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Between Silence and Survival: Trauma, Pregnancy, and Post Traumatic Stress Disorder (PTSD) Among Adolescent Survivors of Sexual Violence in Kiambu County, Kenya

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***Abstract*: Sexual violence–related pregnancy among adolescent girls in peri-urban Kenya produces layered biological, psychological, and structural vulnerabilities that standard PTSD frameworks only partially address. In Kiambu County, where poverty, gender inequality, and fragmented service systems converge, existing clinical approaches remain largely decontextualized, attending inadequately to structural determinants and the cultural landscapes through which trauma is experienced and expressed. This practice-based integrative review draws on clinical psychology, global mental health, and medical anthropology to develop a Structural-Intersectional Formulation (SIF) model for understanding and treating PTSD among low-income pregnant adolescent survivors of sexual violence in Kiambu County. Grounded in intersectionality theory, the social defeat hypothesis, and postcolonial critiques of psychiatric universalism, the SIF model re-orders traditional biopsychosocial formulations by placing structural conditions and cultural meaning-making at the centre of clinical reasoning, with individual cognitive and biological processes nested within them rather than treated as primary. This model is translated into concrete, actionable recommendations: idiom-sensitive and developmentally attuned assessment tools; structurally informed case formulation and care planning; culturally adapted Trauma-Focused CBT and Narrative Exposure Therapy within perinatal contexts; trauma-informed supervision frameworks; and integrated GBV and mental health service pathways embedded within antenatal care systems. Implications for practitioner training and policy reform are also addressed. The SIF framework aims to support more accurate identification of PTSD presentations and more ethically grounded, contextually responsive care for pregnant adolescent survivors in Kiambu and comparable low-resource settings, contributing to a broader shift away from individualised models of trauma toward approaches that genuinely reckon with structural violence, cultural context, and developmental vulnerability.**

***Keywords*: Adolescents, culturally adapted intervention, Intersectionality, Kenya, Kiambu, postcolonial psychiatry, pregnancy, PTSD, sexual violence, structural formulation, trauma.**

1. Introduction

Sexual violence related pregnancy among adolescent girls in peri-urban Kenya produces layered biological, psychological, and structural vulnerabilities that standard PTSD frameworks only partially address. In Kiambu County, a densely populated, economically stratified region bordering Nairobi that encompasses both affluent satellite towns and deeply impoverished informal settlements, these vulnerabilities are compounded by poverty, gender inequality, weakened community structures, and fragmented service systems that together render this population acutely underserved and clinically misunderstood (KNBS, 2019).

Sexual violence against adolescent girls in this context is neither random nor isolated. It is structurally produced, culturally mediated, and institutionally under-addressed. The Kenya Bureau of Statistics Survey (KNBS, 2022) indicates that approximately 14% of women aged 15–49 report having experienced sexual violence, with adolescents disproportionately represented among survivors. In Kiambu, survivors encounter compounding barriers: stigma rooted in cultural shame frameworks, family pressure toward silence, inadequate one-stop crisis centre coverage, judicial processes that frequently re-traumatise, and mental health services that are both scarce and poorly adapted to local contexts (Mwangi et al., 2020). When sexual violence results in pregnancy, as it does in a significant proportion of rape cases involving adolescents, the survivor faces not only acute psychological injury but also social exile, educational disruption, deepening poverty, and elevated obstetric risk (Berg et al., 2055; Grose et al., 2021).

Despite this convergence of crises, existing clinical and policy frameworks have proven inadequate to the task. PTSD, as operationalised in the DSM-5 and ICD-11, provides a necessary but insufficient scaffold: its diagnostic criteria were not developed with adolescent African survivors in mind, the evidence base for PTSD treatment remains skewed toward high-income Western populations, and structural determinants, poverty, gender inequality, displacement, institutional betrayal, are rarely integrated into clinical formulation (Rasmussen et al., 2018). Culturally adapted interventions remain sparsely evaluated in Kenyan contexts, leaving practitioners without

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grounded, actionable guidance.

This practice-based integrative review draws on clinical psychology, global mental health, and medical anthropology to develop a Structural-Intersectional Formulation (SIF) model for understanding and treating PTSD among low-income pregnant adolescent survivors of sexual violence in Kiambu County. Grounded in intersectionality theory, the social defeat hypothesis, and postcolonial critiques of psychiatric universalism, the SIF model re-orders traditional biopsychosocial formulations by placing structural conditions and cultural meaning-making at the centre of clinical reasoning, with individual cognitive and biological processes nested within them rather than treated as primary.

The paper proceeds in four movements. We first map the population and service landscape of Kiambu County, establishing the structural and epidemiological context. We then critically examine prevailing PTSD frameworks, surfacing the ways they misfit this population. Drawing on this critique, we introduce the SIF model and apply it to rethink assessment, formulation, intervention, and supervision. Finally, we translate the model into concrete recommendations, for idiom-sensitive assessment, structurally informed formulation, culturally adapted TF-CBT and Narrative Exposure Therapy in perinatal settings, trauma-informed supervision, and integrated GBV–mental health pathways within antenatal care, alongside implications for training programmes, Kiambu County health services, and national policy.

The framework aims to support more accurate identification of PTSD presentations and more ethically grounded, contextually responsive care for pregnant adolescent survivors in Kiambu and comparable low-resource settings, contributing to a broader and necessary shift away from individualised models of trauma toward approaches that genuinely reckon with structural violence, cultural context, and developmental vulnerability.

2. Problem Statement

A. The Population

The primary population under analysis is adolescent girls (ages 13–19) in Kiambu County who have experienced sexual violence and are pregnant as a result, or whose PTSD onset co-occurs with a pregnancy that arose from sexual violence. This group occupies a multiply marginalised position, as they are simultaneously children in legal and developmental terms, sexual violence survivors, pregnant persons, and, in many cases, poor, rurally or periurbanly located, and without sustained adult advocacy. The Sexual Offences Act (2006) criminalises sexual violence and establishes consent frameworks, yet enforcement is inconsistent, and cultural norms that attribute shame to survivors rather than perpetrators operate to suppress reporting and help-seeking (Odhiambo & Kamau, 2019).

Clinically, this multiply marginalised position carries direct consequences for how PTSD presents and what recovery can realistically mean. PTSD in this population is rarely a single-incident disorder; it is layered onto an ongoing environment of economic dependency, social blame, and profoundly constrained choices that shapes symptom expression, sustains hyperarousal, and actively undermines the conditions necessary for recovery. This point is supported empirically. A study of adolescents in Nairobi's informal settlements found that female students who reported rape had significantly higher rates of PTSD, depression, and anxiety than the broader study population, with poverty and limited healthcare access identified as compounding risk factors, suggesting that mental health outcomes among this group reflect cumulative structural exposure, not incident trauma alone (Friedberg et al., 2023). More recently, a political economy analysis of adolescent mental health policy in Kenya found that socioeconomic factors, cultural stigma, and limited awareness act as compounding deterrents to help-seeking, with poverty functioning as both a cause and a barrier to care for the most vulnerable adolescents (Tele et al., 2025).

Adolescent pregnancy rates in Kiambu are elevated with the KNBS (2022) records indicating that approximately 15% of adolescent girls in Central Kenya have begun childbearing by age 19. While not all adolescent pregnancies result from sexual violence, studies across Sub-Saharan Africa indicate that forced sex is implicated in a substantial proportion of adolescent pregnancies, estimates range from 20–40% in some survey studies, with underreporting significant (Jewkes et al., 2013). The intersection of pregnancy and PTSD creates specific clinical challenges, such as trauma-related hyperarousal and hypervigilance may complicate antenatal attendance, while dissociative symptoms may impair engagement with obstetric care and somatic presentations of distress are frequently miscategorised by health workers without mental health training (Rogathi et al., 2017).

B. The Service Landscape and Its Failures

Kiambu County has one county referral hospital, Kiambu Level 5, supported by a network of sub-county hospitals, health centres, and dispensaries. The county's Gender-Based Violence (GBV) response capacity is anchored in its one-stop crisis centres, the Wangu Kanja Foundation, which provides survivor support in the region, but coverage is geographically uneven and operationally constrained (KNCHR, 2020). Critically, mental health integration into antenatal and GBV services is minimal. The Mental Health Act (2022) mandates community mental health, but implementation funding and trained personnel remain inadequate.

The practical consequence of these gaps is stark. An adolescent presenting for emergency post-rape care or antenatal services may receive post-exposure prophylaxis and obstetric monitoring, but leave without any structured assessment of trauma-related distress, suicidality, or perinatal mental health concerns. This is not an incidental gap; it is a structural one. Mental health is frequently given low priority in health policy planning across sub-Saharan Africa, and Kenya is no exception. There is an urgent and unmet need to address the treatment gap and provide timely mental health promotion and preventative services for pregnant and parenting adolescent girls, a population whose needs remain largely absent from

comprehensive policy frameworks (Obonyo et al., 2023). While the Kenya Mental Health Action Plan 2021–2025 sets targets for integrating mental health into primary care and maternal-child health services, effective service integration requires a comprehensive understanding of existing healthcare infrastructure, providers, and available resources, and limited information currently exists to guide perinatal mental health service integration in Kenya.

The clinical gap is therefore multi-dimensional. It involves: (a) low identification of PTSD in antenatal settings; (b) absent or inadequate culturally adapted psychological intervention; (c) no structured mechanism for joint formulation between mental health, obstetric, and social welfare professionals; (d) supervision frameworks that do not prepare practitioners to hold the complexity of trauma, pregnancy, and cultural context simultaneously; and (e) policy that recognises GBV but does not operationalise mental health care as an integral component of the GBV response pathway.

3. Critique of Current Frameworks

Before advancing an alternative, it is necessary to name the deficiencies in current approaches, not merely as intellectual critique but because inadequate frameworks cause direct clinical harm. Three interlocking failures characterise existing practice: diagnostic universalism, cultural essentialism, and the absence of structural analysis. Each produces its own pattern of misrecognition, and together they render standard PTSD frameworks systematically unfit for adolescent survivors in Kiambu.

A. Diagnostic Universalism

The first failure is the uncritical application of DSM-5 or ICD-11 PTSD criteria in Kiambu's clinical settings without attention to how trauma is phenomenologically experienced and expressed in this context. While the ICD-11's PTSD and Complex PTSD (CPTSD) formulations represent a genuine advance in recognising pervasive developmental and relational trauma, neither nosological framework was developed with East African adolescents in mind. The risk of false negatives is significant: adolescent survivors in Kiambu frequently present with somatic complaints, headaches, abdominal pain, *kufikiria sana* (thinking too much, a widely documented Kenyan idiom of distress), social withdrawal, and behavioural change, rather than with the classic intrusive-avoidance-arousal symptom cluster that Western checklists are designed to detect (Rasmussen et al., 2018). Clinicians trained exclusively in standardised symptom inventories will systematically miss these presentations, and what goes undetected goes untreated.

For Kiambu's antenatal and GBV services, this means that a symptom checklist alone will under-diagnose PTSD in adolescents who present with idioms such as *kufikiria sana*, headaches, or abdominal pain, and may simultaneously over-pathologise culturally expected grief or spiritual distress, producing both false negatives and false positives that distort clinical decision-making from the outset.

B. Cultural Essentialism

The second failure is the inverse error: cultural essentialism, in which culture is treated as a fixed, homogeneous variable that fully explains suffering. When practitioners attribute a survivor's silence, her family's pressure to conceal, or her reluctance to engage with mental health services exclusively to "Kikuyu culture" or "African values," they engage in a form of analytical shortcutting that obscures heterogeneity, elides power, and risks pathologising culture rather than examining how structural forces are culturally mediated (Bhui & Bhugra, 2002; Kirmayer, 2012). Culture is not a stable explanatory container; it is itself a contested, dynamic, and power-laden terrain.

For example, when a clinician attributes a girl's silence solely to Kikuyu cultural norms, they risk ignoring that the family's silence is also shaped by fear of police retaliation, financial dependency on the perpetrator, the church's stance on pregnancy outside marriage, and the very real social and economic consequences of naming a known perpetrator in a tightly networked peri-urban community. Cultural humility, not cultural competency as a fixed checklist, is the appropriate clinical stance, precisely because it keeps these intersecting forces visible rather than collapsing them into a single cultural explanation.

C. The Absence of Structural Analysis

The third failure is the most consequential for this population. PTSD among pregnant adolescent survivors in Kiambu is not simply a disorder that individuals happen to develop; it is produced and maintained by a social environment characterised by ongoing gender-based inequality, poverty, institutional neglect, and impunity for perpetrators. Formulations that locate the problem exclusively within the individual, her biology, her cognitive schema, her coping deficits, reproduce the very decontextualisation that renders care inadequate. Feminist and postcolonial scholars of global mental health have long argued that such individualising frameworks serve an ideological function: they render structural violence invisible while placing the burden of recovery on those who have been harmed.

This is precisely the gap that the Structural-Intersectional Formulation model is designed to address. SIF treats poverty, legal impunity, school exclusion, and service neglect not as background context but as core clinical domains that must be named, formulated, and engaged directly in care planning. A formulation that describes only intrusive memories and avoidance behaviours, without naming the structures that generate, sustain, and constrain recovery from those symptoms, is, in this context, clinically incomplete. To omit structure from the formulation is not clinical neutrality; it is a choice with consequences for what interventions are proposed, what outcomes are considered realistic, and whose responsibility recovery is understood to be.

4. Conceptual Framework

A. Intersectionality as a Clinical-Analytical Tool

Intersectionality, theorised by Crenshaw (1989) in the context of Black women's experiences of discrimination, offers a framework for understanding how multiple, co-constitutive systems of oppression and identity, gender, age, class, ethnicity, disability, geographic location, interact to produce qualitatively distinct experiences of marginalisation and suffering. For the adolescent survivor of sexual violence in Kiambu, intersectionality is not merely a conceptual abstraction, it is descriptively precise. She is simultaneously gendered, in a patriarchal society that attributes honour to her sexual purity and shame to its violation, aged both legally and socially a child, yet frequently held responsible for her own victimisation, classed as either poor, with limited access to legal, medical, or psychological recourse, and located in a periurban zone where formal services are available in principle but practically inaccessible.

The clinical significance of intersectionality is that it prevents single-axis analysis. A framework that attends only to gender misses the class dynamics of access. One that attends only to age misses the gendered script of shame. One that attends only to culture misses the structural conditions, poverty, impunity, that make cultural shame frameworks operative. Collins's matrix of domination (Collins, 2000) extends this, oppression is experienced not merely at the level of individual identity but through institutional (health system), interpersonal (family, community), and structural (law, policy) domains simultaneously.

In practical terms, applying intersectionality in Kiambu means that when formulating an adolescent survivor's case, clinicians must explicitly ask: How does her age as a minor limit her legal autonomy and her ability to consent to or refuse care? How does her class and housing situation shape her options for physical safety between appointments? How does pregnancy change her moral positioning within the family, the church, and the wider community? How does living in a peri-urban settlement, where social networks are dense and information travels quickly, affect her risk of gossip, social surveillance, and retaliation? These questions are not supplementary to formulation; they are the formulation's structural spine.

B. The Social Defeat Hypothesis and Structural PTSD

Selten and colleagues' social defeat hypothesis (Selten et al., 2013), originally advanced to explain elevated psychosis rates in migrant and minority populations, offers transferable insights for understanding PTSD in this context. Social defeat, which is the chronic subjugation, social exclusion, and subordination experienced by those at the bottom of social hierarchies, is proposed as a biological and psychological sensitiser, chronically dysregulating dopaminergic and stress response systems and rendering individuals more vulnerable to severe psychopathology following acute stressors. For the pregnant adolescent survivor in Kiambu, social defeat is operative at multiple, compounding levels: the pre-existing vulnerability of poverty and gender subordination; the acute defeat of the assault itself; and the post-assault defeat of community stigma, family rejection, educational exclusion, and institutional failure.

This framework integrates biology and structure without reducing either to the other. It insists that the body bears the marks of social positioning, and that clinical intervention which ignores the ongoing structural conditions of defeat will be limited in its efficacy. It also provides a partial explanation for why PTSD in this population may be more severe, more persistent, and more treatment-resistant than in populations experiencing PTSD without these contextual compounding factors. Crucially, recognising social defeat also guards against unrealistic individual-level treatment goals. Without direct attention to ongoing defeat, for example, being forced to remain in proximity to the perpetrator, being excluded from school, or facing daily stigma within the household, even well-delivered trauma therapy is likely to show limited or unstable gains. The therapeutic frame must, from the outset, hold both the internal and structural dimensions of recovery as legitimate clinical concerns.

C. Cultural Meaning-Making: Idioms of Distress and the Politics of Diagnosis

Kleinman's explanatory models framework (Kleinman, 1978) and subsequent developments in medical anthropology direct clinical attention to the meaning systems through which survivors and their families interpret distress, assign causation, and seek relief. In Kiambu, as across much of Kenya, distress following sexual violence may be understood through multiple, overlapping explanatory frameworks: biomedical (illness); religious/spiritual (curse, spiritual attack, punishment); interpersonal (shame, stigma, dishonour to the family); and structural ("this is what happens to poor girls"). These are not mutually exclusive, and most survivors navigate several simultaneously.

The clinical implication is not that practitioners should select one explanatory model as authoritative and dismiss others, but that effective assessment requires eliciting the survivor's own meaning-making, understanding how family and community meanings constrain or enable her help-seeking, and offering formulations that neither colonise her experience with biomedical language nor abandon the genuine clinical utility of trauma-specific diagnosis and treatment (Bäärnhielm et al., 2014). Holding multiple explanatory models means neither privileging the diagnostic nor deferring entirely to the cultural, it means working in the space between them, with transparency and collaborative curiosity. A shared formulation might sound like: *"You and your mother see this suffering as both an effect of what this man did to you and as a spiritual attack. In our work together, we can focus on calming your mind and body after what happened, while also making space for the prayers and spiritual support that matter to you."* This kind of framing neither marginalises the clinical nor dismisses the spiritual; it creates a treatment alliance that holds both. The Cultural Formulation Interview (APA, 2013) provides a partially useful scaffold, though it requires significant contextual adaptation for

Kiambu and should not be applied as a decontextualised checklist.

A. Pregnancy as a Complex Compounding Axis

Pregnancy arising from rape creates a clinical and ethical situation of particular complexity. The foetus is simultaneously the survivor's child, a biological product of violence, a site of stigma, and, depending on religious, family, and personal frameworks, a moral and relational object with enormous meaning. Perinatal PTSD has a specific phenomenology, where intrusive symptoms may be triggered by physical reminders of the assault during pregnancy, such as touch, examination, bodily change; hypervigilance may present as excessive anxiety about the pregnancy's outcome; emotional numbing may impair maternal-foetal bonding with downstream consequences for the child (Seng et al., 2011; Muzik et al., 2016).

The obstetric encounter itself can become a site of re-traumatisation in ways that are entirely predictable yet rarely anticipated in clinical planning. A routine vaginal examination in labour may replay the sensory experience of forced penetration. Ultrasound images can elicit both joy and dread in rapid succession, a visible foetus that is loved and resented simultaneously. Decisions about caesarean section versus vaginal delivery may be saturated with family pressure, moral judgement, provider assumptions, and layers of unresolved trauma that no one in the room names aloud. Trauma-informed perinatal care requires that obstetric staff be trained to recognise these moments, offer genuine choice, and communicate with a sensitivity that routine clinical training does not currently provide.

In Kenya's legal context, abortion is constitutionally permissible when the life or health, including mental health, of the mother is at risk (Constitution of Kenya, 2010, Article 26(4)), yet access to safe, legal termination of pregnancy is profoundly restricted in practice by provider conscientious objection, regulatory complexity, and stigma. Many adolescent survivors in Kiambu therefore continue pregnancies not by free choice but by default, a form of reproductive coercion that itself constitutes an ongoing trauma. The clinical framework must account for this.

The proposed intersectional framework for this population is summarised in Table 1.

5. Clinical Implications

A. Assessment

Standard PTSD screening tools, the PCL-5, the CAPS-5, are not validated for adolescent populations in Kiambu and carry significant risks of both false negatives through idiom mismatch and false positives through over-pathologisation of culturally normal grief and distress responses. Assessment must therefore be multi-modal, culturally responsive, and developmentally attuned. Practitioners should begin with open narrative enquiry rather than symptom checklists, explicitly inviting the survivor to describe her experience in her own language and conceptual framework. The Cultural Formulation Interview (American Psychiatric Association, 2013), adapted for Kenyan adolescent contexts, provides a useful structure for eliciting explanatory models, cultural identity, cultural stressors, and culturally inflected help-seeking. Assessment must attend to somatic idioms of distress such as headaches, abdominal pain, fatigue, as potential PTSD equivalents. *"Kufikiria sana"* needs to be viewed as a marker of ruminative intrusion, behavioural and relational changes as avoidance equivalents, and perinatal-specific presentations including tokophobia (fear of childbirth), intrusive thoughts triggered by obstetric examination, and impaired foetal attachment.

Critically, assessment must also be a structural assessment, practitioners should document the survivor's economic situation, housing security, social support availability, legal case status, educational disruption, and access to safe and consistent healthcare. These are not background factors; they are aetiological, maintaining, and prognostic variables. A PTSD formulation that ignores them is clinically incomplete. Risk assessment must be conducted with particular sensitivity with a focus on the suicide risk in adolescent survivors of sexual violence in Sub-Saharan Africa which is normally elevated and under-detected (Devries et al., 2014). Risk assessment protocols should be adapted to avoid re-traumatisation, use local terminology, and be embedded in a relationship of sufficient safety before deployment.

For Kiambu's adolescent antenatal population, a minimum trauma assessment bundle would include: (a) one or two open narrative prompts about what has happened and how it is currently affecting the girl, using her own words and framing;

Table 1
Intersectional analytical framework

Dimension	Structural Level	Cultural Mediation	Clinical Manifestation
Gender/Patriarchy	Legal impunity for perpetrators; gender pay gap; limited female autonomy	Shame attributed to survivor; silence as family protection; honour narratives	Difficulty disclosing; self-blame schemas; avoidance of services perceived as 'exposing'
Age/Adolescence	Legal status as child yet social exclusion from protection; educational exclusion post-pregnancy	Adolescent girls framed as responsibility of family, not state	Developmental complexity in trauma processing; limited autonomous help-seeking capacity
Class/Poverty	No fee exemption in practice for mental health; transport cost; lost wages	Poverty normalised; distress attributed to 'life challenges' not trauma	Somatisation; *kufikiria sana* presentations; non-engagement with formal services
Geographic Location	Uneven distribution of OSCCs and MH services in Kiambu's rural zones	Rural-urban differential in social tolerance and gossip risk	Greater isolation; dependence on informal support (church, TBAs) that may not be trauma-informed
Pregnancy (Assault-Resultant)	Restricted legal access to termination; absent reproductive counselling	Foetus as both 'innocent' and 'product of shame'; contradictory family responses	Perinatal PTSD phenotype; impaired foetal attachment; antenatal non-attendance
Ethnicity/Language	Services predominantly in Swahili/English; Kikuyu-speaking informal settlements underserved	Ethnic-specific shame frameworks; In-group pressure to manage 'internally'	Language barriers in assessment; under-Elicitation of idioms of distress

(b) targeted questions about intrusive memories, sleep disturbance, *kufikiria sana*, and bodily symptoms, using locally familiar language; (c) questions about current safety, including ongoing threat from the perpetrator, family pressure toward silence, and risk of retaliation; and (d) a brief structural scan covering housing stability, schooling status, and legal case status. This bundle is not a replacement for full clinical assessment but a feasible minimum standard for first-contact settings, including antenatal clinics and one-stop crisis centres, where a trained practitioner has limited time and the adolescent may be presenting for the first time.

B. Formulation

A Structural-Intersectional Formulation (SIF) model is proposed as an adaptation of the standard biopsychosocial formulation for this population. The SIF model retains the biopsychosocial structure but introduces three additional domains. The first is structural predisposing and perpetuating factors such as poverty, gender inequality, institutional failure. Second, cultural meaning-making consisting of explanatory models, idioms, shame frameworks. Last, intersectional compounding, that is how multiple axes of marginalisation interact to amplify or constrain vulnerability and recovery.

To demonstrate SIF in action, the following composite formulation is offered, drawn from a fictional but clinically representative case:

Amina is a 16-year-old girl residing in a peri-urban informal settlement in Kiambu, referred via the antenatal clinic at 22 weeks' gestation following a disclosure of rape by a neighbour at age 15. She lives with her mother and two younger siblings in a single-room structure; her mother is a casual labourer. She was excluded from school following disclosure of the pregnancy. The perpetrator remains in the community. Amina's vulnerability was produced by poverty, inadequate community surveillance, and the absence of a protective adult male figure in a patriarchal neighbourhood context. Her ongoing exposure to the perpetrator, her economic dependency on her mother, and her school exclusion constitute active maintaining factors that sustain hyperarousal and social defeat. Institutionally, she received no mental health screening at her initial post-rape care visit and has had no contact with legal support services. Psychologically, Amina presents with intrusive re-experiencing triggered by physical contact during antenatal examination, chronic sleep disturbance, emotional numbing, and social withdrawal described by her mother as "she just sits and thinks." Her own explanatory framework understands her suffering as both a consequence of what was done to her and as a spiritual affliction requiring prayer. Her mother shares this framework and has prioritised church involvement over clinic attendance. Intersectionally, her age forecloses legal autonomy, her class forecloses private care, her pregnancy has repositioned her morally within both family and church, and her peri-urban location means her situation is known and discussed within her social network, intensifying shame and surveillance. A psychologically and ethically complete formulation of Amina's presentation must name all of these domains, not as context, but as clinical material.

In practice, the SIF model produces formulations structured around the following questions. What structural conditions produced this person's vulnerability? What acute experience of violence, defeat, and institutional failure precipitated this presentation? How does this person and her social environment make meaning of her distress? How do her gender, age, class, location, and pregnancy interact to shape both her suffering and her access to relief? What structural changes, in her social circumstances, in service provision, are necessary preconditions for psychological recovery? This formulation approach is explicitly non-individualist, as it names systems, not only psyches, as sites of pathology and intervention. It also provides a basis for advocacy, the formulation becomes a document that supports referrals for legal aid, social welfare, safe housing, and educational re-entry, as well as for psychological intervention.

C. Intervention

The evidence base for PTSD intervention with adolescent survivors of sexual violence in Kenya and comparable LMIC contexts is growing but remains limited. The following recommendations synthesise available evidence with the framework advanced here. Trauma-Focused Cognitive Behavioural Therapy (TF-CBT) has the strongest evidence base for adolescent PTSD across cultural contexts, including adaptation studies in Sub-Saharan Africa (Murray et al., 2014; Dorsey et al., 2017). However, TF-CBT adaptations for Kenya must be adopted to use local cultural frameworks for understanding safety and trust; involve community supports, rather than assuming individual therapy as the default modality, integrate psychoeducation in Swahili and Kikuyu as appropriate, and accommodate the perinatal context by attending to pregnancy-specific trauma triggers and mother-infant relational goals.

Narrative Exposure Therapy (NET) and its adapted forms have shown effectiveness in conflict-affected populations and are particularly suited to complex, developmental, and ongoing trauma (Schauer et al., 2011). NET's lifeline procedure, constructing a coherent biographical narrative that contextualises trauma within a life history, has particular value for adolescent survivors whose trauma may be part of a longer history of adversity rather than a single incident.

Group-based modalities, when carefully designed, offer specific advantages in contexts where individual therapy is scarce, as they reduce stigma, mobilise peer support, and provide psychoeducation at scale. The Empowerment and Creative Expression (ECE) groups piloted in Kenya by Wangu Kanja Foundation and similar organisations represent an important model, though systematic evaluation is needed.

Perinatal mental health intervention must be integrated, not siloed. This means co-locating psychological support within antenatal services; training midwives and Community Health Volunteers (CHVs) in trauma-informed communication; and establishing referral pathways that are genuinely accessible. The WHO mhGAP Intervention Guide provides a platform for task-shared mental health care, but its application to perinatal PTSD in Kenya requires further adaptation and fidelity

monitoring (WHO, 2016). Structural intervention is a clinical responsibility, not only a policy aspiration. Practitioners are ethically obligated to advocate for survivors within legal, educational, and welfare systems, document structural barriers as clinical evidence, and contribute to service audits and policy consultation. Clinical ethics in this context cannot be confined to the individual encounter.

To illustrate how these components, cohere under a SIF-informed care plan, consider the following worked example. A SIF-informed care plan for a 17-year-old in an informal settlement in Kiambu might include: (1) ten to twelve sessions of adapted TF-CBT, timed pragmatically around antenatal appointments to reduce transport barriers and maximise engagement; (2) a safety plan that explicitly accounts for the risk of retaliation, gossip, and perpetrator proximity, developed collaboratively with the adolescent and reviewed at each contact; (3) facilitated communication with a supportive aunt and, where the adolescent wishes, a trusted religious leader, to build a culturally grounded network of relational safety; (4) active liaison with a social worker regarding school re-entry planning, framed as a component of the clinical care plan rather than a separate referral; and (5) structured documentation to support a legal case if and when she chooses to pursue one, with the practitioner functioning explicitly as an advocate within the service system. Structural intervention is a clinical responsibility in this context, not merely a policy aspiration.

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D. Supervision

Working with adolescent survivors of sexual violence in a resource-limited, structurally complex environment places significant demands on practitioners. Supervision frameworks must be restructured to address vicarious traumatisation and secondary traumatic stress, the management of countertransference related to gender, age, and power, ethical tensions between confidentiality and mandatory reporting obligations under the Children Act (Kenya, 2022), and the practitioner's own positionality, including their cultural background, class location, and relationship to structural power.

Supervision should be intersectional in its own practice, as it must not replicate the hierarchies of erasure it seeks to address. This means creating supervision spaces in which practitioners from marginalised backgrounds can name their own experiences of structural constraint without these being pathologised. Group supervision models, when supported by trained supervisors, may be more feasible in Kiambu's resource context than individual clinical supervision.

In Kiambu's current resource context, a feasible and realistic supervision structure would include monthly 90-minute group supervision sessions for midwives and Community Health Volunteers, led by a clinical psychologist, with additional ad-hoc case consultation available for complex or high-risk presentations. Supervision sessions should explicitly allocate time for practitioners to reflect on their own positionalities, experiences of vicarious trauma, and the structural constraints shaping their practice, not as an optional reflective exercise but as a clinical governance requirement. Where individual supervision is not feasible, a peer consultation model with documented case review can provide a minimum standard of oversight. Individual clinical supervision should be reserved for qualified psychologists and counsellors managing the most complex cases.

Training for practitioners must explicitly include intersectionality theory and its clinical applications, structural formulation methodology, culturally adapted assessment tools, and the legal and policy framework governing GBV, adolescent rights, and mental health in Kenya.

Table 2 summarises the clinical implications across domains.

6. Equity Impact Analysis

A. Who Benefits

The primary beneficiaries of the SIF framework are adolescent survivors of sexual violence in Kiambu, particularly those who are pregnant, low-income, and without formal social support. By centring their structural context, the framework increases the likelihood of accurate PTSD identification, reduces both under-diagnosis through idiom mismatch and over-diagnosis through pathologising culturally normal responses, and generates formulations that connect psychological intervention with material and structural support.

Table 2
Clinical implications across assessment, formulation, intervention, and supervision

Clinical Domain	Standard Approach (Critique)	Proposed Approach (SIF Model)
Assessment	Validated Western PTSD scales; individual symptom focus	Multi-modal; idiom-sensitive; structural assessment integrated; CFI adapted for local context
Formulation	Biopsychosocial (individual focus); structural factors as 'background'	Structural-Intersectional Formulation (SIF): structure, culture, and intersecting axes as core domains
Intervention	Individual TF-CBT (manualized); limited cultural adaptation	Culturally adapted TF-CBT/NET; group modalities; perinatal integration; structural advocacy as clinical task
Supervision	Case discussion; clinical risk focus	Intersectional reflection; vicarious trauma; positionality; mandatory reporting ethics; structural constraints on practice
Service Design	GBV and mental health siloed; antenatal mental health absent	Co-located perinatal MH services; task-sharing with CHVs; integrated GBV-MH pathway; policy advocacy

Their children benefit indirectly, as perinatal PTSD treatment reduces the risk of adverse birth outcomes, impaired maternal-infant bonding, and intergenerational trauma transmission (Seng et al., 2011).

Practitioners benefit from a framework that validates the structural complexity they navigate daily, provides conceptual tools for formulation beyond the individual, and legitimates advocacy as clinical work. Supervision structures that attend to vicarious traumatisation support practitioner sustainability in a sector marked by burnout and high turnover. At the systems level, services that adopt integrated GBV–mental health pathways and task-sharing models are better positioned to deploy limited resources efficiently and to demonstrate equity-relevant outcomes to funders and policymakers.

B. Who Could Be Harmed

Several potential harms require explicit acknowledgement and mitigation. First, there is the risk of diagnostic labelling. Applying PTSD diagnoses to adolescent survivors in contexts of high stigma may inadvertently reinforce exclusion: a formal diagnosis can reduce educational and employment prospects, deepen family rejection, and mark girls as permanently damaged within their communities. Psychologists should discuss explicitly with each adolescent how diagnostic terms will be used and by whom. Neutral, less stigmatising language, such as "trauma-related distress," should be considered for letters to schools, employers, or community structures. Any formal diagnosis must be paired with active advocacy to prevent discrimination, and the survivor's own preferences about how her experience is named and communicated should guide clinical documentation decisions.

Second, there is the risk of cultural voyeurism and extractive knowledge production. Frameworks that name cultural practices as objects of clinical analysis, without involving community members and survivors in the production of that knowledge, risk reproducing the colonial epistemics they purport to critique. The SIF framework itself is not immune to this risk. Community participation in service design, implementation, and evaluation is a structural requirement, not an optional consultation gesture. Survivors and community members should have meaningful representation in training design and policy processes. Practitioners and researchers must maintain ongoing reflexivity about who benefits from the knowledge being produced, and the framework should be understood as a starting point for co-production, not a finished clinical technology.

Third, practitioner's exposure and institutional risks. Practitioners who adopt structurally oriented advocacy roles, documenting service failures, supporting legal cases, challenging institutional norms, face real professional and personal risks. Advocacy may conflict with institutional mandates, create role confusion, invite professional sanction, or position practitioners adversarially within health systems that are under-resourced and defensively managed. Training must prepare practitioners explicitly for these tensions rather than assuming that advocacy naturally follows from good values. Supervision structures must provide space to navigate ethical dilemmas about role boundaries. Professional bodies and health system managers must develop clear guidance about the scope of advocacy as a legitimate clinical activity, and practitioners should not be left to absorb institutional risk individually. who adopt structurally oriented advocacy roles face institutional and personal risks, where advocacy may conflict with institutional mandates, create role confusion, expose practitioners to professional sanction, or position them adversarially within health systems. Training and supervision must prepare practitioners for these tensions and support them in navigating them ethically.

Fourth, task-sharing without adequate infrastructure. Task-sharing models are necessary and potentially beneficial in Kiambu's resource context, but they carry genuine risks: inadequate training, insufficient supervision, and practitioner overwhelm. Community Health Volunteers and midwives handed a trauma protocol without ongoing clinical support may inadvertently re-traumatise the survivors they are attempting to help. Task-sharing must thus be understood as a system, not a shortcut. CHVs and midwives require structured pre-deployment training, ongoing clinical supervision as described in Section V, and clear escalation pathways for complex and high-risk presentations. Investment in the supervision infrastructure is not separable from investment in the task-sharing model, the one cannot function ethically without the other.

Last, there is the risk of framework stasis. Intersectionality and structural formulation can become rhetorical devices rather than living analytical practices if they are not continuously updated to reflect the specific, changing conditions of Kiambu's communities. A framework applied mechanically, without ongoing community engagement and critical reflection, reproduces the very decontextualisation it was designed to address. The SIF framework must be treated as a starting point for collaborative, iterative, community-informed refinement, not a fixed clinical technology to be imported and implemented wholesale. Practitioners and service managers should build in regular review cycles, informed by survivor feedback, community consultation, and emerging local evidence. The framework's theoretical commitments demand that its own application remains open to critique and revision.

7. Conclusion and Recommendations

This study has developed a Structural-Intersectional Formulation (SIF) model to guide clinical and policy responses to trauma, pregnancy, and PTSD among low-income adolescent survivors of sexual violence in Kiambu County, Kenya. The adolescent survivor who is pregnant, poor, and living in Kiambu occupies a site of concentrated structural disadvantage. She has been harmed by a person, but she is maintained in suffering by a system. Adequate clinical and policy response demands a framework that can see both, and that generates intervention at both levels. The SIF model is offered as that framework, not as a finished technology, but as a structured starting point for contextually grounded, ethically serious clinical and policy work.

A. Structural Domain

At the county level, the Kiambu County Department of Health should incorporate assessment of PTSD prevalence and service gaps for adolescent GBV survivors using community participatory methods, and establish dedicated mental health budget lines within the GBV response programme rather than treating mental health as an unfunded add-on to clinical care. Clear, resourced GBV–mental health integrated referral pathways must be developed within antenatal and one-stop crisis centre settings, with defined responsibilities, funded staffing, and regular review mechanisms. Co-located perinatal mental health support should be established within Kiambu Level 5 and sub-county facilities as a structural feature of obstetric care, not a discretionary service. School re-entry policies for adolescent mothers must be enforced and actively supported through liaison between health and education departments, given that educational exclusion is both a maintaining factor for PTSD and a barrier to long-term recovery.

At the national level, implementation guidelines for the Mental Health Act (2022) should be amended to explicitly designate perinatal mental health as a priority area. A national protocol for mental health support within the GBV clinical response pathway, with specific provisions for adolescent survivors, should be developed and resourced. The legal and practical barriers to safe, legal termination of assault-resultant pregnancies must be addressed as a mental health imperative, consistent with the constitutional framework already in place.

B. Cultural Domain

Training institutions should incorporate idioms of distress, including *"kufikiria sana"* and somatic equivalents, into core clinical psychology and counselling curricula alongside intersectionality theory and structural formulation methodology. Adapted Cultural Formulation Interviews, contextualised for Kiambu's adolescent population, should be developed collaboratively with community members and integrated into standard assessment practice. Supervision competency frameworks must include structural reflexivity, culturally attuned countertransference, and vicarious trauma, not as elective additions but as core practitioner competencies. Systematic engagement with religious and community leaders should be built into service design, recognising that spiritual and community frameworks are not obstacles to care but potential allies within a culturally integrated treatment model.

C. Individual and Developmental Domain

Trauma-focused intervention must be adolescent-appropriate and perinatal-specific. Clinicians should integrate trauma screening, adapted, culturally responsive, and using the minimum assessment bundle described in Section V, into all antenatal contacts for adolescent attendees. Culturally adapted TF-CBT and NET pilots within existing one-stop crisis centre settings should be funded and systematically evaluated, with survivor co-design embedded in the adaptation process. Perinatal mental health protocols must attend explicitly to the obstetric encounter as a potential site of re-traumatisation, training midwives and CHVs accordingly. Researchers must urgently undertake validation studies of locally adapted PTSD assessment tools for adolescent Kenyan populations, and evaluate the SIF model's efficacy and acceptability through participatory methods with rigorous attention to data sovereignty, publication ethics, and community benefit.

D. Positionality

Any framework that claims intersectional and decolonial commitments must apply those commitments reflexively to its own production. The perspectives, disciplinary formations, and institutional locations of those who develop and apply clinical frameworks inevitably shape what is seen, what is named, and what is proposed as remedy. This paper has been written from within particular professional and geographic positions that carry their own blind spots, and the SIF model should be tested, critiqued, and refined through ongoing engagement with Kiambu's communities, practitioners, and above all, survivors themselves.

Between silence and survival, adolescent survivors deserve clinical frameworks as complex, as structural, and as humane as their actual lives. The SIF model is an attempt to meet that demand, to build a clinical practice worthy of the people it serves.

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