitative data was analysed using thematic analysis where themes were extracted. As a result of the mixed method design chosen for this study, the data for each of the four research questions were analysed using specific statistical and non-statistical techniques.

Research question 1 and 2: These are quantitative questions and were analysed using Pearson correlation analysis to get the relationship between depression and PTG; anxiety and PTG among Refugees in Nairobi County.

Research question 3 - This is a quantitative question and was analysed using simple bivariate statistics. The influence of PTSD on PTG was computed using means, percentages and presented in tables.

Research question 4: This is a qualitative question that was analysed using thematic analysis and participant narratives. The data was cleaned, coded, and categorised before themes and patterns were extracted.

3.11 Limitations/Anticipated Constraints

According to Creswell (2013), limitations are the possible weakness of the study which may occur; it could be anything that limits the researcher on conducting research successfully. Some of the limitations and anticipated constraint the researcher encountered were language barrier, time, and translation of interview data. This was resolved by training the research assistances on the instrument and thereby they translated it into various languages.

3.12 Ethical Considerations

Ethics in research are moral issues that are concerned with protecting and respecting research participants by using and adhering to certain provided standards (Alderson & Morrow, 2011). In order for research to be in the best interest of the refugees as it is noted by Fraser (2004), it is vital that researchers take into account a number of critical issues of which ethics are not an exception. These ethical requirements will be substantiated briefly.

- i. **Permission:** Before embarking on data collection, the researcher ensure that proper permission were obtained from the Catholic University of Eastern Africa, a memorandum of understanding signed between JRS and the researcher, and a research permit from NACOSTI certifying that the researcher has the necessary approval to collect data from the research respondents as this clearly clarify any forms of bias or doubt.
- ii. **Informed Consent:** The researcher briefed the respondents concerning the purpose, nature, data collection methods, and extent of the research prior to commencement of the research. Upon their agreement to partake in the study, their informed consent were obtained by each one of them as they append their signatures in the consent form - see Appendix II
- iii. **Harm and Risk:** In this research study, the researcher ensures that no respondent was put in any situation where they might be harmed as a result of their participation, legal, physical, or psychological. This point is very important because of the very sensitive nature of the study.
- iv. **Privacy, Confidentiality, and Anonymity:** Privacy, confidentiality and anonymity of the respondents were maintained by ensuring that no identifying characteristics of the respondents were included in the returned questionnaires, and the one-on-one interview

with the respondents. This point was held in high esteem because of the sensitive nature of this study.

- v. **Voluntary Participation:** Only the respondents who volunteer and accept to participate in the study were allowed to partake in the study after signing the informed consent form. There was no monetary inducement of respondents or other form of payment for participation in the study.
- vi. **Debriefing:** Oftentimes, there are unusually strong emotions and behaviours attached to the event which have the potential to interfere with a person's ability to function normally. Upon the acceptance to participate in the study, debriefing was carried out before respondents began to responding to the questionnaire and interview, and immediately after they have completed the research. This was done with the help of the researcher, the research assistance and the counsellors.

CHAPTER FOUR

DATA ANALYSIS, PRESENTATION AND DISCUSSION

4.1 Introduction

This chapter presents and interprets the findings of the current study which set out to assess the influence of psychological distress on posttraumatic growth among refugees in Nairobi County, Kenya. Descriptive statistics were presented and summarised using frequency, percentages, and tables, based on data gathered through questionnaires and interviews. Themes were used to analyse and present qualitative data. The target population of this study was refugees in Nairobi County.

The chapter is divided into six sections. The response rate is presented in the first section; the demographic information of the respondents is presented in the second section; third section discusses the relationship between depression and PTG among refugees in Nairobi County, Kenya. The fourth section established the association between anxiety and PTG among refugees in Nairobi County, Kenya. The fifth section examines the influence of PTSD on PTG among refugees in Nairobi County, Kenya and the last section identifies the existing interventions used to address psychological distress among refugees in Nairobi County, Kenya.

4.2 Response Rate

The researcher selected 120 refugees who were the main respondents in the Quantitative study. Eight (8) refugees and five (5) staff members were selected for interviews. The total sample was 133 of which 120 refugees were expected to respond to self-administered questionnaires while 13 were interviewed. All the 120 refugees were issued with the questionnaire while all the 13(refugees and staff) were interviewed. The questionnaires were all completed and returned. With all the 5 staff and 8 refugees participating in the interviews to complete the total number of

participants who successfully completed the study was 133. The response rate is summarized in the table below:

Table 1: Response Rate

Category	Total instruments	Returned instruments	Response rate
Refugees (quantitative)	120	120	100.0%
Refugees (Interview)	8	8	100.0%
Staff (interview)	5	5	100.0%
Total	133	133	100.0%

From Table 1, response rate for the participants was 100%. For the qualitative, the response rate was 100%. The total response rate for the study was 100 %, which was considered adequate as per Baruch and Holtom (2008) who stated that a return rate of more than 55% is good to proceed to data analysis. A greater return rate was achieved because the researcher physically gave the questionnaires and regulated the process with the help of research assistances.

4.3 Demographic Information of Participants

The study examined participant demographics to determine sample characteristics in order to better understand the population in the current study and to assist future researchers who wish to research this topic. The researcher was interested with the information concerning the Age, Religion and Gender of the respondents. The demographic data enabled the researcher to have deeper insights on the differences in age, religion and gender and on how they respond to both trauma and positive growth after a distressing event. The data, which was extracted, were analysed and are presented in the following sections.

4.3.1 Age distribution of Participants

The age of the respondents was sought because age is a vital factor that contributes to how one reacts to unpleasant experiences or events. Age was also considered a significant variable in the study since it may influence cognitive ability and the ability to develop new adaption skills following a traumatic incident. The result of the Age distribution of respondents is presented in Table 2.

Table 2: Age Distribution of the Participants.

Age	Frequency	Percent
18-23	24	20.0
24-29	26	21.7
30-35	25	20.8
36-41	16	13.3
42-47	5	4.2
48-53	14	11.7
54-59	10	8.3

Table 2 indicated that the age of refugees respondents ranged between 18 and 59 years. The highest number of participants (21.7%) were between the ages of 24 and 29, followed by those between the ages of 30-35 (20.8%), 18-23 (20.0%), and the least was in the age bracket of 42-47 years with (4.2 %). Based on these findings, it can be stated that the majority of the respondents in the study were youth between the ages of 18 and 35, which may be of great significance in drawing conclusions about how this specific age group experienced the phenomenon under study.

4.3.2 Distribution of Respondents Religion

The religion of the respondents was considered as an important variable because religion is a vital factor that contributes to how people grow or respond to stressful lives events. The following are the results of the religion distribution of respondents as shown in the table below.

Table 3 shows the results of the Religion distribution for the sample.

Table 3: Religion Distribution of the Participants.

	Frequency	Percent
Christian	98	81.7
Muslim	13	10.8
Hindu	1	.8
African Traditional Religion	1	.8
Others	7	5.8

Table 3 indicated that majority of respondents (81.7%) were Christians, Muslims were 10.8% while others and Hindu / African traditional religion were 5.8% and .8% respectively. The high percentage of the Christians in the sample could be due to the fact that majority of the refugees get help from Jesuits refugee service (JRS).

4.3.3 Gender Distribution of Respondents

The gender of the respondents was also sought because both male and female respond to stressful lives event differently. The gender of the respondents was analysed to establish the true representation of the respondents regarding their sexes. The findings of the respondents' gender are distributed in table 4

Table 4: Gender Distribution for the sample

Gender	Frequency	Percent
Male	60	50.0
Female	58	48.3
Others	2	1.7

Table 4 shows that males made up 50.0% of the participants, while females made up 48.3% of the participants and others made up 1.7%. This indicates that both genders were given the opportunity to participate in the study, and thus the findings were not biased by gender. The researcher was aware that some societal stereotypes could influence the subjective interpretation

of participants' world views, and that a balanced representation of both genders was required to address this issue.

4.4. Demographic Mean Differences in Relation to Trauma Reaction

The study sought to establish the various demographic characteristics of the participants and their distribution of means differences across the different measures. The factors comprise participant's age, gender, religion and their mean differences in response to trauma reaction.

4.4.1 Mean Difference of Trauma Reaction in terms of Age

The study examined the age of the participants to find out whether the level of trauma reaction has influence on age of the participants. The finding is presented in table 5.

Table 5: Mean Difference of Trauma Reaction in terms of Age

Age of Participants	Re-experiencing		Avoidance		Negative alteration in cognition and mood		Hyper-arousal	
	Mean	SD	Mean	SD	Mean	SD	Mean	SD
18 -23	1.82	1.02	1.67	0.94	1.67	0.94	1.75	1.01
24-29	2.49	0.92	2.48	0.79	2.48	0.79	2.32	0.84
30-35	2.50	0.88	2.39	0.87	2.39	0.87	2.06	1.02
36-41	2.50	0.73	2.30	0.79	2.30	0.79	2.06	0.85
42-47	3.16	0.69	2.77	0.71	2.77	0.71	2.66	1.00
48-53	2.67	0.89	2.21	0.82	2.21	0.82	1.89	0.98
54-59	2.24	0.91	2.10	0.57	2.10	0.57	2.10	0.88

Finding in Table 5 shows the mean score was higher between the ages 42-47 in response to re-experiencing traumatic event. There is a consistent pattern of trauma reactions across the different age brackets of the participant with mean score between (Mean 2.06- 2.48). Surprisingly, all the trauma reactions experienced by the participants was reported to be the lowest at the lower ages 18-23 (Mean = 1.67-1.82). The findings showed that trauma reactions as experienced by the participants increases as individual transits from adolescence to adulthood and higher at mid-40s

as seen from the sample in the present study. The findings showed that age of the participants has influence on trauma reaction.

4.4.2 Mean Difference of Trauma Reaction in terms of Gender

The study-targeted gender of participants in order to ascertain whether there was gender differences in how they react to trauma. The finding is revealed in table 6.

Table 6: Mean Difference of Trauma Reaction in terms Gender

Gender of the Participants	Re-experiencing		Avoidance		Negative alteration in cognitive and mood		Hyper-arousal	
	Mean	SD	Mean	SD	Mean	SD	Mean	SD
Male	2.18	0.99	2.12	0.84	2.12	0.84	1.87	0.95
Female	0.60	0.84	2.32	0.88	2.32	0.88	2.22	0.91

Finding in Table 6 shows the mean score was consistent among male participant in the tenet of re-experiencing (Mean = 2.18), avoidance and negative alteration in cognition and mood (Mean = 2.12) and lower in response to hyper-arousal (Mean= 1.87). There is a consistent mean score pattern of trauma reactions experienced by female participants in response to avoidance and negative alteration in cognition and mood (Mean = 2.32), hyper-arousal (Mean= 2.22) and lower in response to re-experiencing traumatic event. The findings showed that re-experiencing trauma reactions is high among male participants and lower among female participants. This implies that female participants recovered from re-experiencing traumatic event faster than male participants re-experience. However, the finding reported that hyperactive arousal is higher among female than male participants. This implies that male has more shock absorber or coping skills than female participants in dealing with trauma reactions. The findings reaffirmed the study of Ainamani et.al

(2020) among Congolese refugees in Uganda, the results shows that the overall high prevalence of PTSD differed among women (94%) and men (84%).

4.4.3 Mean Difference of Trauma Reaction in terms of Religion

The study sought to find out whether the level of trauma reactions has influence on the religion of the participants. The findings are presented in table 7.

Table 7: Mean Differences of Trauma Reaction in terms of Religion

Religion of Participants	Re-experiencing		Avoidance		Negative alteration in cognition and mood		Hyper-arousal	
	Mean	SD	Mean	SD	Mean	SD	Mean	SD
Christian	2.39	0.96	2.21	0.92	2.21	0.92	2.02	0.96
Muslim	2.46	0.87	2.47	0.51	2.47	0.51	2.52	0.65
Hindu	3.00	.	1.42	.	1.42	.	2.83	.
ATR	3.60	.	2.71	.	2.71	.	3.50	.
Others	1.88	0.66	2.00	0.52	2.00	0.52	1.42	0.85

Findings in Table 7 shows the mean score was higher in response to re-experiencing trauma reactions among the Hindu and African traditional religion with mean score (Mean = 3.00) and (Mean= 3.60) respectively. Among Muslim (Mean =2.46), Christian (Mean = 2.39) and lower among other religion (Mean= 1.88). There is a higher mean score pattern of trauma reactions experienced by participants regardless of religion across all trauma reactions. In response to hyper-arousal, there is higher mean score among Africa traditional religion (Mean = 3.50). The findings showed that all participants regardless of religion experience trauma reactions. This implies that belief and understanding people attached to traumatic experience forms a contributing factor to trauma reaction. Various Studies have shown that religion or spiritual beliefs indeed have a

positive effect on dealing with trauma (Bryant-Davis & Wong, 2013; Dueck & Byron, 2011; Brewer-Smyth & Koenig, 2014).

4.5. Demographic Mean Differences in Relation to Posttraumatic Growth

The study sought to establish the various demographic characteristics of the participants and their distribution of means differences across the different measures. The factors comprise participant's age, gender, religion and their mean differences in response to posttraumatic growth.

4.5.1 Mean Difference of Posttraumatic Growth in terms of Age

The study sought to find out whether the posttraumatic growth has influence on the age of the participants. The finding is presented in table 8.

Table 8: Mean Difference of Posttraumatic Growth in terms Age

Age of Participants	Relationship with others		New possibilities in life		Personal strength		Spiritual change		Appreciation of life	
	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD
18-23	2.99	0.95	3.32	0.88	3.12	0.85	3.26	1.12	3.26	1.12
24-29	3.11	0.75	3.20	1.03	3.18	0.97	3.57	1.05	3.57	1.05
30-35	2.89	0.99	2.85	0.98	2.86	0.76	2.94	0.82	2.94	0.82
36-41	2.78	0.62	2.83	0.87	2.92	0.86	2.93	1.10	2.93	1.10
42-47	2.34	1.33	3.28	0.59	3.55	0.69	3.66	0.57	3.66	0.57
48-53	3.00	0.67	3.44	0.50	3.16	0.81	3.66	0.84	3.66	0.84
54-59	2.84	0.74	2.88	0.68	3.02	0.90	3.36	0.80	3.36	0.80

Findings in Table 8 shows the mean score between the ages 18-23 in relation to relationship with others (Mean= 2.99), new possibilities in life (mean = 3.32), personal growth (mean= 3.12), spiritual change (mean =3.26) and appreciation of life (mean=3.26). The mean score between the ages 24-29 in relation to relationship with others (Mean= 3.11), new possibilities in life (mean = 3.20), personal growth (mean= 3.18), spiritual change (mean=3.57) and appreciation of life (mean=3.57). The mean score between the ages 30-35 in relation to relationship with others (Mean= 2.89) , new possibilities in life (mean = 2.85), personal growth (mean= 2.86), spiritual

change (mean=2.94) and appreciation of life (mean= 2.94). The mean score between the ages 36-41 in relation to relationship with others (Mean= 2.78) , new possibilities in life (mean = 2.83), personal growth (mean= 2.92), spiritual change (Mean =2.93) and appreciation of life (mean =2.93). The mean score between the ages 42-47 in relation to relationship with others (Mean= 2.34) , new possibilities in life (mean = 3.28), personal growth (mean= 3.55), spiritual change (mean=3.66) and appreciation of life (mean=3.66). The mean score between the ages 48-53 in relation to relationship with others (Mean= 3.00) , new possibilities in life (mean = 3.44), personal growth (mean= 3.16), spiritual change (mean=3.66) and appreciation of life (mean=3.66). The mean score between the ages 54-59 in relation to relationship with others (Mean= 2.84) , new possibilities in life (mean = 2.88), personal growth (mean= 3.02), spiritual change (mean=3.36) and appreciation of life (mean=3.36)

The mean score was consistent and higher between the ages 24-29 and 48-53 ranging between (Mean = 3.11 to Mean = 3. 57) and (Mean = 3.00 to Mean = 3. 66) respectively in response to all the PTG indicators. However, there is a consistent similar pattern of PTG across the different age brackets of the participants. The findings showed that age of the participants has influence on PTG.

4.5.2 Mean Difference of Posttraumatic Growth in terms of Gender

The study sought to establish whether the gender of the participants has influence on posttraumatic growth. The finding is presented in table 9.

Table 9: Mean Difference of Posttraumatic Growth in terms of Gender

Gender of Participants	Relationship with others		New possibilities in life		Personal strength		Spiritual change		Appreciation of life	
	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD
Male	3.00	0.91	3.20	0.82	3.18	0.84	3.35	0.94	3.35	0.94
Female	2.85	0.79	3.01	0.96	2.96	0.86	3.24	1.06	3.24	1.06
Others	2.92	0.30	2.90	0.98	2.62	0.17	2.83	0.23	2.83	0.23

Findings in Table 9 shows the mean score was higher among male participants across all the PTG indicators between (Mean = 3.00 to Mean= 3.35). The mean score of PTG was equally found to be high among female between (Mean= 2.85 to Mean = 3.24). There is a high mean score pattern of PTG by others participants in response to all the indicators of PTG between (Mean = 2.62 to Mean = 2.92). The findings showed that all the participants regardless of gender experienced posttraumatic growth. However, the finding reported that spiritual change and appreciation life was higher among male participants. This implies that male bounce back easily after traumatic experience than female and other gender. The findings concur with the argument of Tedeschi and Calhoun (2004) that PTG is not stereotyped, various personality types would respond to posttraumatic growth differently in the same way gender differences and religious belief influence how people respond to PTG differently.

4.5.3 Mean Difference of Posttraumatic Growth in terms Religion

The study sought to establish whether the religion of the participants has influence on posttraumatic growth. The findings are presented in Table 10.

Table 10: Mean Difference of Posttraumatic Growth in terms of Religion

Religion of Participants	Relationship with others		New possibilities in life		Personal strength		Spiritual change		Appreciation of life	
	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD
Christian	2.99	0.81	3.18	0.88	3.14	0.86	3.33	1.00	3.33	1.00
Muslim	2.76	0.92	2.90	0.96	2.69	0.69	2.94	1.00	2.94	1.00
Hindu	2.57	.	2.20	.	2.50	.	3.00	.	3.00	.
ATR	3.28	.	3.40	.	2.75	.	4.66	.	4.66	.
Others	2.38	1.17	2.48	0.65	2.85	0.98	3.19	0.81	3.19	0.81

Findings in Table 10 shows the mean score was higher in appreciation to life, spiritual change, new possibility in life, relationship with others and personal growth among African traditional religion with mean score (Mean = 4.66) and (Mean= 4.66), (Mean= 3.40), (Mean=3.28) and (Mean= 2.75) respectively. Interestingly, PTG was equally found to be high among Christians between (Mean =2.99 to Mean =3.33). Among Muslim was between (Mean = 2.69 to Mean=2.94). Among Hindu was between (Mean= 2.20 to Mean = 3.00) and among other religion (Mean= 2.38 to Mean = 3.19). There is a similar pattern in mean score in response to PTG of the participants regardless of religion. However, in response to spiritual change and appreciation life, there is higher mean score among Africa traditional religion (Mean = 4.66). The findings showed that all participants regardless of religion experience posttraumatic growth. This implies that belief and psychosocial support, teaching and understanding people attached to traumatic experience forms a contributing factor to posttraumatic growth. This conclusion supports the findings of various

studies that spiritual beliefs indeed have a positive effect on people who have experience any kind of trauma (Bryant-Davis & Wong, 2013; Dueck & Byron, 2011; Brewer-Smyth & Koenig, 2014).

4.6 Descriptive Statistics on level of Anxiety

The study sought to establish the level of anxiety among the refugee's participants. Detailed of the findings is presented in table 11.

Table 11: Distribution of Participants by Level of Anxiety

Statement	Frequency(f)	Percent (%)
Normal anxiety	35	29.2
Mild anxiety	4	3.3
Moderate anxiety	16	13.3
Severe anxiety	65	54.2

The study examined the level of anxiety as experienced by the participants. Finding in table 11 shows that most of the participants 65(54.2%) experienced severe anxiety, 35 (29.2%) experienced normal anxiety, 16(13.3%) experienced moderate anxiety and less than 5(3.3%) experienced mild anxiety. The findings from the sample of this study showed that anxiety is inevitable and emotional reaction to traumatic experience. The finding is in line with Thabet and Sultan (2016) study on war trauma, anxiety, and resilience among University Students in the Gaza Strip.

4.6.1 Descriptive Statistics on level of Anxiety on Religion

The study further sought to establish whether the level of anxiety has any influence of the religion of the refugee's participants. Detailed of the findings is presented in table 12.

Table 12: Levels of anxiety in Terms of Religion

Religion	Mean	S.D
Christian	2.90	1.34
Muslim	3.46	0.96
Hindu	4.00	.
African Traditional Religion	1.00	.
Others	2.28	1.38

The finding on Table 12 established high mean score among Hindu worshipers in relation to the level of anxiety reported (mean = 4.00), Muslim (mean = 3.46), Christian (mean =2.90), others (mean = 2.28). The result shows lower mean score among African traditional (mean = 1.00). The findings of this study show that the level of anxiety is influenced by religion. This implies that each religion handle challenges of life that lead to anxiety differently. The findings of this study sample shows that the level of anxiety among Hindus and Muslim are high compare to other religion. This could be due to their belief and attitude towards life situation that lead to this emotional reaction.

4.6.2 Descriptive Statistics on Anxiety

The study sought to establish the level of anxiety among the refugee's participants. The questionnaires were given on a 7-items and 4-point Likert Scale: Did not apply to me at all (0); Applied to me to some degree (1); Applied to me to a considerable degree (1); Applied to me very much (3) Applied. The results were summarized into mean and standard deviation for each response. Furthermore, the mean was computed by finding the total score for each item and dividing by the number of participants. Detailed of the findings is presented in table 13.

Table 13: Descriptive Statistics on Anxiety

STATEMENT	Mean	S.D
I was worried about situations in which I might panic and make fool of myself	1.47	1.061
I experience breathing difficulty (e.g., excessively rapid breathing, breathlessness in the absence of physical exertion)	1.15	1.113
I felt I was close to panic	1.46	1.129
I was aware of the action of my heart in the absence of physical exertion (e.g., sense of heart rate increase, heart missing a beat)	1.31	1.143
I experienced trembling (e.g., in the hands)	1.00	1.115
I was aware of dryness of my mouth	1.14	1.09
I feel scared without any good reason	1.36	1.05

The findings in table 13 shows that the level of anxiety as experienced by the participants in this sample study has decrease to a lower degree across all the indicators of anxiety with mean score between (Mean =1.00 to Mean = 1.47). This implies that participants have received psychological assistance that has facilitated to decrease in the level anxiety.

4.6.3 Descriptive Statistics on level of Depression

The study sought to find out whether the religion of refugees participants has any influence on the level of depression as experienced by the participants. Detailed of the findings is presented in table 14.

Table 14: Level of Depression in Terms of Religion

Religion	MEAN	SD
Christian	2.79	1.29
Muslim	3.46	0.96
Hindu	4.00	
African Traditional Religion	1.00	
Others	2.42	1.13

The finding on table 14 shows high mean score among Hindu worshipers in relation to the level of depression reported (mean = 4.00), Muslim (mean = 3.46), Christian (mean =2.79), others (mean = 2.42). The result shows lower mean score among African traditional (mean = 1.00). The

finding of this study shows that the level of depression is influenced by religion. This implies that each religion has level of psychosocial support and assistance they offer to their members facing challenges of life. This could be due to their belief and attitude towards accepting and understanding of life situation in relation to the interpretation given to any circumstances of life experience.

4.6.4 Descriptive Statistics on level of Depression

The study sought to establish the level of depression among the refugee's participants. The questionnaires were given on a 7-items and 4-point Likert Scale: Did not apply to me at all (0); Applied to me to some degree (1); Applied to me to a considerable degree (1); Applied to me very much (3) Applied. The results were summarized into mean and standard deviation for each response. Furthermore, the mean was computed by finding the total score for each item and dividing by the number of participants.

Detailed of the findings is presented in table 15.

Table 15: Descriptive Statistics on Level of Depression

STATEMENT	Mean	S. D
I felt down-hearted and blue	1.53	1.11
I found it difficult to work up the initiative to do things	1.49	1.00
I was unable to become enthusiastic about anything	1.38	1.00
I couldn't seem to experience any positive feeling at all	1.36	0.96
I felt that life was meaningless	1.32	1.12
I felt I wasn't worth much as a person	1.18	1.04
I felt that I had nothing to look forward to	1.38	1.07

The findings in table 15 shows that the level of depression as experienced by the participants in this sample study has decrease to a lower degree across all the indicators of depression with mean score between (Mean =1.18 to Mean = 1.53). This implies that participants have received psychological assistance that has facilitated the decrease in the level depression.

4.6.5 Distribution of Trauma Reaction among Participants

The study further sought to establish trauma reaction among the refugee's participants. The finding is presented in table 16.

Table 16: Distribution of Participants Level of Trauma Reactions

Trauma Reaction	Mean	SD
Re-experiencing	2.39	0.94
Negative alteration in cognition and mood	2.22	0.86
Avoidance	2.22	0.86
Hyper-arousal	2.06	0.95

Finding in table 16 shows a consistent trauma reaction pattern across the four different reaction with re-experiencing higher with mean score (mean =2.39) followed by negative alteration in cognition and mood (mean =2.22), avoidance (mean = 2.22) and hyper-arousal (Mean = 2.06). The findings from the sample of this study showed that trauma reactions are inevitable among participants who had gone through traumatizing experience in life. However, the trauma reactions were at lower degree across all the indicators of trauma reactions.

4.6.6 Descriptive Statistics of Trauma Reaction among Participants

The study sought to establish trauma reaction among the refugee's participants. The researcher adopted standardized tools to obtain the data. The questionnaires were given on a 20-items and 5-point Likert Scale (Not at all - 0, A little bit -1, Moderate - 2, Quite a bit – (3),

Extremely – (4). The results were summarized into mean and standard deviation for each response. Furthermore, the mean was computed by finding the total score for each item and dividing by the number of participants. Detailed of the findings is presented in table 17.

Table 17: Descriptive Statistics of Trauma Reaction Among Participants (n = 120)

Statements	Mean	SD
Feeling very upset when something reminded you of the stressful experience?	2.68	1.15
Repeated, disturbing, and unwanted memories of the stressful experience?	2.68	1.18
Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	2.53	1.25
Having strong negative feelings such as fear, horror, anger, guilt, or shame?	2.48	1.24
Being “super alert” or watchful or on guard?	2.45	1.23
Feeling distant or cut off from other people?	2.41	1.37
Avoiding memories, thoughts, or feelings related to the stressful experience	2.39	1.19
Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	2.37	1.25
Blaming yourself or someone else for the stressful experience or what happened after it?	2.36	1.34
Having difficulty concentrating?	2.35	1.31
Repeated, disturbing dreams of the stressful experience?	2.23	1.16
Trouble falling or staying asleep?	2.20	1.50
Having strong physical reactions when something reminded you of the stressful experience (e.g., heart pounding, trouble breathing, sweating)?	2.20	1.41
Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	2.16	1.34
Irritable, (undefined) behaviour, angry outburst, or acting aggressively?	2.08	1.34
Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	2.03	1.29
Loss of interest in activities that you used to enjoy?	1.97	1.34
Trouble remembering important parts of the stressful experience?	1.97	1.24
Feeling jumpy or easily startled?	1.96	1.33
Taking too many risk or doing things that could cause you harm?	1.35	1.35

The findings in table 17 showed that participants experience trauma reactions at different degree with consistent similar pattern of mean score (Mean 2.03- 2.68). However, the study reported lower mean score of loss of interest in activities that you used to enjoy (Mean = 1.97 ± 1.34) followed by trouble remembering important parts of the stressful experience (Mean = 1.97 ± 1.24), Feeling jumpy or easily startled (Mean = 1.96 ± 1.33) and taking too many risk or doing things that could cause you harm (Mean = 1.35 ± 1.35). The report of the findings showed that participant experienced trauma reactions at different degree depending on the circumstances that led to traumatizing event. Tekie (2018) study that examined the Role of Meaning-Making in Post-traumatic Growth among Eritrean Refugees with post-traumatic stress disorder concurs with the findings of the current study.

4.6.7 Descriptive Statistics on level of Posttraumatic Growth

The study to find out the level of posttraumatic growth experienced among the refugees participants. The questionnaires were given on a 21- items and 6-point Likert Scale: I did not (0), To a very small degree (1), To a small degree (2), moderate degree (3), Great degree (4), Very great degree (5). The results were summarized into mean and standard deviation for each response. Furthermore, the mean was computed by finding the total score for each item and dividing by the number of participants. Detailed of the findings is presented in table 18.

Table 18: Descriptive Statistics on Posttraumatic Growth

STATEMENT	Mean	S. D
I have a stronger religious faith	3.76	1.34
I can better appreciate each day	3.55	1.28
I better accept needing others	3.48	1.22
I have a greater appreciation for the value of my own life	3.46	1.45
I have more compassion for others	3.45	1.28
I am able to do better things with my life	3.43	1.29
I discovered that I'm stronger than I thought I was	3.32	1.31
I developed new interests	3.32	1.30
I am more likely to try to change things which need changing	3.27	1.31
I have a better understanding of spiritual matters	3.27	1.48
I know better that I can handle difficulties	3.23	1.24
I established a new path for my life	3.06	1.46
I put more effort into my relationships	3.02	1.51
I am better able to accept the way things work out	2.93	1.25
I changed my priorities about what is important in life	2.88	1.72
I have changed my priorities about what is important in life	2.81	1.61
I learned a great deal about how wonderful people are	2.74	1.45
I am more willing to express my emotions	2.71	1.48
I have a greater sense of closeness with others	2.63	1.48
I more clearly see that I can count on people in time of trouble	2.51	1.65
New opportunities are available which wouldn't have been otherwise	2.49	1.48

The findings in table 18 shows that participants had experienced posttraumatic growth at different PTG degree with high similar pattern of mean score between (Mean 3.02 to Mean= 3.76). However, the study reported lower mean score between (Mean 2.49 to Mean= 2.93). However, the highest mean score was those who have a stronger religious faith (Mean =3.76 \pm 1.34), those who believe that new opportunities would not have been available otherwise had the lowest mean (Mean =2.49 \pm 1.48). This implies that participant experienced an increase in posttraumatic growth especially in the area of their religious faith. This also suggests that the religion and belief of participants of this study influenced their posttraumatic growth. Findings were consistent with the theoretical framework of Tedeschi and Calhoun (2004) and Calhoun et al., 2010) who opined that when people are faced with an overwhelming or life-threatening events, they start to value what they were not valuing before the experience. The findings reaffirmed Teodorescu, et al (2012) and Heidarzadeh, Dadkhah and Gholchin (2016), finding that showed all patients reported some degree of post-traumatic growth, while only 31% reported greater amounts of growth. The findings concur with Asatsa (2018) study that examined trauma processing strategies and post-traumatic growth among terrorist attack survivors at Garissa University. The finding is in agreement with Acquaye (2016) even though the study used a purposeful and snowball sampling methods but arrived at the same conclusion. The study done by Mark, Stevelink, Choi, and Fear (2018) on PTG among military and ex-military personnel from 2001 to 2017 supported the current findings irrespective of difference in population. The intent of the study was to establish evidence of PTG and possible factors promoting PTG among the sample.

4.7 Relationship between Depression and PTG among Refugees in Nairobi County, Kenya

The first objective sought to examine the relationship between depression and PTG among refugees in Nairobi County, Kenya. The researcher adopted standardized tools to obtain the data. The questionnaires were given on a 21- items and 6-point Likert Scale: I did not (0), To a very small degree (1), To a small degree (2), moderate degree (3), Great degree (4), Very great degree (5) and 7-items and 4-point Likert Scale: Did not apply to me at all (0); Applied to me to some degree (1); Applied to me to a considerable degree (2); Applied to me very much (3) Applied. The results were summarized below.

4.7.1. Correlation between Depression and Posttraumatic Growth

The study sought to investigate the relationship between Depression and Posttraumatic Growth. The findings were presented in table 19.

Table 19: Correlation between Depression and Posttraumatic Growth

PTG	Level of depression		
	Rpb	Correlation level	p-value
Relationship with others	-.330**	Weak	0.000
New possibilities in life	-.376**	Weak	0.000
Personal strength	-.414**	Weak	0.000
Spiritual change	-.510**	Moderate	0.000
Appreciation of life	-.510**	Moderate	0.000

**. Correlation is significant at the 0.01 level (2-tailed).

Table 19 revealed a weak negative relationship between level of depression and relationship with others, new possibilities in life and personal strength respectively ($p < 0.01$, $r = -.330$, $p < 0.01$, $r = -.376$, $p < 0.01$, $r = -.414$). This means, as a traumatic individual improves in relationship with others, seeing new possibilities in life and personal strength, the level of depression will decrease. This implies, when there is improvement in post-traumatic growth,

personal strength, the tendency of relating with others, seeing new possibilities in life will be high; thereby lowering the level of depression. There is a moderate negative relationship between level of depression and spiritual change and appreciation of life respectively. ($p < 0.01$, $r = -.510$, $p < 0.01$, $r = -.510$). This negative correlation indicates a low degree of correlation between the two variables. This means that there is a relationship between the level of depression and spiritual change and appreciation of life. Though not of high degree, the negative coefficient shows that the more individual appreciate life and spiritual change is observed, the less symptoms of depression is reported because growth is a process. Collier (2016) tendered a humble disposition, which upholds that the growth process is not automatic but a process. Siqveland et al., (2015) conducted a longitudinal research on Post-traumatic growth, depression and post-traumatic stress in relation to quality of life among tsunami survivors. The findings are in agreement with the current study despite it was a longitudinal study. Furthermore, the study of Bamonti et.al (2016), reaffirmed the finding of the current study in a cross-sectional study that examined whether spirituality moderates the association between depression symptoms severity and meaning in life among treatment-seeking adults. The findings revealed that there is a significant negative association between depression symptom severity and meaning in life.

4.8 Association between Anxiety and PTG among refugees in Nairobi County, Kenya

The second objective sought to determine the relationship between anxiety and posttraumatic growth among refugees in Nairobi County, Kenya. The researcher adopted standardized tools to obtain the data. The questionnaires were given on a 21- items and 6-point Likert Scale: I did not (0), To a very small degree (1), To a small degree (2), moderate degree (3), Great degree (4), Very great degree (5) and 7-items and 4-point Likert Scale: Did not apply to me

at all (0) Applied to me to some degree, (1) Applied to me to a considerable degree (2) Applied to me very much (3). The results were summarized below.

4.8.1 Correlation between Level of Anxiety and Posttraumatic Growth

The study sought to examine the relationship between level of anxiety and Posttraumatic Growth. The findings were presented in table 20.

Table 20: Correlation between level of Anxiety and Posttraumatic Growth

PTG	Level of anxiety		
	Rpb	Correlation level	p-value
Relationship with others	-.190*	Very Low	0.038
New possibilities in life	-.316**	Weak	0.000
Personal strength	-.345**	Weak	0.000
Spiritual change	-.319**	Weak	0.000
Appreciation of life	-.319**	Weak	0.000

** . Correlation is significant at the 0.01 level (2-tailed).

*. Correlation is significant at the 0.05 level (2-tailed).

Table 20 shows a weak negative relationship between level of anxiety and new possibilities in life, personal strength, Spiritual change and appreciation of live respectively ($p < 0.01$, $r = -.316$, $p < 0.01$, $r = -.345$, $p < 0.01$, $r = -.319$, $p < 0.01$, $r = -.319$). This implies, when there is improvement to personal strength, appreciation of life, spiritual change and seeing new possibilities in life; PTG will be high; thereby lowering the level of anxiety. However, the findings reported a very low negative relationship between level of anxiety and relationship with others. ($p < 0.01$, $r = -.190$). This negative correlation indicates a low degree of correlation between the two variables. This means that there is a relationship between the level of anxiety and relationship with others. Though not of high degree, the negative coefficient shows that the more individual improve in human

relationship, the less symptoms of anxiety is reported. According to (Prasetya, Muhdi, & Atika 2020; Tomaszek & Muchacka- Cymerman, 2020; & Schneider et al., 2019) studies that employed different research design to explore the relationship between previous traumatic experiences, post-traumatic growth, and coping strategy to mental health state on refugees. The finding corroborate with the current study despite differences in research design.

4.9 Influence of PTSD on PTG among refugees in Nairobi County, Kenya

The third objective examines the influence of PTSD on PTG among refugees in Nairobi County, Kenya. The researcher adopted standardized tools to obtain the data. The questionnaires were given on a 20-items and 5-point Likert Scale (Not at all - 0, A little bit -1, Moderate - 2, Quite a bit – (3), Extremely – (4) and on a 21- items and 6-point Likert Scale: I did not (0), To a very small degree (1), To a small degree (2), moderate degree (3), Great degree (4), Very great degree (5). The results were summarized below.

4.9.1 Correlation between Posttraumatic stress Disorder and Posttraumatic Growth

The study sought to investigate the impact of PTSD on PTG. The findings were presented in table 21.

Table 21: Correlation between Posttraumatic Stress Disorder and Posttraumatic Growth

		Post-Traumatic Stress Disorder	Post Traumatic Growth
Trauma	Pearson	1	-.319**
	Correlation		
	Sig. (2-tailed)		
PTG	Pearson	-.319**	1
	Correlation		
	Sig. (2-tailed)		

** . Correlation is significant at the 0.01 level (2-tailed).

Table 21 revealed a weak negative relationship between Posttraumatic stress disorder and posttraumatic growth ($p < 0.01$, $r = -.319$). This implies, as individual who had gone through traumatizing experience progress in posttraumatic growth, the level of post-traumatic stress disorder will decrease with time. This implies that continuous psychological and psychosocial assistance are considered as coping skills that facilitate posttraumatic growth. The findings corroborate with the study done by (Soo & Sherman, 2015; Vloet et al., 2014; Holgersson, Boe & Holen, 2010 & Lewis et al., 2019) regardless of difference in research methodology and objectives but the findings are in conformity with the current study. The findings agrees with the work of Shakespeare-Finch and Lurie-Beck 2014 & Bapolisi et al., 2020) which investigated the strength and the link between post-traumatic stress disorder (PTSD) symptoms and post-traumatic growth (PTG) perceptions. After applying the Bonferroni correction, the perception of stress remained significantly associated with PTSD. Siqveland et al., (2015) conducted a longitudinal research on Post-traumatic growth, depression and post-traumatic stress in relation to quality of life among tsunami survivors. The findings are in agreement with the current study despite it was a longitudinal study.

4.10 Existing interventions used to address psychological distress among refugees in Nairobi County, Kenya

The fourth objective, which was a qualitative study sought to identify the existing interventions used in addressing the psychological distress among refugees in Nairobi County, Kenya. Findings from the 8 refugees and 5 staff members were enquired and recorded as below. Responses to this question threw up a list of far-reaching programmes designed to help alleviate the plight of the distress faced by refugees based on their unique needs at the point of entry into the programme. These responses from the participants itemized the various activities/ programmes

organized by JRS for the refugees in Nairobi County. Themes emerging from their responses were categorized into open-door policy, education program, livelihood project, vocational skills (craft centre), psychosocial support, medical support, rent support and food provision. The findings concur with the review of Jemutai et al (2021) to assess the Situation Analysis of access to refugee health services in Kenya, the findings revealed that the existing mental health intervention includes counselling and psychotherapies. The findings of this study also supports the studies done by Mutiso et al 2018; Silove, Ventevogel, & Rees 2017; The Center for Victims of Torture 2013; and Sannoh (2015), and they affirms that in Kenyan refugee camps, interventions that currently exist include psychosocial support, psychotherapy and clinical services, community sensitization on MHPSS issues, local advocacy strategies and local mental health capacity building.

The themes that emerged from the responses from the participants is shown in the table below followed by the discussions:

Table 22: Themes and Sub-themes from the Qualitative responses

	1	2	3	4	5
Themes	Open-door policy	Education /scholarship program	Livelihood project,	Vocational skills (craft centre),	Psycho-social support
Sub-themes					<ul style="list-style-type: none"> • Medical support, • Counselling • Rent support • Food provision.

4.10.1 Open-door Policy

In an effort to respond to the needs of the refugees, JRS operates an open-door policy where by refugees and displaced persons are welcomed to their facilities. Our mission is to accompany, serve and advocate for refugees. According to all the staff members “we at JRS value attentive

listening to the refugees or displaced persons, our door is open to everyone in need, even Kenyans and none Kenyans”. With our experience of working with the refugees we discover that we need to welcome, listen to them and help them address the situation they find themselves by providing a climate that is accommodating and welcoming and one that promote security. One of the participants narrated:

the open door policy is really helping a lot of refugees, whenever anyone come to JRS there is always someone to welcome and listen to you and so we feel safe coming to JRS or bringing someone who is in need.

(Participant A: interview, May 15, 2021).

The findings agree with Paloma, de la Morena, and López-Torres (2018) study that opined two phases of interventions which includes: preparing a group of settled refugees to serve as peer mentors; and hosting cultural peer support group sessions led by the mentors for newly arrived refugees.

4.10.2 Education/Scholarship Program

JRS over the years has built up a lot of experience in refugee education. The participants explained the effort the Centre makes to achieve the objectives of the program as captured in the summary below

Our main aim is to empower refugees to become competent enough to speak and be heard by providing education for them” In Nairobi, there is an education resource center, run by the education resource person for Africa to promote and facilitate the education of refugees. Also in Nairobi, we have scholarship programme, which is given to student refugees to promote their educational pursuit. We are doing our best to help foster quality education, unlike in 2018, with Covid-19 and the inception of online learning, we at JRS had to tutor them on how to use online services.

(Participant B: interview, May 15, 2021).

According to a staff participant:

“The scholarship program is provided for student at both the secondary and tertiary levels respectively” (Participant D, interview, May 15, 2021).

One of the participants said:

“JRS is providing and catering for our educational needs, every semester we are giving a cheque to use in paying for our school fees and other educational needs”
(Participant F, interview May 15, 2021).

One of the staff participants explained:

“We also have education program mainly targeting students both in the secondary and university level and of course we also have vocational school/skill training whereby we give them scholarship to go to technical institutions”
(Participant H, interview, May 16, 2021).

Another student refugee participant narrated:

“Basically, I will say JRS have been very supportive when it comes to issues to do with refugees, student refugees in general”
(Participant G: interview, May 16, 2021).

4.10.3 Livelihood Project

Another programme for the refugees is the livelihood project. JRS provide social services in many other aspects to support refugees. Rather than being just implementing partners with UNHCR, JRS promote theirs in small scale to fit the needs of refugees whenever they come for help. They provide a livelihood project to support refugees in Nairobi by providing small scale income to refugees which stimulates self-sufficiency and take away over-dependency syndrome.

According to a staff participant who explained the role of the institution:

We have various programmes; with the livelihood project we support refugees to be self-reliant. Various programmes are on ground to address the issues of refugees. One of the key programs is livelihood program which is used to support refugees to be self-reliant through architect program such as engaging in marketing, skill development and enterprise development whereby we also give them some small loans to start business.
(Participant C: interview, May 15, 2021).

The qualitative finding is consistent with Durlak et al.,(2011) who suggested effective programme characteristics which include appropriate sequencing, focus and explicitness of the activities. It helps build resilience in the face of adversity and avoids treating children and youth who have had traumatic experiences

4.10.4 Vocational Skills

JRS involves in many aspects of support to refugees in Nairobi for example, promotion of income generating and capacity- building project.

According to one of the staff participant:

We believe in the need to train others, especially the refugees in any special skills that will promote their wellbeing”. In Nairobi, we have a craft shop “Mikono Craft shop” designed to cater for the needs of the refugees, the centre is met to help refugees retail their crafts which is produced by them on daily basis. We also provide scholarship to refugees who are interested in vocational training.

(Participant B: interview, May 15, 2021).

The qualitative findings corroborate with Aspen Institute, (2017) who suggested intervention of an effective social and emotional learning programmes that tend to use active forms of learning, such as project-based learning, role play or group discussions.

4.10.5 Psychosocial Support

Amongst other support system provided for the refugees, JRS provide psychosocial support to refugees in form of mental health (counselling), rent support, food support, and medical support.

One of the staff participants said:

With our experience of working with the refugees we discover that we need to welcome them and help them address their past by providing a climate for psycho-spiritual healing and growth; as this enable the refugees build a new and better future for themselves. We collaborate with other agencies or organization to provide these services for our refugees, thereby meeting their psychological needs.

(Participant F: interview, May 15, 2021)

The qualitative findings concur with Asatsa, Mutisya, and Owuor (2018) study that found positive significant relationship between the number of counselling sessions attended and post-traumatic growth among the survivors of Garissa University terrorist attack.

According to staff participant:

Psychosocial support program is a key program which aims at helping the refugees address their issues of trauma and distress and indeed help them in overcoming it. A response from a beneficiary “JRS have been very good to me and my family, for example, when someone is like stressed or pained they have a way of making the person see a counsellor.

(Participant A: interview, May 15, 2021).

Another response from a staff member said:

Okay, we have psychosocial counselling which is provided both online and face to face. We also collaborate with other mental health centers/agencies where we send refugees to get professional help. In addition to counselling services, JRS also look into the physical health of the refugees at the beginning and anytime they seek medical attention.

(Participant J: interview May 16, 2021).

According to another staff participant,

“We also have medical program mainly targeting refugees who may be having medical concerns or issues”.

(Participant M: interview, May 16, 2021).

A response from another beneficiary:

“JRS also provide counselling services to us refugees” they take us to see a counsellor and after sharing my problem with the counsellor, I feel okay”

(Participant L: interview, May 16, 2021)

Rent support

Another program under the psychosocial support is the rent support. According to a staff participant who said:

“We also have rent support program mainly targeting refugees who cannot pay their rent; we help in paying their rent”.

(Participant I: interview, May 16, 2021)

Osborn et al., (2020) study came up with the Shamiri group intervention for adolescent who had experienced anxiety and depression, which concurs with the findings of the current study.

Food provision

Food provision is yet another support program provided for the refugees. In the theory of human needs, Abraham Maslow posited physiological need include the need for food, water, shelter and clothing. Hence, it was no surprise to the researcher that the staffs were unanimous in affirming the centrality of food vouchers given to the refugees.

According to a staff participant who said:

We also have food provision program mainly targeting refugees; we do this by providing shopping vouchers for the refugees. JRS also provide for us for example, when you are in a struggling situation, they also get to support you financially, also when you are unable to feed your family they support you financially

(Participant K: interview, May 16, 2021).

On the issue of what the participants considered as the most effective of all the programmes offered at JRS Nairobi.

This question threw up varied responses from different categories of participants. For example, the beneficiaries identified the scholarship programme as the most important, followed by the small scale/ livelihood project. But for the staff, all the programmes are effective because they do address different issues presented by the refugees, for example, if it is in business, there is an enterprise development and also the issue of loan to start a business, this helps them in terms of supporting them to be able to meet their daily needs. Also talk of the counselling/ psycho-social support it helps in addressing their mental wellbeing and reduces their distress of providing for their family when they are not able to do so, so it reduces that. Unfortunately, on the least important of all the programmes, the majority of the participants from the beneficiary group identified none.

According to staff members, who narrated and said:

There is none that is least important, they are all important because they are complementary. To address the issue from a young person perspective we give them education to better their chances of becoming self-reliant in future so education is a human need and a human right” it also gives them the chances in future in terms of being able to address their issues.

(Participant F: interview, May 15, 2021)

Areas of Concern: lastly, the participants were asked to identify the areas they think JRS could probably improve in the future.

The staff suggested that

We still have some gap in the areas of mental health and psycho-social support because we have so many people who are in distress and who have not overcome their trauma and not healed completely, this is one area that I will say we have been having consultation on how to scale out. Although in Kakuma camp, we have a standby counselling services being rendered for the refugees, in Nairobi we don’t have our own but we collaborate with other agencies to provide these mental help to refugee.

(Participant C: interview, May 15, 2021)

Another staff participant supported this mental health provision by saying:

I think we need to focus more on the counselling services, instead of taking the refugees to other agencies or mental health centres I will suggest we have our own psychologist, counsellor and counselling centre to cater for their needs in our centre because it is very expensive taking them outside or to other centres.

(Participant D: interview, May 15, 2021).

Yet another staff participant supported this mental health provision by saying

“Having our own counselling department in Nairobi will go a long way in helping the refugees, even though we collaborate with other organization”.

(Participant A: interview, May 15, 2021).

According to another staff:

“With the support of some refugees participant, they recommend that JRS continue with the livelihood project so that it will make the refugees more of self-reliant rather than becoming over-dependent on JRS”.

(Participant G: interview, May 16, 2021)

According to participant beneficiaries who shared:

We suggest that JRS provide cheques to students to do shopping and pay for their rent. In their words. We suggest JRS to provide cheques to do shopping and they can even pay for rent for student because right now we are doing online study and most of the time we do it at home and it is not easy but distracting. Other family members are there and it is not very conducive for study, sometimes there may be noise and it is hard to study

(Participant A: interview, May 15, 2021).

Other participant supported this view but added that:

We suggest JRS to provide rent voucher to students or hostel facilities where student can stay while they are on studies, a quiet place where we can study by ourselves and avoid any forms of distractions from family members while we study

(Participant F: interview, May 15, 2021).

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

Based on the research findings, this chapter presented the summary, conclusion, and recommendations. The first part recorded the summary of the discussions of the findings in chapter four. It was succeeded by conclusions established on the research objectives/questions. Furthermore, the study presented the recommendations in line with the findings of this study and suggested areas for further research.

5.2 Summary of the Findings

This section presented a summary of findings based on the four objectives that guided the study.

5.2.1 Relationship between Depression and PTG among Refugees in Nairobi County, Kenya

The first objective focused on the relationship between depression and PTG among refugees in Nairobi County, Kenya. The findings from the descriptive statistics showed that the level of depression as experienced by the participants in this study sample has decrease to a lower degree across all the indicators of depression with mean score between (Mean =1.18 to Mean = 1.53). This implies that participants have received psychological assistance enabling post traumatic growth that has facilitated the decrease in their level of depression. The study further revealed that participants had experienced posttraumatic growth at different PTG tenets. However, the highest mean score was those who have a stronger religious faith. (Mean = 3.76). This implies that participant experienced an increase in posttraumatic growth especially in the area of their religious

faith. This means that religion and belief has influence on posttraumatic growth among the participants of this study sample. The findings revealed a weak negative relationship between level of depression and PTG. This implies, when there is improvement in post-traumatic growth, participants will report lower level of depression.

The study sought to find out whether the religion of refugee's participants has any influence on the level of depression as experienced by the participants. The findings showed high mean score among Hindu worshipers in relation to the level of depression. The findings of this study revealed that religion has an impact on the level of depression. This implies that each religion has level of psychosocial support and assistance they offer to their members facing challenges of life. This could be due to their belief and attitude towards accepting and understanding of life situation in relation to the interpretation given to any circumstances of life experience.

5.2.2 Relationship between Anxiety and PTG among Refugees in Nairobi County, Kenya

The second objective sought to determine the relationship between anxiety and posttraumatic growth among refugees in Nairobi County, Kenya. The findings from the descriptive statistics showed that participants had experienced posttraumatic growth at different degree with high mean score of similar patterns between (Mean 3.02 to Mean= 3.76). The study reported lower mean score between (Mean 2.49 to Mean= 2.93). However, the highest mean score was those who have a stronger religious faith (Mean =3.76 \pm 1.34) and the lowest were those who believe that new opportunities are available which would not have been otherwise (Mean =2.49 \pm 1.48). This implies that participant experienced an increase in posttraumatic growth especially in the area of their religious faith. This means that religion and belief have influence on posttraumatic growth depending among the participants of this study sample.

The findings further revealed that the level of anxiety as experienced by the participants in this sample study has decrease to a lower degree across all the indicators of anxiety with mean score between (Mean =1.00 to Mean = 1.47). This implies that participants have received psychological assistance that has facilitated a decrease in their level of anxiety. Finding showed that most of the participants 65(54.2%) experienced severe anxiety, 35(29.2%) experienced normal anxiety, 16(13.3%) experienced moderate anxiety and less than 5(3.3%) experienced mild anxiety.

The correlation result showed a weak negative relationship between level of anxiety and new possibilities in life, personal strength, Spiritual change and appreciation of life respectively ($p < 0.01$, $r = -.316$, $p < 0.01$, $r = -.345$, $p < 0.01$, $r = -.319$, $p < 0.01$, $r = -.319$). This implies that, when there is improvement in PTG tenets; post-traumatic growth will be high; thereby lowering the level of anxiety.

The study further sought to establish whether the level of anxiety has any influence on the religion of the refugee's participants. The findings of this study showed that the level of anxiety is influenced by religion with a high mean score among Hindu worshipers in relation to the level of anxiety reported (mean = 4.00), Muslim (mean = 3.46), Christian (mean =2.90), others (mean = 2.28). This implies that each religion handles challenges of life that lead to anxiety differently. The findings of this study sample shows that the level of anxiety among Hindus and Muslim are high compare to other religions. This could be due to their belief and attitude towards life situation that led to this emotional reaction.

5.2.3 Influence of PTSD on PTG among refugees in Nairobi County, Kenya

The third objective sought to examines the influence of PTSD on PTG among refugees in Nairobi County, Kenya. The findings from the descriptive statistics showed that participants experience trauma reactions at different degree with consistent similar pattern of mean score

(Mean 2.03- 2.68). However, the study reported lower mean score of loss of interest in activities that you used to enjoy (Mean = 1.97 ± 1.34) followed by trouble remembering important parts of the stressful experience (Mean = 1.97 ± 1.24), Feeling jumpy or easily startled (Mean = 1.96 ± 1.33) and taking too many risk or doing things that could cause you harm (Mean = 1.35 ± 1.35). The report of the findings showed that participant experienced trauma reactions at different degree depending on the circumstances that led to the traumatizing event.

The study further sought to establish trauma reaction among the refugee's participants. Findings revealed a consistent trauma reaction pattern across the four different reaction with re-experiencing higher with mean score (mean =2.39) followed by negative alteration in cognition and mood (mean =2.22), avoidance (mean = 2.22) and hyper-arousal (Mean = 2.06). The findings from the sample of this study showed that trauma reactions are inevitable among participants who had gone through traumatizing experience in life. However, the trauma reactions were at lower degree across all the indicators of trauma reactions.

The result revealed a weak negative relationship between Posttraumatic stress disorder and posttraumatic growth ($p < 0.01$, $r = -.319$). This implies, as individual who had gone through traumatizing experience progresses in posttraumatic growth, the level of post-traumatic stress disorder will decrease with time. This implies, continues psychological and psychosocial assistance are considered as coping skills that facilitate posttraumatic growth.

5.2.4. Existing interventions used to address psychological distress among refugees in Nairobi County, Kenya

The fourth objective, which was a qualitative study sought to identify the existing interventions used in addressing the psychological distress among refugees in Nairobi County, Kenya. Findings from the 8 refugees and 5 staff members were enquired and recorded as below.

Responses to this question produced a list of far-reaching programmes designed to help alleviate the plight of refugees based on their unique needs at the point of entry into the programme. These responses from the participants indicated the various activities/ programmes organized by JRS for the refugees in Nairobi County. Themes emerging from their responses were categorized into open-door policy, education program, livelihood project, vocational skills (craft centre), psychosocial support, medical support, rent support and food provision. Qualitative narratives from the participants are evidences of the programmes designed to help alleviate the plight of the distress faced by refugees based on their unique needs at the point of entry into the programme. Another fact, which was revealed during the course of the interviews, was the recommendation of the staff about having a day school with children with disabilities. Having a special program for women and girls like micro finance program, for them will go a long way in helping them. Also teaching the women creativity, life skills (cooking and trading) and vocational studies, this will be beneficial to them.

Another issue raised by the participants as the most effective of all the programmes offered at JRS Nairobi threw up varied responses from different categories of participants. For example, the beneficiaries identified the scholarship programme as the most important, followed by the small scale/ livelihood project. Nevertheless, for the staff, all the programmes are effective because they address different issues presented by the refugees, for example, if it is in business, there is an enterprise development and the issue of loan to start a business; this helps them in terms of supporting them to be able to meet their daily needs. Counselling and psychosocial support, in particular, assist in addressing their mental health and reducing the stress of not being able to provide for their families when they are unable to do so. The participants from the beneficiary group were unable to name the least important of all the programs when asked.

5.3 Conclusion

The aim of this study was to assess the influence of psychological distress on post-traumatic growth among refugees in Nairobi County, Kenya. The study found a weak negative relationship between the level of depression and posttraumatic growth among the study sample. This means, as a traumatized individual improves in all the tenets of posttraumatic growth the level of depression decreases. The study found a moderate negative relationship between level of depression in spiritual change and appreciation of life respectively. This negative correlation indicates a low degree of correlation between the two variables. There is a weak negative relationship between level of anxiety and posttraumatic growth. This implies that when PTG improves, people experience a lower level of anxiety. The findings revealed a weak negative relationship between Posttraumatic stress disorder and posttraumatic growth. This implies, as individual who had gone through traumatizing experience progresses in posttraumatic growth, the level of post-traumatic stress disorder will decrease with time. Finally, the different intervention provided for the refugees (open-door policy, education program, livelihood project, vocational skills (craft-centre), psychosocial support, medical support, rent support and food provision) by JRS implies that continuous psychological and psychosocial assistance are considered as coping skills that facilitate posttraumatic growth.

5.4 Recommendations

Based on the findings of this study, the following recommendations were made:

- **Family:** From the quantitative study, the study established that as a traumatized individual improves in relationship with others, seeing new possibilities in life and personal strength, the level of depression, anxiety and PTSD will decrease. This means that the more individual improve in human relationship, the less symptoms of anxiety, depression and

PTSD is reported. The researcher recommends that family members should be supportive of each other as this brings about wellness.

- **JRS Center:** from the findings of the current study a host of factors contribute to the posttraumatic growth of refugees in urban area, who have experienced distressing situation over time. It was established during the study that the efforts of JRS in responding to their distress has also gone a long way in reducing the psychological distress brought by their distressing situation and thereby bringing about a stable mental health and posttraumatic growth experience. The researcher recommends that JRS should continue rendering these services to refugees.
- **Refugees:** from the findings of the study which reveals that refugees moved from their distressing situation to growth due to their exposure to different programmes and services. Therefore, this study recommend that refugees should be open to whatever programme is organized for them in order to enhance their wellbeing and livelihood.
- **NGOs and Government:** The study recommended that refugees be empowered by the government and non-governmental organizations to engage in small-scale businesses in order to enhance their livelihood. Alternatively, they can be empowered with a certain amount of loan to start a small business in line with their areas of specialization at the centre. This recommendation stems from the qualitative finding where the participants suggested that JRS provide cheques to students to do shopping and pay for their rent. Lack of support from NGOs and Government leaves some of the refugees vulnerable.
- **Counselling psychologists** – the findings of the current study suggested that refugees are psychologically distressed population (they experience anxiety, depression and PTSD). It also reveals that anxiety, depression and PTSD are natural emotional reactions to

distressing events. Therefore, counseling psychologist should collaborate with the government, other NGO's and agencies to offer free counselling services to refugees.

5.5 Suggested Areas for Further Research

Based on the current research findings, conclusions and the recommendations, this study has made greater contribution towards understanding the influence of psychological distress on posttraumatic growth among refugees in Nairobi, Kenya. However, there still exists knowledge gap, which may necessitate further studies. Thus, future research can be conducted in the following areas:

- i. A comparative study with other refugee facilities outside Kenya should be conducted to see if a new research methodology, other than embedded mixed method design, should be used.
- ii. Further research should focus on determining the effectiveness of the approaches and programmes used in addressing the psychological distress of refugees.
- iii. Another study could be carried out among refugees or displaced persons from different countries in sub-Saharan Africa to investigate if refugees in these countries have different experiences or not, and if they are exposed to the same programmes as provided by JRS.

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APPENDICES

Appendix 1: Verbatim instruction to Respondents

Dear respondents, this researcher intends to ask you questions which will require of you to give a detailed explanation of your understanding and experiences of psychological distress and posttraumatic growth. Kindly read the questions and you are free to ask questions or seek clarifications when you are not sure of the meaning of the question. Kindly give your honest response to these questions. Tick where appropriate.

Appendix II: Respondent's Consent Request Form

Introduction

My name is Henrietta Amen Usunobun, a postgraduate student in counselling psychology at the Catholic University of Eastern Africa. I am currently carrying out an academic research on **“Psychological Distress and Post Traumatic Growth among Refugees in Nairobi County, Kenya”**. Your contribution will help in the completion of this study.

I therefore request you to provide information on this topic to enable me achieve this goal. The information you provide will only be used strictly for academic purposes and treated with utmost confidentiality. Do I have your voluntary consent to proceed with the interview? YES (☐), NO (☐). If the respondent declines, s/he is NOT interviewed.

I agree to take part in this research exercise.

Signature Date of completion

Thank you for your support and contribution

Appendix III: Questionnaire for Respondents (Posttraumatic Stress Disorder Checklist (PCL5)

Section A: Demographic information

Instructions: Please read the following questions carefully and fill in the blank space or put a tick in the brackets () where appropriate.

1. **Age :** 18- 23 years (), 24 – 29 years (), 30 – 35 years (), 36 – 41 years(),
42- 47years (), 48-53 years (), 54 -59 years ().
2. **Gender :** Male () Female () others ()
3. **Religion:** Christian () Muslim () Hindu () Sikhs () Parsees () Bahais () African
Traditional Religion ATR() others ()

Section B: Trauma Reactions

Instructions: The table below list problems that people sometimes have in response to a very stressful experience. **Keeping your worst event in mind** please read each problem carefully and then circle one of the numbers to the right to indicate how much you were bothered by that problem in the past month following your experience.

In the past month, how much were you bothered by	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening	0	1	2	3	4

again (as if you were actually back there reliving it)?					
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience (e.g. heart pounding, trouble breathing, sweating)?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4

14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	0	1	2	3	4
15 Irritable, (undefined) behaviour, angry outburst, or acting aggressively?	0	1	2	3	4
16. Taking too many risk or doing things that could cause you harm?	0	1	2	3	4
17. Being “super alert” or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4

Section C: Posttraumatic Growth Inventory (PTGI)

Instructions: Indicate for each of the statements below the degree to which this change occurred in your life as a result of your experience using the following scale of 0-5.

0= I did not experience this change as a result of my crisis.

1= I experienced this change to a very small degree as a result of my crisis.

2= I experienced this change to a small degree as a result of my crisis.

3= I experienced this change to a moderate degree as a result of my crisis.

4= I experienced this change to a great degree as a result of my crisis.

5= I experienced this change to a very great degree as a result of my crisis.

Statements

1. I changed my priorities about what is important in life. ()
2. I have a greater appreciation for the value of my own life. ()
3. I developed new interests. ()
4. I have I changed my priorities about what is important in life. ()
5. I have a better understanding of spiritual matters. ()
6. I more clearly see that I can count on people in times of trouble. ()
7. I established a new path for my life. ()
8. I have a greater sense of closeness with others. ()
9. I am more willing to express my emotions. ()
10. I know better that I can handle difficulties. ()
11. I am able to do better things with my life. ()
12. I am better able to accept the way things work out. ()
13. I can better appreciate each day. ()
14. New opportunities are available which wouldn't have been otherwise. ()
15. I have more compassion for others. ()
16. I put more effort into my relationships. ()
17. I am more likely to try to change things which need changing. ()
18. I have a stronger religious faith. ()
19. I discovered that I'm stronger than I thought I was. ()
20. I learned a great deal about how wonderful people are. ()
21. I better accept needing others. ()

Section D: Depression, anxiety, stress scale

Instructions: Please read each statement and circle a number which indicates how much the statement applied to you over the past week. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

0 = Did not apply to me at all

1 = Applied to me to some degree, or some of the time

2 = Applied to me to a considerable degree or a good part of time

3 = Applied to me very much or most of the time

1. I was aware of dryness of my mouth	0	1	2	3
2. I couldn't seem to experience any positive feeling at all	0	1	2	3
3. I experienced breathing difficulty (e.g. excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3
4. I found it difficult to work up the initiative to do things	0	1	2	3
5. I experienced trembling (e.g. in the hands)	0	1	2	3
6. I was worried about situations in which I might panic and make a fool of myself	0	1	2	3
7. I felt that I had nothing to look forward to	0	1	2	3
8. I felt down-hearted and blue	0	1	2	3
9. I felt I was close to panic	0	1	2	3
10. I feel scared without any good reason	0	1	2	3
11. I felt I wasn't worth much as a person	0	1	2	3
12. I was unable to become enthusiastic about anything	0	1	2	3
13. I was aware of the action of my heart in the absence of physical exertion (e.g. sense of heart rate increase heart missing a beat)	0	1	2	3
14. I felt that life was meaningless	0	1	2	3

Appendix IV: Interview Guide for Staff

Interventions used in addressing psychological distress among refugees

Following your experience of the refugees

Question : What are some of the interventions used in addressing the psychological distress of refugees in your agency?

- a) List some of them
- b) Which is more effective?
- c) Which are least important for the refugees?
- d) Which other areas do you think could be focused on to improve the intervention given?
- e) Could you recommend any additional program that could be beneficial to the refugees?

Appendix V: Interview Guide for Refugees

Interventions used in addressing psychological distress among refugees

Following your experience as a refugees

Question: What are some of the interventions used in addressing the psychological distress of refugees by this agency?

- a. List some of them
- b. Which of these programmes do you think are more effective?
- c. Which are least important for the refugees?
- d. Which other areas do you think could be focused on to improve the intervention given?
- e. Could you recommend any additional program that could be beneficial to the refugees?

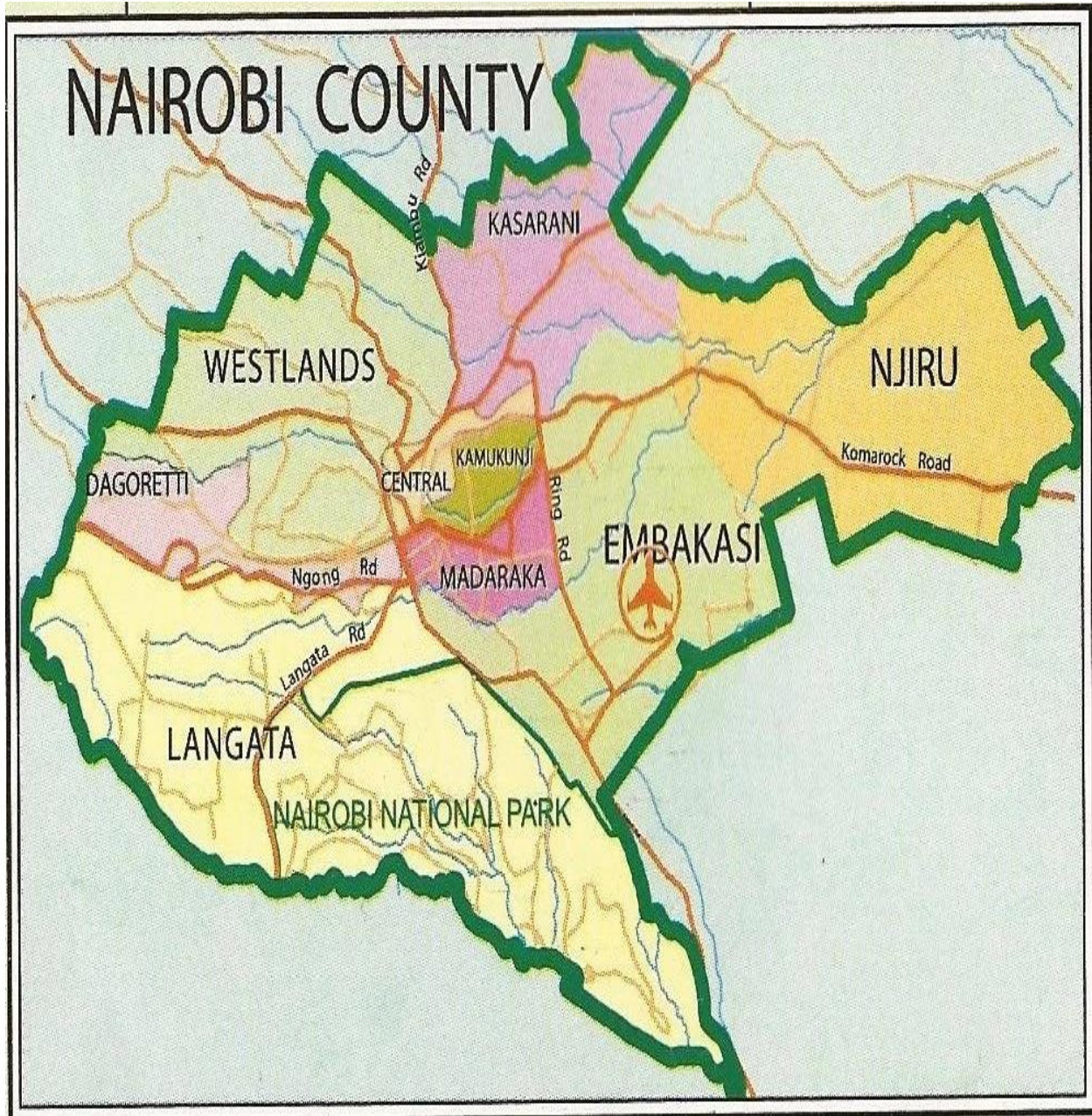
Appendix VI: Research Budget

Item	Cost in Kenyan shillings
Stationary	20,000
Research License	3,000
Research Assistants @ 15000	60,000
Data Analysis	65,000
Transport	30,000
Editing (Professional)	80,000
Final Report	70,000
Miscellaneous	30,000
Total	358,000

Appendix VII: Research Schedule

Activity	Aug - Sept 2020	Oct 2020	Oct - Jan 2021	Feb 2021	Feb - Mar 2021	Apr May 2021	May June 2021	June - July 2021	July - Aug 2021
Topic development	❖								
Concept Defence		❖							
Proposal Dev.			❖						
Proposal Defence				❖					
Research License					❖				
Pilot study						❖			
Data Collection							❖		
Data Analysis								❖	
Final Report writing & Submission									❖

Appendix VIII: Map of Nairobi County



Source: Google maps 2021

Appendix IX: Permission to use the DASS-21 Scale

From : Peter Lovibond <p.lovibond@unsw.edu.au

1/23/2021 3:17 AM

To: hettybaby82@yahoo.com

Dear Henrietta,

You are welcome to use the DASS in your research. You can download the questionnaires (including translations in certain languages) and scoring key from the DASS website www.psy.unsw.edu.au/dass/. Please also see the FAQ page on the website for further information.

Best regards,

Peter Lovibond

Dr. S.H Lovibond and Dr. Peter F. Lovibond

Psychology foundation of Australia

Sydney, N.S.W

Appendix X: Permission to use the PCL-5 Instrument

From: Angkaw, Abigail Abigail.Angkaw@va.gov

1/21/2021 10:11 PM

To: hettybaby82@yahoo.com Cc: PTSDConsult

Hi Henrietta,

Thank you for reaching out regarding the PCL-5. It is great to hear that you are considering using this measure in your work. This measure was developed by US government employees and is therefore in the public domain, not copyrighted, and free to use by qualified health professionals.

<https://www.ptsd.va.gov/professional/assessment/adult-sr/ptsd-checklist.asp>

Warm regards,

Abigail

Abigail C. Angkaw, Ph.D.

Section Chief, Impact Unit 6, VA San Diego Healthcare System

Consultant, PTSD Consultation Program, National Center for PTSD

Associate Clinical Professor of Psychiatry, University of California, San Diego

Office: 619-680-1720

VA cell: 858-378-5407



866-948-7880 or PTSDconsult@va.gov

<http://www.ptsd.va.gov/professional/consult/>

Appendix XI: Permission to use PTGI instrument

From: [Rich Tedeschi](#)

Sent: Monday, January 25, 2021 1:40 AM

To: [Henrietta Amen](#)

Subject: Re: Permission to use the PTGI instrument

Yes, you have my permission.



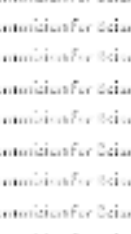


Richard G. Tedeschi, Ph.D.

Distinguished Chair

Boulder Crest Institute for Posttraumatic Growth

Bluemont, VA

Appendix XII: Research Permit from NACOSTI

 <p>REPUBLIC OF KENYA</p>	 <p>NATIONAL COMMISSION FOR SCIENCE, TECHNOLOGY & INNOVATION</p>
<p>Ref No: 345248</p>	<p>Date of Issue: 09/April/2021</p>
<p align="center">RESEARCH LICENSE</p>	
<p>This is to Certify that Dr. HENRIETTA AMEN USUNOBUN of Catholic University of Eastern Africa, has been licensed to conduct research in Nairobi on the topic: PSYCHOLOGICAL DISTRESS AND POST TRAUMATIC GROWTH AMONG REFUGEES IN NAIROBI COUNTY KENYA for the period ending : 08/April/2022</p>	
<p>License No: NACOSTI/21/0464</p>	<p>Applicant Identification Number: 345248</p>
<p>NOTE: This is a computer generated license. To verify the authenticity of this document, Scan the QR Code using QR scanner application.</p>	<p>Signature of Director General: </p> <p>DIRECTOR GENERAL NATIONAL COMMISSION FOR SCIENCE, TECHNOLOGY & INNOVATION</p>
<p>Verification QR Code</p>	

Appendix XIII: Letter of Introduction from Catholic University of Eastern Africa



THE CATHOLIC UNIVERSITY OF EASTERN AFRICA

Faculty of Arts and Social Sciences

Department of Counseling Psychology

Our Ref: CUEA/DVC-ACAD/FASSc/Psychology/NACOSTI/003/March 2021

Date: 15th March 2021

TO WHOM IT MAY CONCERN

Dear Sir/Madam

RE: HENRIETTA AMEN USUNOBUN REG.NO. 1039714

I am writing to introduce to you **Henrietta Amen Usunobun** who is a final year Master's Degree student at The Catholic University of Eastern Africa, Nairobi – Kenya, and to request you to assist her to accomplish her academic research requirements.

Henrietta's Master's Degree specialization is in Counseling Psychology. She has completed all course work requirements for this programme. However, every student in the programme is required to conduct research and write a report/thesis submitted during the final years of studies.

Accordingly, Henrietta's research topic has been approved. She will conduct research on the following topic:

"Psychological Distress and Post Traumatic Growth among Refugees in Nairobi County, Kenya"

Thanking you in advance for any assistance you give to Henrietta.

Sincerely,

**Dr. Stephen Asatsa,
HOD, PSYCHOLOGY**



THE CATHOLIC UNIVERSITY OF EASTERN AFRICA (CUEA) P.O. BOX 62157 00200 Nairobi – KENYA
Tel: 020-2525811-5, 8890023-4, Fax: 8891084, Email: psychology@cuea.edu, Website: www.cuea.edu
Founded in 1984 by AMECEA (Association of the Member Episcopal Conference in Eastern Africa)

Appendix XIV: Plagiarism Report

7/7/2021

1039714 HENRIETTA USUNOBUN.docx (07/05/2021, 08:22 AM)

PlagScan | PRO

Filename: 1039714 HENRIETTA USUNOBUN.docx Date: 07/05/2021, 08:22 AM

Results of plagiarism analysis from 07/05/2021, 08:55 AM

This report is in the account of pmwaniki@cua.edu

766 matches from 101 sources, of which 71 are online sources. Plagiarism level: 2.2%

Showing best match per source - click on match to display all matches or on URL to show source.

56 matches from <https://stars.library.ucf.edu/cgi/viewcontent.cgi?article=6071&context=etd>

The PTGI is a ... self-report scale which is scored on a six-point scale from 0 I did not experience this change as a result of my crisis to 5 I experienced this change to a very great degree as a result of my crisis ...

29 matches from https://digitalcommons.odu.edu/cgi/viewcontent.cgi?article=1028&context=chs_etds

Most often this relates to ... close family members ... as they may serve as supports to one another through the traumatic event but the experience of a greater connectedness with others may extend beyond close family and friends Calhoun et al ...

18 matches from <https://core.ac.uk/download/pdf/268799283.pdf>

(+ 1 document with identical matches)

However meaning made and social support were not significant moderators on the relationship between number of traumatic life events and PTSD and depression as well as the relationship between negative outcomes and PTG ...

18 matches from <https://www.mdpi.com/2254-9625/10/1/28/pdf>

(+ 1 document with identical matches)

This is consistent with findings found in 2 630 Asian participants from Malaysia Indonesia Singapore Taiwan and Thailand who after removing three items identified a three-factor structure DASS-18 ...

13 matches from <https://dsc.duq.edu/cgi/viewcontent.cgi?article=2493&context=etd>

... extensive research on PTG has been done on the American European and Asian continents but not ... on the African continent and ... universal phenomenon may ... depending on the ... on the frequency intensity and scope of the trauma ... as well as the ... socioeconomic status SES ... status SES and other benefits and risk factors ...

22 matches from <https://www.hindawi.com/journals/ism/2012/937582/>

The PTGI is a ... 0 I did not experience this change as a result of my crisis to 5 I experienced this change to a very great degree as a result of my crisis ...

18 matches from https://www.researchgate.net/publication/338450572_Depression_Anxiety_and_Stress_Scales_DASS-21_Construct_Vaildity_Problem_in_Hispanics

This is consistent with ... found in 2 630 Asian participants from Malaysia Indonesia Singapore Taiwan and Thailand who after removing three items ... a three-factor structure DASS-18 ...

18 matches from <https://reference.medscape.com/calculator/684/post-traumatic-stress-disorder-pcl-5>

... Suddenly feeling or acting as if the stressful experience were actually happening again as if you were actually back there reliving it ...

18 matches from <https://onlinelibrary.wiley.com/doi/10.1002/emp2.12305>

... Suddenly feeling or acting as if the stressful experience were actually happening again as if you were actually back there reliving it ...

20 matches from [https://theses.whiterose.ac.uk/26207/1/JULIANA_TIPOKERE_TSEPIISO_MUNLO_THESIS_ONLINE_SUBMISSION_FEBRUARY_2020_\(1\).pdf](https://theses.whiterose.ac.uk/26207/1/JULIANA_TIPOKERE_TSEPIISO_MUNLO_THESIS_ONLINE_SUBMISSION_FEBRUARY_2020_(1).pdf)

... I am more likely to try to change things which need changing ...

19 matches from <https://militaryreach.auburn.edu/DetailResult?resourceid=f2697c32-f5eb-469c-8a13-3c332a15cdde&resType=resSum>

... I have a greater appreciation for the value of my own life ...

15 matches from

https://www.researchgate.net/publication/5447305_The_factor_structure_of_the_Posttraumatic_Growth_Inventory_A_comparison_of_five_models_using_confirmatory_factc

... Various international organisations have identified the development of programmes that mitigate the negative impact that forced displacement has on refugees mental health as a priority intervention area ...

16 matches from https://www.researchgate.net/publication/327861358_Post-traumatic_growth_in_the_military_a_systematic_review_accepted

... higher levels of social support spirituality and rumination and minority ethnicity were most frequently associated with more post-traumatic growth ...

10 matches from

https://www.researchgate.net/publication/327369341_Relationship_between_Initial_Trauma_Processing_Strategies_and_Posttraumatic_Growth_among_Survivors_of_Gazi

The study further found that participants who attended between 5 and 10 counseling sessions after the attack reported the highest ... growth while those who ... critical incident debriefing ... the lowest growth ...

14 matches from https://www.researchgate.net/publication/26652367_A_short_form_of_the_Posttraumatic_Growth_Inventory

... on a six-point scale ... 0 I did not experience this change as a result of my crisis ... 5 I experienced this change to a very great degree as a result of my crisis ...

16 matches from <https://www.careinnovations.org/wp-content/uploads/Post-Traumatic-Growth-Inventory.pdf>

... I have a greater appreciation for the value of my own life ...

15 matches from <https://positivepsychology.com/post-traumatic-growth/>

... I have a greater appreciation for the value of my own life ...

9 matches from https://www.researchgate.net/publication/310831250_War_Trauma_Anxiety_and_Resilience_among_University_Students_in_the_Gaza_Strip

... and forced to ... forced to move from home to a safer place during the war 42 ...

13 matches from https://digital.lib.washington.edu/researchworks/bitstream/handle/1773/23355/Keidar_washington_0250O_11866.pdf?isAllowed=y&sequence=1

<https://www.plagscan.com/report?140130086&sharekey=QUm76VQM6aHmrm37EIP>

1/5

APPENDIX XV: Journal



JRRIE Journal of Research Innovation
and Implications in Education
**Center for Research
Implications & Practice**

Website: www.jrrijournal.com

SSN 2520-7504 (Online) Vol.5, Iss.3, 2021 (pp. 26 - 37)

Influence of Posttraumatic Growth on Posttraumatic Stress Disorder among Refugees in Nairobi County, Kenya

Henrietta Amen Usunobun, Dr. Stephen Asatsa & Dr. Elijah Macharia

The Catholic University of Eastern Africa

Corresponding author: hettyamen@gmail.com

Abstract: Most refugees have frequently been subjected to a variety of potentially traumatic events, which have a wide range of negative consequences for their mental health and quality of life. However, some have also reported positive personal changes, and post-traumatic growth related to these potentially distressing events. This study was restricted only to Nairobi County, which accommodates most of the urban refugees in Kenya (UNHCR, 2020). The study used a simple random sampling technique for the quantitative strand and purposive/convenient sampling technique for the qualitative strand to select respondents. A sample of 133 respondents, which was determined using Yamane's formula, was selected. Quantitative data were collected using standardized questionnaires; the 21-item posttraumatic growth inventory (PTGI) and 20-item Posttraumatic stress disorder checklist (PCL-5). This study adopted the embedded mixed method research design by combining correlational and phenomenological research design. The study revealed a weak negative relationship between Posttraumatic stress disorder and posttraumatic growth ($p < 0.01$, $r = -.319$). This implies, as individual who had gone through traumatizing experience progress in posttraumatic growth, the level of post-traumatic stress disorder decreases with time. This indicates that continuous psychological and psychosocial assistance are considered as coping skills that facilitate posttraumatic growth.

Keywords: Coping skills, Influence, Posttraumatic Stress disorder, Post traumatic growth, Refugees, Nairobi County, Kenya

How to cite this work (APA):

Usunobun, H.A., Asatsa, S. & Macharia, E. (2021). Influence of posttraumatic growth on posttraumatic stress disorder among refugees in Nairobi County, Kenya. *Journal of Research Innovation and Implication in Education*, 5(3), 26 - 37.

1. Introduction

The influx of refugees in the 21st century is on the rise due to overwhelming experiences brought by political, social, economic and environmental factors, which have left those affected psychologically distressed and traumatized.

According to the global report of the United Nations Refugee Agency, the number of people displaced from their home countries due to war, armed conflict, political violence, and related threats is growing. Indeed, if current trends continue, one in every 100 persons will soon be a refugee (UN Refugee Agency, 2016). Kenya's refugees and asylum seekers come from a diverse range of

Appendix XVI: JRS Memorandum of Understanding



MEMORANDUM OF UNDERSTANDING

between

Jesuit Refugee Service – Kenya

and

Henrietta Amen Usunobun

The mission of the Jesuit Refugee Service is to Accompany, Serve and Advocate for the rights of refugees and other forcibly displaced persons. As a Catholic organization and a work of the Society of Jesus, JRS is inspired by the compassion and love of Jesus for the poor and excluded. Its service is direct, pastoral, human and exposed to the sufferings and limitations of refugee life.

This document establishes the basic terms and conditions in support of providing access to information and data to facilitate completion of a Master's degree research for Henrietta Amen Usunobun. The basic terms are as follows:

Goals and objectives

The purpose of this agreement is to support **Henrietta Amen Usunobun** for her academic research as a final year master's degree student at the Catholic University of Eastern Africa, Nairobi -Kenya

JRS Responsibility :

1. Facilitate access to beneficiaries for data collection through interviews.
2. Provide space for conducting interview within JRS premises.

Henrietta Amen Usunobun Responsibility

1. Conduct interviews and administer questionnaire to beneficiaries.
2. Share the data and information collected with the JRS coordinator.

Consensus of Publication

In the event that the result of this research is to be published, JRS needs to be informed in advance and grant its consensus.

Confidentiality: Except with the prior written consent of JRS and the persons of concern, you will not at any time communicate to any person or entity any confidential information disclosed for the purpose of your services, or discovered in the course of the data collection, nor shall you make any information public as to the recommendations formulated in the course of or as a result of your services.

Code of Conduct & Child Protection Policies

The Religious hereby undertakes to abide by all JRS policies and procedures as a condition of this agreement including those contained within the attached Code of Conduct & Child Protection Policy and those that may come into force after the signing of this Agreement. Failure to do so may result in disciplinary action, resulting in sanctions up to and including termination of the agreement in cases where the complaint is upheld. In particular, this contract shall be deemed null and void unless and until the attached JRS Code of Conduct and Child Protection Policy are signed and abided by.

I hereby declare that I am aware, understand the conditions of employment stipulated above, and confirm that I accept the same.

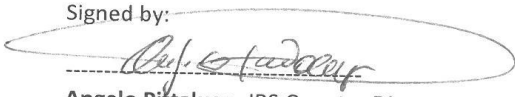
Name: Sr. Henrietta Amen Usunobun

Signature: 

Date: 26th March 2021

This agreement is made on 26th March 2020 at Nairobi

Signed by:



Angelo Pittaluga, JRS Country Director – Kenya

Jesuit Refugee Service - Kenya, Gitanga Road, P.O. Box 76490, Nairobi 00508, Kenya
Phone +254 (0)20 3874152 | Fax +254 (0)20 3871905 | Mobile +254 (0)722 788814
Email ken01.director@jrs.net | Website www.jrsea.org