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Original Paper

Virginia Satir's Model Treatment and Coping Mechanisms among 2007/08 Post Election Violence Integrated Internally Displaced Persons in Thika Sub-County, Kenya

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Abstract

Kenya experienced post-election violence in 2007/2008; leaving 1,113 people dead and over 650,000 people displaced from their homes. The purpose of the study therefore, was assessment of effectiveness of Virginia Satir's Model in trauma recovery of 2007/08 Post Election Violence Integrated Internally Displaced Persons in Thika Sub County in Kiambu County. The study used quasi-experimental research design in which the researcher used Solomon's Four Non-equivalent Control Group Design. The researcher sampled 125 participants from the accessible 240 Integrated Internally Displaced Persons from Kiandutu, Kiganjo, Gachagi and Umoja slum villages in Thika Sub County who formed the four groups of study. The control groups were taken through regular counseling model while the experimental groups were exposed to Virginia Satir's Model. Quantitative methods of data analysis involving the use of Analysis of Variance and t-test was used to list statistical significant difference within and among means in the posttest scores for the groups. Computations were conducted using Statistical Package for Social Sciences version 21 for windows. The researcher established that the Virginia Satir's Model had minimal effect on enhancing coping mechanisms among IIDPs.

Keywords

Virginia Satir's Model, Integrated Internally Displaced Persons, coping mechanisms, post-election violence

1. Introduction

Research on World Mental Health (WMH) assessing Post-Traumatic Stress Disorder (PTSD) following natural and human-made disasters has been undertaken for more than three decades. WHO World Mental Health Surveys in 24 countries (n = 68,894) assessed 29 lifetime traumas and evaluated PTSD twice for each respondent: once for the "worst" lifetime trauma and separately for a randomly-selected trauma with weighting to adjust for individual differences in trauma exposures. PTSD onset-persistence was evaluated with the WHO Composite International Diagnostic Interview. In total, 70.4% of respondents experienced lifetime traumas, with exposure averaging 3.2 traumas per capita. Substantial between-trauma differences were found in PTSD onset but less in persistence. Traumas involving interpersonal violence had highest risk. Burden of PTSD, determined by multiplying trauma prevalence by trauma-specific PTSD risk and persistence, was 77.7 person-years/100 respondents. The trauma types with highest proportions of this burden were rape (13.1%), other sexual assault (15.1%), being stalked (9.8%), and unexpected death of a loved one (11.6%). The first three of these four represent relatively uncommon traumas with high PTSD risk and the last a very common trauma with low PTSD risk. The broad category of intimate partner sexual violence accounted for nearly 42.7% of all person-years with PTSD. Past trauma history predicted both future trauma exposure and future PTSD risk. In conclusion, trauma exposure is common throughout the world, unequally distributed, and differential across trauma types with respect to PTSD risk. Although a substantial minority of PTSD cases remits within months after onset, mean symptom duration is considerably longer than previously recognized (Kessler et al., 2015). The researcher in this study did a baseline pre test for PTSD before adminstering VSM treatment.

The result of PEV 2007/08 was collective trauma that left many Kenyans angry, bitter, frustrated, confused, insecure, suspicious of one another, and very anxious about the future. According to a study done by the African Mental Health Foundation, 18% of the youth in Kibera developed chronic PTSD after PEV 2007/2008. Kibera currently known as Kibra is an informal settlement in the capital city of Nairobi, Kenya. Kibra is considered as one of the hot spots for pre and post -election violence in Kenya. More than 600 people were killed in North Rift following the post-election violence. North Rift is also considered as a very volatile region in the history of prone political violence region after security mapping. The people who witnessed the atrocities like torching of houses and other properties, murder of innocent people and children were highly traumatized (Waki R., 2008). PEV 2007/08 remains the most traumatic post-election violence in Kenya hence calling for serious mental health intervention strategies.

There are trauma models like cognitive behavior therapy, Eye Movement Desensitization and Reprocessing (EMDR), trauma focused counseling among other traditional individual and group theories that have been largely mentioned and applied in trauma situations. There are limited reports showing assessment of systemic therapy's effectiveness in trauma healing. It was against this background that this study sought to assess the effectiveness of Virginia Satir's Model in trauma

counseling of the 2007/08 IIDPs. Virginia Satir started family camps in 1976 to promote both individual and systemic self-actualization by raising members' self-esteem's focused on raising individual consciousness, personal esteem and promotion of world peace. Satir's work has been adopted in practice by many therapists and edited by many scholars since her death in 1988. The model was tested with political work in California Task Force that promoted self-esteem, inner peace, joy, personal and social responsibility of people's from all sectors of society (Satir V. M., The therapist and family therapy, 2000). By the time Virginia Satir died, there were established professional training groups in the Middle East, Asia, Western and Eastern Europe, Central and Latin America and Russia. This showed that the model worked in multicultural settings hence worth trying in related studies in Kenya.

2. Literature Review

A traumatized individual affects those around him/her, especially the immediate family, workmates and friends. Therefore, trauma needs to be viewed not only from an individual and family perspective, but also from a community perspective. This would necessitate the combined use of trauma theory, family therapy theory and community family therapy approaches. The response to trauma becomes the adapted behavior of traumatized clients if timely help is not offered. The affected cease to live productive lives in the face of triggers or fear of recurrent trauma incidence(s). Numerous studies document an association between posttraumatic stress disorder and impairments in intimate relationship functioning, and there is evidence that PTSD symptoms and associated impairments are improved by cognitive-behavioral conjoint therapy for PTSD (Myer & Priozie, 2013).

A fast-growing population of refugees and survivors of violent conflict and atrocities are at risk for trauma-related mental health problems. Experimental clinical research key to the development of interventions tailored to this population is limited. In an experimental psychopathology laboratory paradigm, researchers tested the expression and function of avoidance in Posttraumatic Stress (PTS) among a highly traumatized community sample of forcibly displaced refugees seeking asylum. They measured behavioral avoidance and emotional reactivity to repeated exposure to threatening stimuli (trauma-, war-, and geographically-relevant natural threat) in 110 Sudanese male asylum seekers ($M(SD)_{age}$ = 32.7(6.5) recruited from the community in Israel. Evidence of sensitization-traumatized refugees expressed increasing levels of behavioral avoidance and emotional reactivity in response to repeated exposure to threatening stimuli. Second, as predicted, refugees suffering from more severe PTS were more likely to exhibit greater behavioral avoidance and emotional reactivity reflexively or immediately upon exposure to threat stimuli. Finally, as predicted, behavioral avoidance mediated the effect of PTS severity on emotional reactivity to threat exposure. Findings were consistent with theorizing that avoidance may function as a trans-cultural malleable risk process sub-serving PTS and thereby a promising intervention target among highly traumatized refugees from Eastern Africa (Yuval,

Zvielli, & Bernstein, 2017, Attentional bias dynamics and posttraumatic stress in survivors of violent conflict and atrocities: New directions in clinical psychological science of refuge mental health).

A study carried out in 2012 investigated changes across treatment in clinician-rated PTSD symptom clusters and patient-rated trauma-related cognitions in a randomized controlled trial comparing CBCT for PTSD with waitlist in a sample of 40 individuals with PTSD and their partners. Compared with waitlist, patients who received CBCT for PTSD immediately demonstrated greater improvements in all PTSD symptom clusters, trauma-related beliefs, and guilt cognitions (Macdonald, Pukay-Martin, Wagner, Fredman, & Monson, 2016). The most important task of a counselor is listening to the client's trauma story especially when they really need to talk about it. Trauma clients attach varied and in most cases negative meaning to their trauma stories; the counselor's work is to help them attach positive meaning that can help them move on with life positively. Trauma has its own stigma and many traumatized individuals would rather keep quiet about it. Positive publicity and involvement through community activities would be of help to hasten the process of self-awareness and acceptance and subsequently improve health seeking behavior. Some communities in Uganda are still carrying out cleansing rituals to heal the victims and perpetrators of war so they can be readmitted into the community (Sebit, 2013; Whiston, 2009). This means trauma takes a long time to heal and the traumatized people need external support in the healing process.

Clinical trials assist in determining effectiveness of evidence based interventions. For example, the US Preventive Services Task Force recommended that clinicians refer obese adult clients to intensive multi-component behavioral counseling programs rather than leave them on self-help programs after a study to compare the two showed a 5% higher success rate for the former in weight loss (Johnson, 2008). A study by University of Chicago Crime Lab carried out between 2009-2010 with 800 boys showed 44% decline in violent crime arrests and greater engagement by participants long after the counseling and mentoring program (UOC, 2012). A randomized trial describes health conditions and health-related characteristics of populations. This study sought to promote evidence based trauma intervention through pre and post testing of PTSD before and after treatment respectively. This was to establish the difference in participants' coping mechanisms before and after treatment (Witing, Jensen, & Brown, 2016). The counseling centers in Kenya carry out community out-reach services alongside training and supervision of counselors.

Peter C, Alderman's Foundation in partnership with city council public health services in Kenya has established community based mental health services in Uganda and Kenya. The main aim is to assist local communities to understand mental health issues affecting them and to be of help to the community members affected (Musisi, 2005; Lewis, 2003). Gender Violence Recovery Centres offer psychosocial support to survivors of gender based violence and their families in Nairobi County. Community counseling is offered in form of awareness creation, advocacy and debriefing sessions. In April 2009-March 2010, 2521 survivors received help in Nairobi Women's Hospital. There is need to try the effectiveness of these trauma interventions to find out their therapeutic effect on PTSD recovery.

A randomized control experiment elucidates the etiology of and risk factors for any health issue (Lewis, 2003). In this study, IIDPs in the experimental groups were tested before and the effect of new VSM Gitau model on trauma recovery was tested. The aim was to promote evidence based intervention of PTSD cases.

A significant proportion of trauma survivors experience an additional critical life event in the aftermath. These renewed experiences of traumatic and stressful life events may lead to an increase in trauma-related mental health symptoms. In a longitudinal study, the effects of renewed experiences of a trauma or stressful life event were examined. For this purpose, refugees seeking asylum in Germany were assessed for Posttraumatic Stress Symptoms (PTS), Posttraumatic Stress Diagnostic Scale (PDS), anxiety, and depression (Hopkins Symptom Checklist [HSCL-25]) before treatment start as well as after six and twelve months during treatment (N = 46). Stressful life events and traumatic events were recorded monthly. If a new event happened, PDS and HSCL were additionally assessed directly afterwards. Mann-Whitney U-tests were performed to calculate the differences between the group that experienced an additional critical event (stressful vs. trauma) during treatment (n = 23) and the group that did not (n = 23), as well as differences within the critical event group between the stressful life event group (n = 13) and the trauma group (n = 10). Refugees improved significantly during the 12-month period of our study, but remained severely distressed. In a comparison of refugees with a new stressful life event or trauma, significant increases in PTS, anxiety, and depressive symptoms were found directly after the experience, compared to the group without a renewed event during the 12 months of treatment. With regard to the different critical life events (stressful vs. trauma), no significant differences were found regarding overall PTS, anxiety, and depression symptoms. Only avoidance symptoms increased significantly in the group experiencing a stressful life event. Although all clinicians should be aware of possible PTS symptom reactivation, especially those working with refugees and asylum seekers, who often experience new critical life events, should understand symptom fluctuation and address it in treatment (Shock, Bottche, Rosner, Wenk-Ansohn, & Knaevelsrud, 2016).

Many traumatized individuals and communities find it hard to get answers to their distress and are stuck in life. Frankl asserts that, the way traumatic experience is handled can be a catalyst for growth and transformation and past emotional wounds can be transformed into wisdom (Frankl, 2012). The question that is not yet answered to date is whether PEV 2007/08 IIDPs survivors and victims have found meaning in their experience and adapted to life productively. This study sought to assess the new ways of coping for IIDPS herein referred to as coping mechanisms after trauma recovery.

According to the Satir's model, the pain people experience is the result of the way they manage their perceptions, expectations, emotions, and behaviors. By focusing on three primary areas; the Intra psychic System (intrapersonal), the Interactive System (interpersonal), and the Family of Origin System, traumatized people can examine their experiences and relationships, develop goals, and work toward change (Johnson & Thompson, 2008). While people cannot change what happened in the past, they can change how those past events affect them in the present. By resolving past trauma they can live with

more positive energy and do the best they can at any given time (Atkinson, 2009; Evans & Coccoma, 2014). Even destructive or otherwise negative behaviors serve to indicate the best coping behavior possible at that time. When IIDPs were put in charge of their emotions, thoughts and behaviors; they had a choice to hold onto positive feelings, thoughts and subsequent behaviors which provided validation and letting go of negative experiences (Corcoran & Pillai, 2009; Levers, Trauma counseling: Theories and interventions, 2012).

Virginia Satir's model is a humanistic brief therapy that focuses on the here and now and seeks to get immediate working solutions. Only one meta-analytic study examining the effectiveness of Solution-Focused Brief Therapy (SFBT) was done in 1988 to 2005. This meta-analysis included a sample of twenty-two distinctive studies. Findings from this meta-analysis demonstrated small but positive treatment effects favoring solution focused behavior therapy group on the outcome measures (d = 0.13 to 0.26). Only the magnitude of the effect for internalizing behavior problems was statistically significant at the $p < .05$ level, thereby indicating that the treatment effect for SFBT group is different than the control group. Two reviews of controlled outcome studies of were undertaken in 2000 and 2009 respectively. Each of these reviews noted the methodological limitations of the studies examined, but there was a consistent finding for the efficacy of solution-focused brief therapy (Corcoran & Pillai, 2009). About 50 percent of the studies reviewed showed improvement over alternative conditions or no-treatment control. Three randomized control studies were also located pertaining to the effectiveness of solution-focused brief therapy (Corcoran & Pillai, 2009; Kane et al., 2016). In this study, the researcher assessed the significant effect of Gitau's VSM in PTSD recovery among the IIDPs following the 2007/08 post-election violence.

Individuals with PTSD may have other life threatening issues or stressors in life that may complicate PTSD recovery. Traumatized refugees often report significant levels of chronic pain in addition to posttraumatic stress disorder symptoms, and more information is needed to understand pain in refugees exposed to traumatic events. A study aimed to assess the frequency of chronic pain among refugee psychiatric outpatients, and to compare outpatients with and without chronic pain on trauma exposure, psychiatric morbidity, and psychiatric symptom severity. Traumatized refugees often report significant levels of chronic pain in addition to posttraumatic stress disorder symptoms, and more information is needed to understand pain in refugees exposed to traumatic events. This study aimed to assess the frequency of chronic pain among refugee psychiatric outpatients, and to compare outpatients with and without chronic pain on trauma exposure, psychiatric morbidity, and psychiatric symptom severity. A cross-sectional study of sixty-one psychiatric outpatients with a refugee background using structured clinical diagnostic interviews to assess for traumatic events [Life Events Checklist (LEC)], PTSD (Posttraumatic Stress Disorder) and complex PTSD [Structured Clinical Interview for DSM-IV PTSD Module (SCID-PTSD) and Structured Interview for Disorders of Extreme Stress (SIDES)], chronic pain (SIDES Scale VI) and psychiatric symptoms [M.I.N.I. International Neuropsychiatric Interview (M.I.N.I.)]. Self-report measures were used to assess symptoms of posttraumatic stress [Impact of Event

Scale-revised (IES-R)], depression and anxiety [Hopkins Symptom Checklist (HSCL-25)] and several markers of acculturation in Norway.

Out of the 61 outpatients included, all but one reported at least one chronic pain location, with a mean of 4.6 locations per patient. Chronic pain at clinical levels was present in 66% of the whole sample of outpatients, and in 88% of the outpatients with current PTSD diagnosis. The most prevalent chronic pain locations were head (80%), chest (74%), arms/legs (66%) and back (62%). Women had significantly more chronic pain locations than men. Comorbid PTSD and chronic pain were found in 57% of the outpatients. Significant differences were found between outpatients with and without chronic pain on posttraumatic stress, psychological distress, and DESNOS severity. In conclusion chronic pains were seen to be common in multi-traumatized refugees in outpatient clinics in Norway, and were positively related to symptomatology and severity of psychiatric morbidity (Teodorescu, Heir, Hauff, Wentzel-Larsen, & Lien, 2012). In this study, the researcher sought to find out the coping mechanisms of the IIDPs after the new Gitau's VSM treatment holding all other factors constant.

3. Methodology

This study was a quasi-experimental research in which the researcher used Solomon's Four Non-equivalent Control Group Design suitable for pretest and posttest studies (Kothari, 2004; Martin, 2009; Thayer & Martha, 2009). A baseline survey on IIDPs living in Thika that was conducted by Community Counseling Resource Centre in 2012 showed 340 IIDPs had PTSD symptoms. The study recommendation was further trauma specific assessment followed by trauma focused intervention. The goal was to provide evidence based trauma intervention for the IIDPs.

3.1 Research Design

Solomon's Four Non-equivalent Control Group Design partially eliminates the initial difference between the experimental and control groups. This design is also considered rigorous enough for experimental and quasi-experimental studies. This is because it provides effective and efficient tools for determining cause and effect relationship and also provides adequate control of other variables that may interfere with the validity of the study (Thayer & Martha, 2009; Kamau, Githii, & Njau, 2014; Abbot & Mc Kinney, 2013).

How Solomon Four Non-equivalent Group Designs was used in the study is shown in Table 1 below.

Table 1. Solomon Four Non-Equivalent Control-Group Design

Group	Pre-test	Treatment	Post-test
Experimental Group 1	0_1	X (Kiandutu)	0_2
Control Group 2	0_3	- (Kiganjo)	0_4
Experimental Group 3	-	X (Gachagi)	0_5
Control Group 4	-	- (Umoja)	0_6

Source: Shuttle Worth (2009).

3.2 Location of the Study

The research was carried out in Thika Sub County in Kiambu County. This group of 640 IIDPs had been tested for broad psychological disorders in 2012 by Community Counseling Resource Centre (CCRC). The results showed 340 IIDPs reported out had Post-traumatic Stress Disorder. This findings recommended trauma focused intervention for this group. The choice of the study location was guided by the fact that the PEV 2007/08 IIDPs had been integrated in the county where they lived in large numbers in Thika Sub County in Kiandutu, Kiganjo, Gachagi, Umoja and Athena slum villages and psychosocial survey on mental disorders by CCRC.

3.3 Population of the Study

The participants composed of survivors of PEV 2007/08 Integrated Internally Displaced Persons aged 18 years and above because the study used Harvard Trauma Questionnaire that is suitable for adults. These IIDPs were the ones who neither went back to the eviction site nor to their ancestral homes after the 2007/2008 political violence. The recorded IIDPs population stood at 640 but the researcher targeted the accessible population of 240 IIDPs who tested positive for PTSD during a baseline survey carried out by CCRC in 2012. This background informed the researcher's decision to carry out an experimental study on assessment of effectiveness of VSM on trauma recovery of IIDPs living in Thika Sub County. A sample of 125 IIDPs from this baseline survey population was randomly selected.

3.4 Sampling Procedures and Sample Size

The researcher used pretest on two groups, treatment for two groups and posttest on all groups. The actual sample size of the study is shown in Table 2.

Table 2. Sample Size

Village	Number of Respondents
Kiandutu	32
Kiganjo	34
Gachagi	30
Umoja	29
Total	125

3.5 Data Analysis

The researcher scored, coded and organized the data for analysis. Inferential statistics was used to analyze, interpret and support decisions based on the results (Nassiuma, 2000; Kothari, 2004). In this study, data was analyzed using both descriptive and inferential statistics. Descriptive data was analyzed using means, standard deviation and percentages so as to meaningfully describe the distribution of the measurements. Quantitative methods of data analysis involving the use of Analysis of Variance (ANOVA) and t-test was used to list statistical significant difference within and among means in the posttest scores for the groups exposed to VSM and those exposed to regular counseling model.

4. Results and Discussion

Community Based Trauma Counseling is also used to support people recovering from trauma. This model promotes indirect client healing through four vital facets of counseling: direct community counseling, direct client services (outreach), indirect community services (influencing) public policy, and indirect client services (client advocacy). What is rated as best practice in holistic health embrace general, mental and public health approaches (Yoder & Zehr, 2005). This model has sustainability because clients own it and take responsibility over their healthy coping following the trauma. Eye Movement Desensitization and Reprocessing (EMDR) trauma treatment has been found useful to treat individuals with complicated trauma or a series of untreated trauma. The intervention helps clients see previously disturbing material or images as less disturbing. EMDR is based on the premise that when an individual is highly stressed the brain cannot function normally and the brain becomes temporary frozen and the memories of disturbing images are stored and retrieved as such. This is made worse when individuals continue perceiving self as helpless and powerless (Lisanby, Luber, Schlaepfer, & Sackeim, 2003). Persistent disturbing memories and images are indicators of poor coping mechanisms in trauma recovery. In this study, the researcher sought to find out the significant effect of VSM on enhancing IIDPs coping mechanisms. The results are shown in Table 3.

Table 3. ANOVA of Coping Mechanisms Scores for IIDPs

	Sum of Squares	df	Mean Square	F	p-value
Between Groups	277.713	3	92.57	1.82	.147
Within Groups	6046.206	119	50.81		
Total	6323.919	122			

The results in Table 3 shows that the mean scores of respondents on IIDPs were not statistically significant F (3,119) = 1.82, P = 0.147 this p value is more than 0.05. This implies that experimental groups 1 and 3 and control groups 2 and 4 had similar coping mechanisms. The sum of squares column represents the sum of squared differences from the mean-it is a measure of deviation from the mean. The mean square (mean sum of squares) measures the average of the sum of squares. It is obtained by dividing the sum of squares by the degrees of freedom. Degrees of freedom are the number of values that are free to vary while estimating a statistic. These scores showed that VSM treatment had minimal statistical significant effectiveness on enhancement of IIDPs coping mechanisms. The hypothesis that stated the effectiveness of Virginia Satir's Model on enhancement of Integrated Internally Displaced Persons' coping mechanisms is not statistically significant was therefore accepted.

A study conducted in 2012 investigated changes across treatment in clinician-rated PTSD symptom clusters and patient-rated trauma-related cognitions in a randomized controlled trial comparing CBCT for PTSD with waitlist in a sample of 40 individuals with PTSD and their partners (N = 40). Compared with waitlist, patients who received CBCT for PTSD immediately demonstrated greater improvements in all PTSD symptom clusters, trauma-related beliefs, and guilt cognitions; Hedge's gs -.33 to -1.51 (Macdonald, Pukay-Martin, Wagner, Fredman, & Monson, 2016). Listening to the client's trauma story is recommended for encouragement and assessing the behavior change (Mackay, Bourne, & Holmes, 2013; Gingerich & Eisengart, 2000). Trauma clients attach varied meaning to their trauma stories; the counselor's work is to help them attach positive meaning that can help them move on with life positively (Goleman & Horne, 1980). Trauma has its own stigma and many traumatized individuals would rather keep quiet about it. Positive publicity and involvement through community activities would be of help to hasten the process of self-awareness and acceptance and subsequently improve health seeking behavior (Sebit, 2013). Some people in Uganda are still carrying out cleansing rituals to heal the victims and perpetrators of war to facilitate readmission into the community (Akello, Richters, & Reis, 2006). Clinical trials assist in determining effectiveness of evidence based interventions. For example, the US Preventive Services Task Force (USPSTF) recommended that clinicians refer obese adult clients to intensive multi-component behavioral counseling programs rather than leave them on self-help programs after a study to compare the two showed a 5% higher success rate for the former in weight loss (Johnson M., 2013). A study by University of Chicago (UOC) Crime Lab carried out

between 2009-2010 with 800 boys showed 44% decline in violent crime arrests and greater engagement by participants long after the counseling and mentoring program (UOC, 2012). A randomized trial describes health conditions and health-related characteristics of populations. This study sought to promote evidence based trauma intervention through pre and post testing of PTSD before and after treatment respectively. This was to establish the difference in participants coping mechanisms before and after treatment.

A randomized control experiment elucidates the etiology/cause of and risk factors for any health issue. The counseling centers in Kenya carry out community out-reach services alongside training and supervision of counselors. However, there are notable mental health clinics at Kangemi and Lower Kabete set up by Basic Needs (an international NGO registered in Kenya in 2005) which are practical examples of community based mental health treatment and management centers. The staff in these clinics encourage the community to understand the nature mental illness and manage the same with the help of their significant others and medical support from the professionals deployed in the centers. They have outreach programs for educating the community members. The Peter C. Alderman's Foundation (PCAF) also began trauma community centre in Woodley, near Kibera slums in Nairobi in 2010 to cater for diverse trauma clients around Kibera in partnership with city council public health services (Ndetei, Ngui, & Khasakhala, 2010; Lewis, 2003). Gender Violence Recovery Centres (GVRC), offer psychosocial support to survivors of gender based violence and their families in Nairobi Kenya. Community counseling is offered in form of awareness creation, advocacy and debriefing sessions. In April 2009-March 2010, 2521 survivors received help in Nairobi Women's Hospital GVRC). None of the above counseling centers have documented studies on randomized controlled trials (RCT) though studies elsewhere show remarkable success (Lewis, 2003; Daniels et al., 2011). Many traumatized individuals and communities find it hard to get answers to their distress and are stuck in life. Victor Frankl asserts that, the way traumatic experience is handled can be a catalyst for growth and transformation wounds of the past can be transformed into wisdom (Frankl, 2012). The question that is still unanswered to date is whether PEV 2007/08 IIDPs survivors and victims have found meaning in their experience and adapted to life productively. This study assessed the new ways of coping for IIDPS herein referred to as coping mechanisms after trauma recovery.

According to the Satir model, the pain people experience is the result of the way they manage their perceptions, expectations, emotions, and behaviors. By focusing on three primary areas; the Intra psychic System, the Interactive System, and the Family of Origin System where people can examine their experiences and relationships, develop goals, and work toward change. While people cannot change what happened in the past, they can change how those past events affect them in the present. By resolving past trauma they can live with more positive energy and do the best they can at any given time. Even destructive or otherwise negative behaviors serve to indicate the best coping possible at that time. If IIDPs were in charge of their emotions, thoughts and behaviors; they can choose to hold onto positive

feelings, thoughts and subsequent behaviors which provide validation and letting go off negative experiences.

Two reviews of controlled outcome studies of SFBT were undertaken in 2000 and 2009 respectively. Each of these reviews noted the methodological limitations of the studies examined, but there was a consistent finding for the efficacy of SFBT (Gingerich & Eisengart, 2000; Corcoran & Pillai, 2009), with Corcoran and Pillai (2009) reporting about 50 percent of the studies reviewed showing improvement over alternative conditions or no-treatment control. Three randomized control studies were also located pertaining to the effectiveness of SFBT (Corcoran & Pillai, 2009). A recent study showed that some people may fail to cope with current traumatic situations or stress due childhood traumatic experiences despite treatment given.

It is not a guarantee that people who have received trauma counseling will automatically cope with the current or future traumatic stress (Amirkhan & Marckwordt, 2017). This may explain why some of the respondents in the study did not develop coping mechanisms after the VSM intervention. The study only focused on post-election violence of 2007/2008 but never took into consideration the past traumatic experiences of the IIDPs that may hinder the trauma recovery of the 2007/08 postelection violence trauma.

For some people, coping during stressful situations may also be determined by earlier parenting and nurturing approached styles. The way parents and caregivers shaped their children as they grew up determined how they built resilience in difficult emotional situations. This may mean some of the IIDPs had dominant low resilient abilities and VSM was not effective in enhancing personal coping mechanisms to deal the trauma. This translates to more time dedicated to training and education to assist participants to develop high resilience in stressful situations. The researcher never established how the IIDPs coped in past stressful situations in their lives before the post-election violence. The intervention was scheduled for five weeks only with two sessions per week.

Ample evidence demonstrates that disasters of both natural (e.g., floods, bushfires, earthquakes) and human origin (e.g., interpersonal violence, terrorism, major life-threatening accidents) can result in adverse mental health outcomes among those directly or indirectly exposed .While the majority of those affected recover over the first few months, traumatic events often mark the start of a complex series of secondary stressors such as the need to relocate or rebuild, fear of a recurrence and legal, financial and compensation issues, assurance of safety among others.

Evidence from Australian and international disaster research demonstrates that, although some survivors will experience no problems and others only minor difficulties that resolve with time and naturally occurring support, a substantial minority will go on to develop clinical or sub-threshold psychiatric conditions which, for some people, will persist for many years. These conditions, which may include depression, anxiety, Posttraumatic Stress Disorder (PTSD) and substance use disorders, not only cause great personal suffering and distress but also interfere with family, social and occupational functioning. The cost to the community in both human and financial terms is enormous

and is recognised by global agencies as one of the most urgent public health issues (Forbes, O'Donell, & Bryant, 2016). Out of 125 respondents, only 45% had temporal employment, 0.8% had permanent employment and 28% were unemployed. The IIDPs in the study were still waiting for government compensation. This economic strain would contribute to negative coping mechanisms because their basic needs are not met. The fact that only 28% of the participants had received some form of counselling following the post-election violence, meant majority of them had a weak foundation for mental stabilization. Trauma intervention proposes psychological debriefing immediately after a traumatic event to alleviate negative coping mechanisms and enhance positive coping among survivors of traumatic incidences. The IIDPs had experienced many psychosocial stressors after displacement from their homes. These stressors may play a role in enhancement of PTSD marked by poor coping mechanisms. During the group process, all the IIDPs expressed a concern that life was economically, socially and psychologically stressful and that the national government had not compensated them after the PEV 2007/08. The hypothesis that stated the effectiveness of Virginia Satir's Model on enhancement of Integrated Internally Displaced Persons' coping mechanisms is not statistically significant was therefore accepted.

5. Conclusion and Recommendation

Results from the study revealed that the Virginia Satir's Model has no statistically significant effects in enhancing coping mechanisms among the IIDP's. Therefore, VSM is not an effective model in enhancing coping mechanisms among IIDPs.

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