SOCIAL SUPPORT IN PROMOTING RESILIENCE AMONG THE INTERNALLY DISPLACED PERSONS AFTER TRAUMA: A CASE OF KIAMBAA VILLAGE IN UASIN GISHU COUNTY, KENYA

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ABSTRACT: *Trauma after adversity affects an individual's life, families and the entire community. Traumatized individuals experience hardship and distress. In conflict situations, people go through moments of turmoil and severe loss of loved ones and property. Social support is an important factor that can contribute to resilience after trauma. The importance of family, friends and community in contributing to resilience has been emphasized over time; today it still remains a key factor in building resilience. This study looked into the importance and effectiveness of social support in promoting resilience after trauma among Internally Displaced Persons (IDPs) in Kenya. The study focused on survivors from Kiambaa fire incident after the 2007 general Elections. The study adopted a mixed method design approach. The target population for this study comprised individuals who were victims of the fire tragedy at Kiambaa village. Respondents for this study were selected using purposive and snow ball sampling techniques. Questionnaire and unstructured interview schedule were the main tools of data collection. The study established that social support is a key element in building resilience in traumatized individuals. The results of a Pearson correlation analysis confirmed a strong positive correlation between social support and resilience of individuals (r=0.835, p<0.05). The study recommended that there is need for professionals working with traumatized individuals to be more familiar with social support and other factors that contribute to resilience. More emphasis should be put in incorporating awareness of these factors in the training of professionals working with traumatized individuals.*

KEYWORDS: Trauma, Resilience Social Support, Effect

INTRODUCTION

When an individual's emotions are stripped away by adversity, the effects are felt by the family, community and society at large and, thus, it is an important aspect to understand trauma broadly (Gonge, 2012). Successful treatment and interventions of trauma requires the incorporation of family members, peer groups and the community members at large. Individuals experience traumatic events in various ways, some individuals develop post-traumatic stress disorder (PTSD), while others respond through denial of the severity of the event (Leaman & Gee, 2011).

The availability of social support from family, friends and professionals may boost the recovery of a person (Seeman, 2008) who has previously undergone trauma of some kind. This support helps the victim to come to terms with certain aspects of their tragedy. The more support an individual receives the more resilient they can become. In studies with children affected by mental disorders, Armstrong *et al.* (2005) assert that social support contributed to their recovery. Other factors that may promote resilience in individuals include hardiness, autonomy, and self-confidence (Zautra *et al.,* 2010). According to Maddi and Khoshaba (2008), hardiness comprises elements such as finding a purpose in life, and positive and negative

experiences that promote growth opportunities. Hardiness also involves one's ability to influence and change their environment. Positive personal identity allows a person to stay focused after the traumatic event. These individuals adapt and adjust to the difficult situations, something that gives them a better chance of coping. Social support is therefore an important factor that boosts recovery after trauma and enables individuals to be resilient.

Social support has been defined as the assistance or comfort to other people to help them cope with a variety of problems. Social support comes from interpersonal relationships, family members, neighbors, religious groups and friends. This support provides positive effect in times of stress (Psychology Dictionary) http://psychologydictionary.org/social-support). It is also the support that is available to an individual through social ties to other individuals, groups and the larger community. It has also been defined as a network of family, friends, neighbors and community members who are available in times of need to give psychological and financial help (www.cancer.gov).

Social support has also been conceptualized to involve developing and nurturing friendships; seeking resilient role models and learning from them (Ballenger-Browning & Johnson, 2010). Social support has been conceptualized as structural and functional support. Social ties such as marriage, family, religious groups and other groups form the structural support (McNally et al., 1999). These are important sources of social support. Structural thinking emphasizes on belonging to groups, where individuals have shared values or beliefs that can have significant influence on their cognitions, affect, behavior and biological responses. Social network can reduce psychological despair and increase the motivation of caring for oneself (Van Dam et al., 2005). Research has also conceptualized social support as care, value and guidance provided by the family, peers and community members (Smith et al., 2011). The functional dimension of social support involves emotional components such as love and empathy. It also includes instrumental or practical support such as giving gifts of money or assistance with child care (Charney, 2004).

It is evident that social support is an expansive construct that offers emotional comfort to individuals at the time of adversity. This support may be offered by family, friends and other significant persons in and groups in an individual's life (Dollete, Steese, & Mathews, 2006).

Studies have shown that resilient individuals are more likely to have more social support than non-resilient individuals (Hickling *et al.,* 2011; Lee *et al.,* 2011; Prati & Pietrantoni, 2010; Simmons & Yoder, 2013; Waters, 2002; Smith *et al.,* 2011). An investigation on resilience in service member indicated that it is important for service members to receive support from their colleagues because it would increase the feeling of belonging and personal control (Simons & Yoder, 2013). The same study also mentioned that adequate social support may prevent post traumatic stress disorder (PTSD) during the transition period from military to home. Traumatized people with high social support have indicated high resilient levels than those with low social support (Ozbay, Douglas, & Southwick, 2007). In a study on US soldiers returning home from operations in Iraq, Pietzak et al. (2009) determined that higher resilience levels were evident in those who adequately utilized post-deployment social support as compared to those who did not appreciate the support given. It is therefore evident that social support is important in nurturing and reinforcing resilience in the lives of traumatized individuals. The researcher contends that social support is important in preventing posttraumatic stress disorder (PTSD) and therefore and important in boosting resilience of traumatized individuals.

A survey study on war affected youths in northern Uganda showed that family connectedness and social support were important in lowering the levels of emotional distress and promoting better social functioning (Annan & Blattman, 2006). A study of childhood sexual abuse survivors, indicated that a combination of self-esteem support (the individual perceives that he or she is valued by others) and appraisal support (individual perceives that her or she is capable of getting advice when coping with difficulties) was important in preventing the development of PTSD (Hyman, Gold & Cott, 2003). Studies on children have observed the interactions between social support and gender and have indicated that girls receive higher social support at times of adversity compared to boys. This type of support helps to moderate the traumatic distress in individuals (Hyman, Gold & Cott, 2003).

 Effective social support is determined by the size of the network and the frequency of interactions as we'll as how rewarding it is emotionally and physically. Social support comes in the form of emotional reassurance that can be instrumental in helping out with the immediate tasks of daily living or provision of information about how to do something or deciding on the best course of actions to be taken (Kaniasty & Norris, 2009). Positive social support makes one feel confident that help is forthcoming or the pain will heal. It also facilitates access to material resources such as food, clothing and shelter, and to financial, educational, medical and employment assistance (Ungar *et al.,* 2007).

Several studies have found social support as a strong indicator of resilience, particularly the larger support network of an individual (Chang & Taormina, 2011; DiMaggio *et al.,* 2008; Hickling *et al.,* 2011; Lee *et al.,* 2011; McAllistar & McKinnon, 2009; Prati & Pietrantoni, 2010; Simmons & Yoder, 2013; Smith *et al.,* 2011; Solomon, Berger, & Ginzburg 2007). In a study investigating resilience, military personnel social support was seen to be a strong indicator of resilience and also important in preventing post-traumatic stress disorder, particularly in the transition period from military to home (Simmons & Yoder, 2013). Another study by Devenson (2003) appreciates that while social support is an indicator to resilience, the quality of the social support should always be taken into account. In another study on health professionals, the importance of community support in promoting resilient levels of individuals is explored. This involves strong connectedness to the social environment, and also the satisfactions of these relationships (McAllister & McKinnon, 2009; Chang & Taormina, 2011). In a cross sectional study of body handlers, the researchers emphasized the importance of cohesive communities and religious communities in bolstering resilience (Solomon et al., 2007).

In cases where there is low social support there is usually a high degree of social strain being exhibited such as developing symptoms of posttraumatic stress disorder (PTSD). Studies on family resilience have provided a framework that contains three domains of family functions; the belief systems, organizational patterns and communications processes (Walsh, 2003). Beliefs assist families to create meaning in times of crisis and promote optimism and encouragement. The family members rely on each other, motivate and encourage each other. Resilient families remain hopeful, focus on their strengths, adopt a can do attitude and accept the aspects of the situations that are out of control (Knowles, Garrison, & Betsy, 2010). The communications processes in the family include the ability to maintain clarity in crises situations. The family does this by communicating clear messages about crisis and also sharing and empathizing their feeling towards each other. They also work together, brainstorm and identify the required resources to make decisions that can help them recover from the adversity

(Walsh, 2003). The family members provide each other with love, care, comfort and emotional support which are important aspects in building resilience after adversity.

Social support is an important aspect as it is seen to promote positive mental health in the military. Studies have shown that when new recruits are being socialized to the army culture, it involves learning to rely on team members and to look out for them in order to accomplish a mission (Greenberg & Jones, 2011). Socialization is seen as a key element of a socially supportive environment which could have boosted the psychological and physical well-being of the soldiers. The process of socialization in the military starts during the orientation and basic military trainings and aims to indoctrinate the recruits into the military culture (McGurk, Cotting, Britt, & Adler, 2006).

The functional model is more specific if the social support being provided is useful and timely. The activities involved in this model include aiding emotionally focused coping, giving relevant information or assisting with problem solving. The model suggests that social support is meant to fulfill an overt or implicit need that if not met will lead to distress and if successfully met will lead to amelioration. Functional social support has links to the hypothesis of stress buffering which was first coined by Cassel (1976) and Cobb (1976). They suggested that individuals are at the risk of developing mental and physical disorders because of confusing or absent feedback from their socials environment. A social environment that provides appropriate feedback and rewards to an individual helps in buffering stress related issues. In summary, there are considerable studies suggesting that social support is an important factor that can contribute to resilience after trauma. Social support should be need- based, adequate and timely.

MATERIALS AND METHODS

The study was carried out in Kiambaa Village, Kabongo sub-location, Ngeria location in Eldoret East sub-County of Uasin-Gishu county, Kenya. The target population comprised adults above eighteen years. The total adult population in the village was approximately four hundred (400) people. Of this population, 287 were male while 113 were female (IOM, 2009).

Following the post-election violence in Kenya, the village of Kiambaa was left depleted and ravaged by the malice of the two groups trying to revenge. People lost their lives and property and some were forced to live in make-shift camps. The exposure to violence was a stressful experience leading to drastic psychological responses such as dissociation, numbing and hyper arousal (Kenya Red Cross Report, January, 2009).

Despite the devastating experience that the Kiambaa residents went through, it is notable that there were those who were resilient enough to overcome the difficulties and continue with their day to day lives. The focus of the study was on resilience after the trauma that the people experienced during the violence. The study therefore sought to explore the effectiveness of social support in building resilience among IDPs after trauma.

Mixed methods research design which is a procedure for collecting, analyzing and "mixing" both quantitative and qualitative data in a single study to understand a research problem better (Creswell, 2012) was employed. The study made use of close ended questionnaires and unstructured interview schedule for data collection.

Purposive sampling was used to identify the respondents. According to Fraenkel and Wallen (2000), purposive sampling is carried out when the researcher purposely uses a sample of

individuals based on the objectives of the study and also based on the specific knowledge of the population to be studied. The study focused on the sample population of the people who were in the church at the time of the fire tragedy (over 50 in number) thirty of whom lost their lives (IOM, 2009). The sample for this study comprised 22 victims of the fire tragedy (11 males and 11 females). These are the individuals who were affected by the fire tragedy, were traumatized and later became resilient. The participants in this study were identified with the help of Chiefs, Assistant Chiefs, Social Workers and Elders who were trustworthy and were not biased towards the participants.

Analysis of the collected data was done using SPSS. Descriptive data was organized into themes and presented thematically. Quantitative data were presented in form of cumulative frequency counts and percentages.

RESULTS

Case Analysis of Selected Interviewees

1st Respondent: the first respondent was female, a 30 year old married self-employed famer and housewife. Her education level was at Primary level and her traumatic experience was out of loss of a child and property. She had this to say on social support:

The respondent explained that she received support from her family members, particularly her husband and parents. She also received substantial support from counselors, social workers, religious groups and volunteers. The participant also indicated that she offered help to others who were more traumatized than her. At the time of the interview, she was actively involved in church activities which include supporting and encouraging each other. Generally, the participant believed she had adapted and had learnt to cope with the post trauma situations. She indicated she had a strong faith and purposeful life and was optimistic about the future.

2nd Respondent: this was a male aged 28 years. He was a married self-employed businessman who had achieved up to primary level of education. He had experienced loss of parents and property. He reported that:

He received social support from friends, family, counselors, volunteers, spiritual leaders and other agencies. This support he says helped him to learn to appreciate others and got encouraged as he interacted with others and also as they shared the experiences. He believed his family played a major role in enhancing his recovery after the trauma. He indicated that his father and uncle were his role models and his pillar. This participant believed that the attachment he had to his family provided him with love and a sense of belonging. His community members were also instrumental in offering social support although he valued the support from his family members more.

3rd Respondent: a third respondent was a female widow aged 40 years who had attained education to primary school level. She was a self-employed farmer who had lost her husband and property. She indicated that she had adapted well to the trauma and the loss she encountered after the fire tragedy. She received social support from family, friends, relatives, counselors, social workers, government health workers and other community based workers. The participant believed the social support from family and others provided her with understanding, companionship, and sense of belonging and positive self-regard. This participant also indicated

that she was engaged in offering support activities to others because she had understood the importance of social support and the positive outcomes it contributes to stressed individuals.

Forms of Social Support

The study also identified different forms of social support that the respondents received during the post-election violence period. This later formed a basis for correlating social support and resilience exhibited by respondents. Majority of respondents 86.4% (19) indicated that they received overwhelming support from the Kenya Red Cross Society (KRCS) during the post-election violence incidence. The KRCS was appointed by the government as the lead coordinating agency for response to the emergency arising from the post-election violence. A female respondent indicated that:

KRCS organized psychosocial interventions to support victims of the post-election violence, especially IDPs, in coping with the trauma. Activities centered on psychological support, First Aid, group debriefing sessions, referrals for specialized care or treatment and support in accessing basic needs. Outreach programs were also conducted in institutions of learning and Orphans and Vulnerable Children centers that hosted displaced children (*Female Respondent 4*).

KRCS, in collaboration with other stakeholders such as the UN Population Fund, UN Refugee Agency, the government of Kenya, and Liverpool VCT (a Kenyan HIV care and treatment NGO), conducted training sessions in designated areas (among them Kisii, Kisumu, Eldoret, Nakuru and Nairobi), to build the local capacity in addressing gender-based violence issues in internally displace persons (IDP) camps.

Those who indicated that they received social support from the International Organization for Migration (IOM) accounted for a proportion of 22.7% (5). The study found out that the IOM, in collaboration with the Ministry of Health's Department of Mental Health, and other agencies, provided psychosocial support to the IDPs.

A proportion of 40% (9) of the respondents indicated that they received social support from UNICEF while 19 (86.4%) received social support from the church during the post-election violence incidence. The study found out that UNICEF, in collaboration with Trans-Cultural Psycho-Social Organization, KRCS, and a number of nongovernmental and community-based organizations, created a program to ensure provision of community-based psycho-social support, through training of community-based service providers, including teachers (in cooperation with education). Those respondents who indicated that they received social support from social workers and community members were 5 (22.7%) and 6 (27.3%) respectively. Finally, a proportion of 45.5% (10) of the respondents indicated that they received social support from professional counselors as indicated in Table 1**.**

Table 1: Forms of Social support

Social Support Provider	Frequency	Percentage
Families	4	18.2
Friends	5	22.7
Church	19	86.4
KRCS	19	86.4
IOM	5	22.7
UNICEF	9	40.9
Social workers	5	22.7
Community members	6	27.3
Professional counselors	10	45.5

Respondents were asked to indicate on a rank of a five-point Likert scale whether they received social support during the time of adversity or otherwise 13.6% (3) indicated that they relied on themselves and, therefore, did not receive social support during the time of adversity. Furthermore, 18.2% (4) indicated that their families listened to their problems during the trauma period and never judged or criticized them while 22.7 % (5) indicated that their friends in the community were always part of their everyday activities at the time of adversity. The study established the extent to which social support was significant in helping those respondents who received it to bounce back to normalcy after the time of adversity. A proportion of 77.3% (17) indicated that the social support they received during the time of adversity significantly helped them to bounce back to normalcy. The remaining proportion of 9.1% (2) of the respondents indicated that they were suspicious of the social support they received and hence indicated that support did not significantly help them to bounce back after the pain they experienced.

In order to establish the relationship between social support and resilience, a Pearson product moment correlation analysis was computed. The results obtained showed the existence of a positive and significant relationship between social support and resilience levels of individuals. Table 2shows the tabulated results from the computation.

Table 2: Pearson Correlation Analysis Results

		Resilience
Social support	correlation coefficient	.835[**]
	Sig. (2-tailed)	.007
	N	22

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

The results indicated that, the calculated p-value for all the predictor variable was less than the significant p-value (0.05). Further, the results confirmed a strong positive correlation between social support and resilience of individuals (r=0.835, p<0.05).

The study further established that resilience levels among respondents who received social support and acknowledged its significance in helping them bounce back to normalcy, varied between individuals of different age and gender. Tables 3 and 4 present these findings.

Table 3: Gender, Social Support and Resilience

Gender	Response Rate	Social Support	Mean Resilience Score
Female	45.5%	Received	82.11%
	4.5%	Did not receive	17.89%
Male	40.9%	Received	85.37%
	9.1%	Did not receive	14.63%

N = 22

The results indicated that male respondents who received social support were more resilient than the female respondents. However, respondents who received social support during the time of adversity scored highly on the resilience scale than those who did not.

Table 4: Age, Social Support and Resilience

Age Bracket	Response Rate	Social Support	Mean Resilience Score
20-35 years	36.4%	Received	65.79%
	0.0%	Did not receive	0.0%
36-55 years	36.4%	Received	79.81%
	9.1%	Did not receive	31.56%
56-75 years	13.6%	Received	77.31%
	4.5%	Did not receive	36.45%

N = 22

Generally, respondents who did not receive social support recorded lower mean resilience scores than those who received. However, respondents who received social support in the older age brackets recorded higher resilience level than those in the younger age brackets.

DISCUSSION

A majority of the respondents, 89.5% (17) agreed that they received social support from the community during the time of adversity or otherwise. The results confirmed a strong positive correlation between social support and resilience of individuals. There is evidence that the individuals in the current study received considerable social support and acknowledged its significance in helping them bounce back to normalcy. The author is of the opinion that the social support the individuals received involved emotional aiding (psychological debriefing), relevant information given, problems solving, health care provided and material support provided such as food, clothes and shelter. Similar concepts were coined by Cassel (1976) and Cobb (1976); in their model, named the functional model, they suggested that social support is meant to fulfill an overt and implicit need that if not met well will lead to distress and if successfully met will lead to amelioration. Functional support is, therefore, significant in boosting the resilience levels of the individuals in the current study.

 A large proportion of the individuals in the study (86.4%) received structural support which was mainly provided by the Kenya Red Cross Society (KRCS) and the church. These

organizations facilitated access to material resources such as food, clothing and shelter, and also financial, educational and medical assistance. Similar findings are found in other studies reviewed which showed that strong and satisfying relationships with the social environment during extreme stress increases an individual's confidence and coping ability (McAllister & McKinnon, 2009; Chang & Taormina, 2011). The respondents also indicated that they received emotional support from counselor, social workers and other professionals. This type of support was instrumental in helping out with the immediate tasks of daily living and also in decision making. Similar to other studies by Kaniasty & Norris, (2009) who found the positive social support is instrumental in providing emotional reassurance.

The social support the respondents received from family and friends was relatively insignificant contrary to other studies reviewed in the literature which showed that social support from family and friend was highly significant (Dollete, Steese, & Mathews, 2006). The research is of the opinion that during the traumatic episode the families and their friends were equally devastated and overwhelmed by the crisis event and were not able to offer each other adequate support. They were equally KRCS, IOM, church and other community member.

This support varied between individuals of different ages and gender. Male respondents who received social support were more resilient than the female respondents, although the difference in the percentages may not be highly significant (85.37% and 82.11% for males and females respectively). These findings are contrary to previous findings reviewed in the literature that females utilize more social support than males (Friborg *et al.,* 2003). Both males and females in the study were involved in nurturing friendships and seeking professional help from professionals such as counselors and resilient peers who acted as role models and assisted them to cope with the adversity. This is similar to what was conceptualized by Ballenger-Browning and Johnson (2010) that individuals who develop nurturing friendships, seek resilient role models and are able to learn from them and thus cope with adversity effectively.

The respondents who did not receive social support recorded lower mean resilience scores than those who received. The high levels of resilience indicate that such individuals who received social support networked and interacted frequently with family members, friends, counselors and other professionals. Ungar *et al.* (2007) referred to this as positive social support that enables one to feel confident and help in boosting one's ability to deal with adversity. In the current study, social support was beneficial to the individuals because it made them feel confident and thus tackle the adversities they were facing at the time of the fire tragedy. It seems social support was associated with increased hope and better coping thereby making the individuals to be more inclined to resilience than receiving support. Social support in the current study had a significant positive relationship with the resilience of the individuals.

CONCLUSIONS

Individuals who receive social support after trauma become more resilient than those who do not receive any support. Male respondents receiving social support record a higher resilience scale score than the female respondents who receive social support. Besides, older respondents who receive social support have higher resilience than the younger individuals accorded the same social support. Social support is, therefore, an important feature in promoting resilience among victims of violence who have undergone trauma

RECOMMENDATIONS

There is need for professionals, specifically health professionals, such as nurses, social workers, psychologists and religious leaders working with individuals who are traumatized after adversities to pay more attention to giving social support towards creating resilience.

A study to integrate biological correlates, community relationships and cultural supports that aid in processes that promote resilience is advised by the author.

REFERENCES

Annan, J., & Blattman, C. (2006). *The psychological resilience of youth in northern Uganda: Survey of War Affected Youth,* Research Brief 2. *www.sway-ganda.org/SWAY.RB2.pdf.*

Armstrong, M. I., Shelly, B., & Michael, T. U. (2005). Pathways between social support, family well-being, quality of parenting and child resilience. *Journal of child and family studies, 14.*

Ballenger-Browning, K., & Johnson, D. C. (2010). *Key Facts on Resilience* Retrieved July, 10 2013 from www.nccsc.navy.mill

Cassel, J. (1976). The contribution of the social environment to host resistance. *American Journal of Epidemiology,* 104, 107–123.

Chang, K., & Taormina, R. J. (2011). Reduced Secondary Trauma among Chinese Earthquake Rescuers: A Test of Correlates and Life Indicators, *Journal of Loss and Trauma: International Perspectives on Stress & Coping, 16*, (6), 542-562, DOI: 10.1080/15325024.2011.600682

Charney D. S. (2004) Psychobiological mechanism of resilience and vulnerability: Implications for successful adaptation to extreme stress. *American Journal of Psychiatry.* 161:195–216.

Cobb, S. (1976). The contribution of social environment to host resistance. *American Journal of Epidemiology, 104,* 102-123

Devenson, A. (2003). *Resilience. Biography and Autobiography*. Allen & Unwin: 83 Alexander Street. Crows Nest NSW 2065, Australia.

DiMaggio, C., Madrid, P.A., Loo, G.T., & Galea, S. (2008). The Mental Health Consequences of Terrorism: Implications for Emergency Medical Practitioners. *The Journal of Emergency Medicin*e, 35(2), 139-147. DOI: http://dx.doi.org/10.1016/j.jemermed.2007.03. 037 retrieved 31.8.2014

Dollete, M., Steese, S., & Mathews, G. (2006). Understanding /girls, circles as an interview on perceived social support, body image, self efficacy, locus of control and self-esteem. "The locus of control and self-esteem." *The Journal of psychology 90*(2), 204-215.

Friborg, O., Hjemdal, O., Rosenvinge, J.H., & Martinussen (2003). A new rating scale for adult resilience: what are the central protective resources behind healthy adjustment? *International Journal of Methods in Psychiatric Research,* 12 (2), 65-76

Gonge, B. (2012). *Global Trauma and Scripture Engagement.* Retrieved from Global scripture impact 610647.8080 or www.gs.impact.

Hickling, E.J., Gibbons, S., Barnett, S.D., & Watts, D. (2011). The Psychological Impact of Deployment on OEF/OIF Healthcare Providers. *Journal of Traumatic Stress, 24(6),* 726-734. HSPD-8, http://www.fas.org/irp/offdocs/nspd/hspd-8.html, retrieved 15-08-2014.

Hyman, S.M., Gold, S. N., & Cott, M. A. (2003). Forms of social support that moderate PTSD in childhood sexual abuse survivors. *Journal of Family Violence. 3*(18), 295–300.

IOM (2009) *Strategic Report on Post-election violence – Kenya.* (Unpublished)

Kaniasty, K., & Norris, F.H. (2009). Distinctions that matter: Received social support, perceived social support, and social embeddedness after disasters. In Neria Y., Galea S., Norris F.H. (Eds.), *Mental health and disasters* (pp. 175–200). New York: Cambridge University Press.

Kenya Red Cross Report, January, (2009) (unpublished)

Leaman, S. & Gee, C. (2011). *Religious coping and risk factors for psychological distress among African torture survivors. Psychological Trauma: Theory, Research, Practice, and Policy.* Advance online publication. doi: 10.1037/a0026622

Lee, Jennifer E. C; Sudom K. A., & McCreary D. R., & McCreary, Donald R. (2011). High Order Model of Resilience in the Canadian Forces. *Canadian Journal of Behavioral Science 43*(3), 222-234.

Maddi, S.R & Khoshaba, D.M (2008). *Hardiness Training Managing Stressful Change* (4th Ed.). Irvine, California: The Hardiness Institute Inc.

McAllistar, M., & McKinnon, J. (2009). The Importance of Teaching and Learning Resilience in the Health Disciplines: A Critical Review of the Literature. *Nurse Education Today, 29,* 371-179. Doi: 10.1016/j.nedt.2008.10.011. .

McNally, S., Ben-Shlomo, Y., & Newman, S. (1999). The effects of respite on informal carers' well-being: A systematic review. *Disability and Rehabilitation*, *21*(1), 1-14.

Ozbay, F., Douglas, C. J., & Southwick, S. (2007). *Social support and resilience to stress 4*(5), 35-40

Pietrzak, R. H., Johnson, D. C., Goldstein, M.B., Malley, J.C., & Southwick, S. M. (2009). Psychological resilience and post deployment social support project against traumatic stress and depressive symptoms in soldiers returning from Operations Enduring Freedom and Iraqi Freedom. *J Spec Oper Med.* 9(3), 67-73.

Prati, G., & Pietrantoni, L. (2010). Risk and Resilience Factors among Italian Municipal Police Officers Exposed to Critical Incidents. *Journal of Police and Criminal Psychology, 25*(1), 27-33. doi 19,1007/5/11896-009-9052-0

Seeman, T. (2008). Support and social conflicts. Section one - social support. Research psychosocial notebook. www.macses.ucsf.edu/reseach/psychosocial/socsupp.php. Retrieved 9.9.2014

Simmons, A., & Yoder, L. (2013). Military Resilience: A Concept Analysis. *Nursing Forum, 48(1),* 17-25. Doi: 10.1111/nuf.12007.

Smith, B.W., Ortiz, J.A., Steffen, L.E., Tooley, E.M., Wiggins, K.T., Yeater, E.A., Montoya, J.D. & Bernard, M.L. (2011). Mindfulness is Associated with Fewer PTSD Symptoms, Depressive Symptoms, Psychical Symptoms and Alcohol Problems in Urban Firefighters. *Journal of Consulting and Clinical Psychology, 79*(5), 613-617.

Solomon, Z., Berger, R., & Ginzburg, K. (2007). Resilience of Israeli body handlers: Implications of repressive coping style. *Traumatology, 13(4),* 64-74. Doi: 10.1177/1534765607312687

Ungar, M., Brown, M., Liebenberg, L., Othman, R., Kwong, W.M., Armstrong, M., & Gilgun, J. (2007), 'Unique pathways to resilience across cultures'. *Adolescence, 42*(166), 287–310

Van Dam, H. A., van der Horst, F. G., Knoops, L., Ryckman, R. M., Crebolder, H. F. J. M., & van den Borne, B. H. W. (2005). Social support in diabetes. A systematic review of controlled intervention studies. *Patient Education and Counseling, 59,* 1–12. doi:10.1016/j.pec.2004.11.001

Waters, J.A. (2002). Moving Forward from September 11: A Stress/Crisis/Trauma Response Model. *Brief Treatment and Crisis Intervention 2,* 55-74.

Zautra, A. J., Hall, J. S., & Murray, K. E. (2010). *A new definition of health for people and communities. Handbook of Adult Resilience*. New York: Guilford.