PSYCHOSOCIAL EFFECTS OF TRAUMATIC EXPERIENCES IN CHILDREN LIVING IN ORPHANAGES: A SELECTED CASE OF KINGS KID VILLAGE AND OUR HOME CHILD CARE CENTER IN NAIROBI COUNTY, KENYA

by

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A thesis presented to the School of Human and Social Sciences of Daystar University Nairobi, Kenya

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APPROVAL

PSYCHOSOCIAL EFFECTS OF TRAUMATIC EXPERIENCES IN CHILDREN LIVING IN ORPHANAGES: A SELECTED CASE OF KINGS KID VILLAGE AND OUR HOME CHILD CARE CENTER IN NAIROBI COUNTY, KENYA

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DECLARATION

PSYCHOSOCIAL EFFECTS OF TRAUMATIC EXPERIENCES IN CHILDREN LIVING IN ORPHANAGES: A SELECTED CASE OF KINGS KID VILLAGE AND OUR HOME CHILD CARE CENTER IN NAIROBI COUNTY, KENYA

I declare that this thesis is my original work and has not been submitted to any other college or university for academic credit.

Signed: ______________________ Date: ________________

Waithera Margaret Wangui 11-0901
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I would like to express gratitude to God who has given me strength all through. My deep appreciation also goes to my supervisors, Dr. Michael Kihara and Dr. Niceta Ireri, for their continuous encouragement, guidance, and direction throughout the entire writing of this thesis. To my husband, Jones Muinde - thank you for believing in me and encouraging me to carry on even when I was feeling weary. Lastly, I am so thankful to my classmates who have been very supportive and to my friend, Jane Mwihaki and my sister, Sabina Magiri; may God bless every one of you!
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<tr>
<td>APA</td>
<td>American Psychological Association</td>
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<tr>
<td>CBT</td>
<td>Cognitive Behavior Therapy</td>
</tr>
<tr>
<td>CIPEV</td>
<td>Commission of Inquiry into the Post-Election Violence</td>
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<tr>
<td>ERB</td>
<td>Daystar Ethics and Review Board</td>
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<tr>
<td>NACOSTI</td>
<td>National Commission for Science, Technology, and Innovation</td>
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<tr>
<td>NSCH</td>
<td>National Survey of Children’s Health</td>
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<tr>
<td>SPSS</td>
<td>Statistical Package for the Social Sciences</td>
</tr>
<tr>
<td>UN</td>
<td>United Nations</td>
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<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<tr>
<td>VAC</td>
<td>Kenya Violence against Children Study</td>
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<td>WHO</td>
<td>World Health Organization</td>
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ABSTRACT

This study explored the psychosocial effects of traumatic experiences in children living in two orphanages: Kings Kid Village and Our Home Child Care Center in Nairobi County, Kenya. The study was guided by two theories: the psychosocial theory and cognitive behavior theory, and it adopted the descriptive research design while the data collection tool was a questionnaire. Stratified sampling technique was used with a sample size of 98. The data was analyzed using the Statistical Package for the Social Sciences (SPSS) Version 22. It was established that the children in the selected children's homes suffered different kinds of traumatic experiences that contributed to psychosocial effects. For example, 61% were sexually abused, 53% suffered abandonment, and 74% faced violence. The majority of the participants agreed that children's traumatic experiences caused various psychosocial effects such as loss of sense of self, poor attachment, and poor association with other people. The study recommends that family members and caregivers in children's homes need to find ways to eliminate any form of abuse - be it verbal, physical, or emotional, against children in order to avoid the risk of trauma that may result in negative psychosocial effects.
DEDICATION

I dedicate this work to Jones Muinde, my husband and the love of my life, for the endless emotional support; to my son, Finn Kasenge, to my sponsors, Bill and Mary Reeves, for the continuous support and fervent prayer, and for harkening to God’s call in holding my hand through the program; and to my ever-present guardians, Dan and Jane Pope, for your love and paving my academic path. To everyone who supported me in one way or another, may God shower you with His blessings.
CHAPTER ONE
INTRODUCTION AND BACKGROUND TO THE STUDY

Introduction

This chapter presents the background on the psychosocial effects of traumatic experiences in children living in the selected children homes. The chapter also highlights the statement of the problem in relation to the study and the purpose for the study. The research objectives, research questions, justification, and the scope of the study are also discussed in depth as part of the introduction and the background to the study. This gives more details of psychosocial effects of traumatic experiences in children living in the selected children homes.

Background to the Study

Eriksson (2018) defined trauma as the neglected disease of the modern society. Curran (2013) regarded trauma as the most avoided, ignored, misunderstood and untreated cause of suffering in human life. Trauma is an area of mental health that still poses a global health concern, especially when it comes to children’s health and wellbeing. Traumatic experiences can affect children’s daily lives as well as their (children) ability to get along with others (Cunningham, 2004).

Children experience some stress of a kind at one point or another in their lives. There are instances where children grow up in healthy and functional families and may not experience traumatic experiences during childhood. On the other hand, there are children who tend to face hardships which leaves them at a crossroad of traumatic experiences. The child may feel overwhelmed even in adulthood (Hebert & Ballard, 2007). This necessitates the need to address trauma in children.
According to Curran (2013), trauma acts as a rapture loss of connection to the families as well as the world. Psychologically, the loss, although enormous, can be manifested later in the child’s life, and therefore, it is best understood as a spectrum of conditions. Curran also highlighted that trauma is a source of tremendous distress and dysfunction in the life of a child. Children have and are continually experiencing war, parental neglect, crime, domestic violence, physical abuse such as rape or molestation at a young age, post-election violence, or even frequent shifts from one children’s home to another. These children may have developed wounded hearts from these bad experiences, thus continually reliving these experiences that caused their past trauma (Bagge, Miersma, & Hill, 2016).

A traumatic life event is one that threatens a child’s life and results in childhood exposure to victimization (Statman-Weil, 2015). Trauma has a great impact on a child’s development, and that results in disruptions in giving care, thus the need to address the social and psychological effects of the trauma as depicted in the child’s life. Traumatic experiences include any type of abuse, be it sexual, physical, psychological, violence, abandonment, neglect, war, accident and injuries, presence of an unsafe caregiver, lack of permanent safe person, among other traumatic experiences. In addition, children affected by trauma in one way or the other or have been exposed to any kind of traumatic event sometimes avoid people or situations that threaten them. These children are exposed to psychosocial threats, and therefore, they might fail to build relationships as they may feel isolated, lonely, and may not engage in activities that give them a sense of fulfillment. These individuals may be set on a frustration path, and the feeling of failure may also creep in, thus hopelessness and despair (Brown & Lowis, 2003).
The psychosocial effects that children are exposed to are negative self-thought, loss of sense of self, hypervigilance - where the child is constantly anticipating harm, loss of safety, as well as the loss of danger cues that are necessary for proper response in the interactions with the stimuli. The child may have the image of the traumatic event in their mind as a result, and their thoughts may be interrupted (Walkley, Meg, & Cox, 2013). A close relationship exists between the traumatic experiences and the psychosocial effects, as was reflected in this study. Curran (2013) asserted that individuals develop different characteristics of personality changes, which may include alterations of identity formation and ability to relate with ones surrounding. Moreover, the individuals are prone to repeated harm, which is likely to arise from their interactions with other people or even be self-inflicted. According to previous studies as highlighted by Eriksson (2018), there is an association between residency in a region with lower socioeconomic status and an increased risk of traumatic event as well as death due to trauma. This necessitates the need to address the impact of traumatic experiences in children.

Before the age of 16 years, two-thirds of children in the United States of America are exposed to a traumatic event. Each year, between 3.5-10 million children witness the abuse of their mother (Osofsky, 1999). Up to half of these children are also abused as cited by Hodas (2006). According to the American Psychological Association (2008) update by the presidential task force on trauma in children, more than two-thirds of children reported that they had already experienced trauma by the age of 16 years, with an estimated rate of witnessing community violence from 39% to 85%. In the same report, 7.9 million children are reported to have undergone acute trauma and other forms of traumatic experiences. The United Nations reported that out of four million, two million people killed in conflict circumstances are children.
(Novelli & Cardozo, 2008). The report further highlighted that over 10 million children had suffered severe psychological trauma either from experiencing or witnessing.

Uehara, Chalmers, Jenkins, and Shakoor (1996) illustrated a research carried out by Community Mental Health Council in 1990 on 536 African American school children in grades two, four, six, and eight in Chicago. This showed that a high number of children had witnessed violence in their environment. Approximately 26% of the children reported that they had witnessed other people's shooting, and 29% had witnessed an actual stabbing of other people. A subsequent survey on 1000 middle and high school students found similar results, where 46% reported having been personal victims of one to eight violent crimes. Further, 35% had witnessed stabbing, 39% had been exposed to shooting, and nearly one quarter had observed individuals being killed. About 47% of the victims were very familiar to the perpetrators as family members, classmates, or neighbors (Bell & Jenkins, 1991).

Data analyzed from a study focusing on 1,279 students in 70 schools around Kenya in 2006, revealed that 57.5% had faced sexual harassment with the girls recording a slightly higher frequency of 60%, as boys recorded 55% (Ruto, 2009). The World Health Organization (WHO) estimated that 36%-62% of all sexual assault victims were aged below 15 years. Nairobi Women’s Hospital showed that 55% of those violated are girls aged 0-15 years while boys were also victims (WHO as cited in Ruto, 2009).

A survey done by the Kenya Violence against Children (VAC) in 2010 on the current and lifetime events of the Kenyan children between 13 to 24 years indicated that violence against children is one of the serious problems in Kenya (United Nations Children’s Fund [UNICEF], 2012). The same survey indicated that during childhood,
32% of females and 18% of males experience sexual violence. Females and males, 66%, and 73% experienced physical violence, respectively, while 26% of females and 32% of males experience violence as children (UNICEF, 2012).

Statement of the Problem

Children’s early experiences deeply affect their future psychological and social development. When children experience stressful events, they are prone to more immediate and long-term psychological and social trauma (Cook et al., 2017). Traumatic experiences affect each child differently. The study investigated these traumatic experiences that affect the child in negative ways, such as inhibiting the child’s ability to cope. Children are more vulnerable to traumatic experiences than adults, whether such experiences occur in the community or in the name of “treatment.” Children who experience trauma at an early age are set on a trajectory path that leads to possible mental health issues well into adulthood (Hodas, 2006).

This research was conducted to find out if there is a relationship between traumatic experiences and psychological effects in children.

Purpose of the Study

The purpose of this study was to find out the psychosocial effects of traumatic experiences in the children living in the selected children homes

Objectives of the Study

The researcher was guided by the following specific objectives:

1. To determine the traumatic experiences that children in Kings Kid Village and Our Home Child Care Center experience.

2. To establish the psychological and the social effects of traumatic experience in children living in Kings Kid Village and Our Home Child Care Center.
3. To determine the relationship between the psychosocial effects and the traumatic experiences in children living in Kings Kid Village and Our Home Childcare Center.

Research Questions

1. What were the traumatic experiences that children in ‘Kings Kid Village’ and ‘Our Home Child Care Center’ experience?
2. What were the psychological and the social effects of traumatic experience in children living in Kings Kid Village and Our Home Child Care Center?
3. Was there a relationship between the psychosocial effects and the traumatic experiences in children living in Kings Kid Village and Our Home Childcare Center?

Justification for the Study

One cannot underestimate the different experiences that children go through. The immediate and long-term consequences of traumatic experience are multifaceted; therefore, the need to address the traumatic experiences and the relationship with the psychosocial effects in children (Cook et al., 2017). As highlighted by Bolton et al. (2014), the study findings create a groundbreaking approach on how the child’s mental health is viewed and create an understanding on the need for effective health and wellbeing of children.

Significance of the Study

The findings of the present study would be of great advantage to different people who may be handling children who have faced trauma. These include parents, teachers, guardians, counselors, among others.

The information would be useful to the relevant government organizations that are responsible for children matters.
The information would also be useful to the mental health practitioners by guiding them in knowing how to deal with the children affected by trauma.

Assumptions of the Study

The following were the assumptions of the study:

1. Participants in the study would be willing to share the psychosocial and the social effects of traumatic experiences.

2. Participants in the study had suffered psychosocial effects as a result of traumatic experiences. The study results confirmed that the majority had experienced abuse and violence.

Scope of the Study

The study was conducted in the selected two orphanages: Kings Kid Village and Our Home Child Care Center, Nairobi County. The orphanages have 57 and 41 children respectively, thus a total population of 98. The age range is the criteria of the study sample desired, which is 11-18 years in the selected two orphanages. The children who were not within this age range were not included in the study.

The children included both boys and girls from the two children homes who are from various economic backgrounds, social status, religious backgrounds as well as cultural beliefs. Based on this, the researcher was able to obtain diverse information necessary for this study. The research was carried out in October 2019 when the children from the two orphanages were not on a very tight schedule.

Limitations and Delimitations of the Study

In this study, some of the limitations encountered were as follows:

1. The participants in the study were potentially stressed by the traumatic experiences. In order to deal with this, the research participants were well
debriefed about the exercise that they were to undertake and the possible effects emanating from the exercise.

2. Some of the participants were not aware of the psychosocial effects of the traumatic experiences. Hence, the researcher used a tool that enabled the participants to recognize possible effects of traumatic experiences and their psychosocial effects in their life.

3. The tool for data collection was a questionnaire that was distributed to children who were not fluent in the English language. The researcher, therefore, involved an interpreter to help the participants in understanding the questionnaire.

4. The researcher’s use of an interpreter would have interfered with confidentiality. To address this, the interpreter was trained on the need to ensure confidentiality with all the participants.

Definition of Terms

Child: According to Kenya’s Sexual Office Act as cited in Ruto (2009), a child is defined as a human who is under the age of 18 years. In this study, the participants were children living in Kings Kid Village and Our Home Child Care Center who were between the age of 11-18 years.

Psychosocial effect: The psychological and social aspect of the child’s functioning in terms of interaction with others. In this study, the term was used to describe the social and psychological issues in children such as loss of sense of self, loss of danger cues, dissociation, among others as a result of trauma.

Stress: Defined as being overwhelmed by emotions or situations. Stress inhibits a person’s ability to cope and increases the degree of trauma (Curran, 2013).
Trauma: Defined by Pelletier (2016), is the experience of an unpredictable event, which is perceived to be a threat to one’s sense of integrity or survival. In this study, trauma was used to show the mental state of people.

Traumatic experience: According to Bell (1995), are powerful and overwhelming events in the life of an individual that leaves one hopeless or in helpless situation. In the context of this research, the term indicated different experiences that are regarded as traumatic, such as sexual abuse, violence, neglect, and abandonment.

Summary

This chapter has outlined the background information to the study in relation to the topic of research, which is the psychosocial effects of traumatic experiences in children living in the selected orphanages. The problem statement and the purpose of the study have been discussed. Research objectives, research questions, justification, scope, and the limitations and delimitations have also been discussed.
CHAPTER TWO

LITERATURE REVIEW

Introduction

This chapter presents a review of literature on psychosocial effects of traumatic experiences in children living in orphanages, with a focus on Kings Kid Village and Our Home Child Care Center. Literature was reviewed from primary sources.

Children are affected by traumatic experiences. These traumatic experiences include sexual abuse, emotional abuse, physical abuse, neglect, exposure to community violence, to mention but a few. The epidemiology of trauma and traumatic experience in children, and the review of the psychosocial effects in children living in the two orphanages are discussed. The last section of this chapter discusses the study’s conceptual and theoretical frameworks to explain the relationship between traumatic experiences and the psychosocial effects in children living in the two orphanages.

Theoretical Framework

The present study was based on two theoretical orientations: the psychosocial theory and cognitive behaviour theory.

Cognitive Behaviour Theory

According to Corey (1993), cognitive behaviour theory was first developed by Ellis in 1962 and was further developed by Beck (1976). This theory combines cognitive and behaviour principles and its approach. These approaches are described as active, problem-oriented and require explicit identification and situations. The main characteristic of this theory is that it focuses on cognitive processes which are related
to the individual’s interpretation of his or her thoughts and behavior (Hupp, Reitman, & Jewell, 2008).

Cognitive behaviour theory (CBT) is influential when it comes to behavior changes and emphasizes on the need to look at the thinking aspect and the deciding (Macavei, 2005). The main assumption is that people contribute to their own psychological problems through their interpretation of their surroundings. Ellis also stated that emotions, interpretation, and behavior interact significantly and may result in a reciprocal cause-effect relationship. In the view of human nature, this theory holds that human beings have both rational and irrational thoughts and avoidance thoughts of pattern.

In this study, the researcher focused on this theory which perceives psychological problems as stemming from faulty thinking as a result making incorrect inferences. Cognitive behaviour theory incorporates the individual’s psychological and social aspects. The goal is to recognize the particular or the multiple traumatic experiences that a child goes through in his or her life and the relationship resulting. The theory also illustrates that there are thoughts and maladaptive beliefs that a child may be prone to when they go through a traumatic experience. When a child has gone through trauma, they define the world around them, as it is evident in this theory, that the child’s thoughts and feelings will be determined by how they perceive and structure their experiences (Corey, 2009).

Cognitive behaviour theory aims at helping children identify and change the disturbing thoughts of self and interfere with those negative patterns that influence the behavior and the feelings. Children who have experienced any form of traumatic experience exhibit some psychosocial effects such as avoiding people, places and things that remind them of the traumatic experience. These children as depicted in
this theory, may not be in a position to control every aspect of how they think or feel, but can learn how to control how they interpret and deal with their social surrounding that they are living in.

Cognitive behaviour theory tends not to focus on the underlying unconscious and the need for change, just as other theories such as psycho-analytic theory. Cognitive behaviour theory tends to focus more on the thought, which does not make it easy to change the distorted thoughts (Cheavens, Feldman, Woodward, & Snyder, 2006). Despite the weaknesses of this theory, its strength is evident, especially when it comes to addressing both psychological and the social aspects of a child’s life with an elaborate, well-planned approach. CBT, therefore, poses as the best for the study even in instances where little modification might be necessary (Lin, 2002). According to Corey (2009), CBT is designed for all ages and for various population. Therefore, the theory stands as the best and most appropriate for this study. This theory aims at helping children who are experiencing trauma identify and change the disturbing thoughts of self and the principles of this theory interfere with those negative patterns that influence children’s behavior, thoughts, and social interactions.

Erikson’s Psychosocial Theory

Erikson’s theory of development highlights the different stages that help a child grow into impactful individual and contribute positively to the society. According to Sokol (2009), this theory indicates that every individual goes through different life stages in which he or she must cope with a central psychosocial problems or crisis. The individual goes through a crisis and is supposedly expected to maneuver each stage successfully in order for them to develop into healthy human being.
This theory’s principles and stages contribute to an individual psychosocial effectiveness especially in the instances of traumatic experiences in a child’s life. Psychosocial theory gives a range of factors that show the psychosocial effects of traumatic experiences which interfere with the wellness of children. Erikson’s theory also serves as the best theory in evaluating the relationship that exist between the traumatic experiences and the psychosocial effects in the children living in the orphanages.

The purpose of this study was to explore the psychosocial effects of traumatic experiences in the life of children living in two orphanages. The theory pauses as the best fit due to its strength in depicting the crisis that children go through in life, especially when these children are under a threat of traumatic experiences, that interfere with their (children) normal growth and development. Various crisis stages by Erikson put emphasis on the integration of the psychosocial forces in the determination of personality functioning of a child. The focus is on unique interpersonal, social, and historical experiences of the child during socialization.

Industry verses inferiority is a phase that involves children who are eleven to thirteen years of age. As illustrated by Erikson, children at this stage try to involve themselves in different tasks, which are typical normal developmental milestones. According to Sokol (2009), identity verses role confusion is a stage where the child is between the age of thirteen to twenty-one years. Identity verses role confusion is a phase where adolescent is faced with a lot of growth. Children may at some point have so many questions about self, which involves integration of all that the child has picked up from the social surrounding such as family, peers, church, school, among others. Children who have experienced trauma display changes which inhibit their
ability to cope in a normal and acceptable style of development. Such changes may impact the way these children respond to conflicts versus the identity formation.

The stages that best inform this study are industry versus inferiority as well as identity versus role confusion stage. The reason being these are the exact ages of the participants that are involved in this study. In other words, these two stages form the most applicable phases for the study because the participants involved in this study are between eleven years of age and extends to eighteen years of age. One of the critics of this theory questions its validity by asking if each of Erikson’s crisis is measured on one or two continuum and how one can operationally define and measure the ratios representing the degree to which a crisis has been resolved (Ochse & Plug, 1986).

The psychosocial theory illustrates the different stages that a child goes through and the need to be able to negotiate each stage effectively to lead a healthy life. In addition, this theory practically embraces the children as actively attempting to deal with the traumatic experiences in a constructive way.

Cognitive behaviour theory and psychosocial theory have been selected in the past studies in order to assess and support in the study of psychopathology as well as depression (McGrew, 2005). Psychosocial theory has been instrumental in assessing the psychosocial perspectives that can help people evaluate how relationships are formed (Dwairy, 2002).

General Literature Review

According to Berger (2004), trauma studies have emerged over the years as the most important new fields in humanities studies. According to Evers (2018), it is estimated that 26% of youth in the United State of America, witness or experience a traumatic event before the age of 4 years and others experience chaos at home.
Children are exposed to different traumatizing experiences and what maybe traumatizing to one child, may not be traumatizing to the other. It is therefore important that different techniques be employed to address traumatic experiences. Acknowledging the effects of trauma on children’s development is critical for providing the support and understanding necessary for their (children) healing.

According to O’Brien (2010), there are three primary developmental tasks in the psychological and social development of a child. These tasks or skills are classified as attachment, initiative, and self-regulation. Traumatic experience can be manifested in many ways in the life of a child. According to Curran (2013), traumatic experiences results to psychological loss that is difficult to appreciate, as it happens gradually overtime. There is a need to understand what the childhood trauma is and the challenges that are involved, even when the information might be accessible in different studies.

In a study comparing levels of exposure to traumatic events amongst South African and Kenyan youth, it was found that 80% of these individuals had been exposed to severe trauma at some point in their lives (Seedat, Nyamai, Njenga, & Vythilingum, 2004). A traumatic event is comprised of a painful negative emotion, that interferes with coping mechanism of children. Some of the examples are death of a loved one, violence, neglect, sexual abuse, and child’s mistreatment. Children who have gone through traumatic experiences may have negative psychosocial effects about themselves. They might believe that the traumatic experience like sexual abuse, neglect or abandonment occurred because of something they did or something that they failed to do. However, this is not the case as the child is not the one to blame for the trauma they experience (Kaminer & Eagle, 2010). The presence of a caregiver is very important, as this helps the child to learn new skills, that may enable them
(children) to develop a sense of industriousness that helps in coping with the social environment.

When painful events occur, they bring about traumatic experiences which could result to psychosocial effects in the life of children. Children are usually exposed to different types of mistreatments that result to trauma even in their future lives. Some of the examples of these exposures are physical, sexual, and psychological and negligence from the elders. When children experience trauma, and care is not given, challenges arise, and this exposes children to other risks that impact their life.

Types of Trauma

There are different types of trauma that children might experience. Acute trauma is a type of trauma that results from a single incident. According to Pine and Cohen (2002), acute traumatic stress is a terrifying event that one individual experience or may learn about and causes a lot of fear or hopelessness in return. This kind of trauma is experienced by anyone who witnesses a traumatic violence or any other painful event for that matter. An example is when an individual is driving a car and is involved in an accident. The individual might take sometimes until they can comfortably drive a car again without experiencing any triggers of the accident or fearing that they might be involved in a car accident.

Children are often exposed to traumatizing events and sometimes they may develop symptoms or urgency that need to be probed in order to help them (children) from the painful experiences. In other instances, the symptoms may involve flashbacks and nightmares that are unpredictable in the life of a child. Other times, children might end up avoiding of anything that reminds the child about trauma. Parents, teachers, professional psychologists, care workers and others can help
children heal and grow by ensuring that they are safe persons whom the child can identify with and easily reach out to for help in processing the difficult situations (Bath, 2008).

Chronic trauma is another type of trauma and this happens in a repeated and prolonged pattern. It is when a child experiences many repeated traumatic events such as violence or neglect for a prolonged period, and at one point or another, they may end up reacting differently to the experiences. Some of the chronic traumatic experiences that a child may experience are sexual abuse, child maltreatment, domestic violence.

Complex developmental trauma is another type of trauma that happens when a child experiences far more than acute and chronic trauma. Van der Kolk (2017) asserted that complex developmental trauma develops from chronic and acute trauma. When a child is exposed to danger unpredictably and uncontrollably (chronic) at an early age, their psychological functioning is affected. Children who experience complex developmental type of trauma exhibit certain behaviour which is unpredictable (Terrasi & Crain-De Galarce, 2017). In addition, when the caregiver is not efficiently present and responsive to the child, the child lacks the necessary nurturing thus he or she is negatively impacted by complex developmental trauma. The child may feel neglected and abandoned which may leave the child at a hopeless situation.

Complex developmental trauma has a negative effect on child’s life, in that it affects the key areas of developmental milestones of children. Some of these milestones are the child’s touch hunger, executive functioning of the child which interferes with the brain’s proper functioning and control of impulses. A research on neurobiological functioning highlighted the impact of chronic fear on brain
development and the impact that this has on the way people interact with each other, even when brain determines the individual’s thoughts and behaviour and it also impacts the capacity to respond to threat (Erickson, 2010).

Homes, Levy, Smith, Pinne, and Neese (2014), asserted that complex trauma exposure result into effects that can extend from childhood to adolescents and even adulthood. This type of trauma leads to a loss of core potential developmental milestone in the life of a child. This is as a result of the problems that put children at a vulnerable position for more exposure to risks in their lives and in the life of their families. Traumatic events can lead to adverse outcomes such as alcoholism, poor self-related health and even diseases. Many forms or examples of childhood trauma, specifically the interpersonal violence, often happen in closed doors and is therefore rarely witnessed or seen by people from the outside the family. More often, the perpetrators as opposed to the victims, mostly children, have the knowledge of what really happened. The perpetrators are fearful to face the law and to bear the social consequences in the instances that they are discovered.

According to D’Andrea, Sharma, Zelechoski, and Spinazzola (2011), multiple exposures to traumatic event can greatly impact the intensity of individual’s psychological functioning. The authors illustrated that stress also result to physical harm and is likely to expose individuals to psychiatric disorders as well as the children’s ability to regulate, identify, and express emotions. In a safe and nurturing surrounding, the child can connect with the care provider, which help children’s brain to develop and grow despite the stressful environment. The individual learns to control how he or she is feeling and is capable of developing a framework necessary to deal with future psychological stress. When children are born, they are not able to form a safe and secure interaction and therefore, they rely on a primary care provider
for comfort. This can lead to various struggles as they try to calm themselves especially when they (children) find themselves in threatening situations. For children to be able to regulate their emotions and respond flexibly to painful situations, there is a great need to express the emotions and to form relationships even when it is challenging. This, therefore, impact a child’s capacity to establish and sustain significant attachments throughout his or her life.

Sometimes when children experience trauma, they may not talk about their sad experiences for many psychological reasons. These may include the fear of the unknown, how other people will view them, guilt and shame, fear of the offender or even the fear that the person who has defiled them may suffer. Some children who suffer from psychosocial effects, may not understand that it is okay to share their pain with a trusted and safe adult (Bagge et al., 2016).

The prevalence of trauma exposure and its effect in children is a concern and may lead to changes in the individual’s long-term response to stress. Exposure to trauma also affect children’s ability to express emotions and may place these children at risk of internalizing and externalizing problems when exposed to a harsh environment. (Grasso, Ford, & Briggs, 2013). Children must identify their temperaments and the traumatic events. They (children) learn by being able to identify and express their emotional state. This eventually helps them learn how to regulate the emotions and the internal experiences (Spinazzola et al., 2017).

Psychosocial Effects of Traumatic Experiences in Children

Research on children’s response to trauma and traumatic events document that children who experience traumatic events appear to have a high ‘dose effect’ and worse psychological outcome. Children who experience trauma at an early age are predisposed to other health risks (Modgil et al., 2012). Children are resilient and are
normal human beings who should be subjected to normal feelings, and experiences. Every child is affected by trauma differently when it comes to the psychological, and social aspects. This could differ in severity and nature of traumatic experience. The degree of the effect that trauma has on each child depends on factors such as age, child’s perception of danger, a child being the victim or witness and child’s past experiences of trauma. Traumatic events can affect how a child’s brain develops and this can be a lifelong consequence. The following are the psychosocial effects of traumatic experiences in children:

Effects of trauma on brain development

LeDoux (2003) highlighted how emotional brain presents fascinating findings and how brain can detect danger before even one can experience the feeling of being afraid. This is further explained on how the very same brain initiates the physical responses even before one is aware of the associated feeling. Children may avoid anyone or anything that reminds them (children) of the trauma or they may re-enact their trauma in their play as they interact with other children as the memory that is recurring in their brain. Thompson and Cui (2000) stated that trying to understand trauma, brain, and human development as well as the relationship, is important when it comes to understanding children’s response.

Trauma can have a serious consequence to the normal development of the brain and its chemistry as well as the nervous system coordination. There is a particular way that the body responds to trauma. This response is controlled by a natural alert system which is designed to evaluate threats and help in keeping the body safe. Traumatic experiences affect the balance of the brain by disrupting its homeostasis in multiple areas. These areas are specifically aimed at responding to threat or any kind of attack. Although the brain is continually developing, the
experiences of trauma highly affect its development. Comprehensive developmental experience is key in determining the functional status of a mature brain (Perry & Pollard, 1995).

A child’s brain is continuously changing with time. The changes occur through a selective loss or ‘pruning’ which can be interfered with or completely damaged as a result of trauma. The brain continuously develops and therefore proper nurturing is very vital as this shape and restructures the brain and this helps in making sound judgments. The change also affects different functions such as regulations, that may influence the social interactions of the child to their surroundings. The loss of neurons and their connections can lead to the psychosocial problems that might affect the logical thinking and the impulse control (Putnam, 2006). The child is then prone to be on constant alert to any threatening situation by flight, freeze or fight. This is often exhibited in the child’s social interactions or in the behavior.

Balbernie (2001) illustrated how the brain has an ability to change according to the surrounding. The nervous tissue is so unique that it is structured in a way that it can change and respond to the external signals as reflected in the environment. The child’s brain is not fully developed but continues to gain permanency and appropriate connections. The child need help in order to be able to interact with the surrounding, as this is one way of allowing the brain to continually grow. Balbernie highlighted that as the brain continues to grow, it is setting up synaptic connections and storing critical information. With a traumatic experience, some areas of the brain are activated and this results into the child exhibiting neural response patterns that are associated with their traumatic experiences. These children may react to threat in an exaggerated manner that other children who have not experience trauma may not.
A physiological change to the developing brain in response to trauma causes perceptive losses and delays in physical, emotional, and social development of a child. These provoke emotional and behavioral responses that interfere with children’s learning and school engagement (Holmes et al., 2014). When a child is exposed to a traumatic event, it becomes very difficult for the child to process information and some of the children may even develop sensory issues or difficulties. This can hinder their learning whether it is writing or reading. Trauma inhibits learning ability and exposes children to more adverse childhood experiences as highlighted by (Burke, et al., 2011).

Trauma or traumatic event in an individual’s life affect the ability to build relationships with classmates and teachers. Children who have experienced trauma may be distrustful or suspicious of others, leading to question the reliability and predictability of their relationships. Additionally, children who have been exposed to violence often have difficulty responding to social indications, and they may withdraw from social situations or bully others (Van der Kolk, 2003). In addition, children who have been physically abused have been found to engage in less intimate peer relationships and tend to be more aggressive and negative when it comes peer interactions (Margolin & Gordis, 2000).

Trauma affects many areas of a child’s life. Some of the affected areas being the body, the brain as well as the children’s belief system. Children like adults, learn by experiences that they go through. When the experience is good, the child’s brain has a room for healthy sensory development, if the experience is bad, the child suffers from a sensory processing disorder where the brain is not able to distinguish the incoming senses thus the child is exposed to risk. Children may constantly operate from what is known as the survival brain as opposed to thinking brain. The thinking
brain has somehow gone offline. The child may constantly be on the survival mode, which is clearly seen in either their behavior or reactions towards the external surrounding (Fox, Levitt, & Nelson 2010). The child is not able to make sense of what is happening in the environment and he or she may continually communicate through their behavior.

The child may portray some protective strategies such as aggression or violence. The child may also become so manipulative, and to some extent, the child may often try to be in control. These protective factors ought not to be confused to disobedience that need to be punished, but the caregiver needs to deal with the behaviour from an angle of understanding that the child is operating from the survival mode. The child may be acting from the point of being overwhelmed by emotions such as anger, fear and frustration as highlighted by Elliot (2012).

Effect of trauma on belief system

Trauma affect the belief system of a child by altering the child’s worldview. These belief systems originate from the words the child has constantly heard either being called or being said to him or her. The belief system may emanate from the child’s painful past experiences. These traumatic experiences shape a child ‘s belief about themselves as well as what they believe to be true. The child might begin to see the world through the lens of new formed beliefs. Emotions and behavior are impacted by thoughts about life. For children, the belief system affects feelings, which in turn affect the behavior towards other people. There is a great need to change the child’s experiences. Giving children new affirming words will eventually change their belief system (Peres, Moreira-Almeida, Nasello, & Koenig 2007).
Effect of trauma on self-regulation

Trauma overwhelms the child’s capacity to be able to handle and adapt to emotional responses. According to McCraty and Zayas (2014), it becomes a challenge when a child is not able to successfully handle and adapt to emotional responses. Psychological problems following early onset interpersonal trauma involves emotional regulation challenges. These challenges can result to emotional hyperactivity to trauma and/or hypo-reactivity in form of emotional numbing (Ehring & Quack, 2010).

Lack of capacity for emotional self-regulation is probably the most striking feature of children who are chronically traumatized. Self-regulation of a child is built on the attachment that the child has towards a safe adult. When the attachment is greater, the more open the child is to the safe adult’s guidance of external regulation and the better the child becomes in co-regulation. This child eventually develops the skill of self-regulation to adulthood. Abuse and neglect affect children in a major way, and this may result to self-regulation disorders, in which dissociation seems to be a common feature. Self-regulation is the ability to control arousal and enhance equilibrium of the physiology, self-relatedness, interpersonal skills as well as the affect. This influences the deregulation across all domains of an individual. The behavioral expressions of absence of self-regulation range from antagonism against the self or others and may drive the individual to more addictive behaviors.

When trauma is part of the child’s story, the child is rarely able to self-regulate or soothe themselves which is an important skill for any individual throughout life (Cunningham, 2004). For a child who is experiencing traumatic event, they could be having difficulties when it comes to self-regulation, challenges of expressing their
emotions and even putting a name to internal states or labeling. These children may also not be able to effectively negotiate and communicate their needs.

Traumatic experiences brought about by people who should be providing care puts children at risk of hopelessness and helplessness. The child feels undesirable of love and care which can damage the child immensely. The child may always expect to be despised and not appreciated for who they are. These children may take the blame as a result of the traumatic experiences that happens or happened to them. This can in turn affect their interactions especially when it comes to responding to social support (Pizzolongo & Hunter, 2011).

Effect of trauma on emotional safety and stability

Children go through many overwhelming life events. This affect their cognitive, affective, behavioral, and psychological aspect. The impact poses a challenge to children’s wellbeing (Armsworth & Holaday, 1993). Presence of a safe adult enhance practices and strategic principles that are child-oriented to impact the child’s felt safety and security as the child receives the necessary help (Saunders & Hall, 2018). When a child has experienced trauma, they are overwhelmed with intense fear, horror in face of death or helplessness. Trauma leads to grief, as it involves loss of some sort. Some losses are traumatic while others are not. There are variations in the intensity of effect of trauma. The way different people process life stressors is critical in determining if trauma will be experienced or not as highlighted by (Peres et al., 2007).

Trauma is perceived not as experienced by the second person or listener, but as being experienced by the individual first and foremost (Schick, 2011). During adulthood, past experiences and issues may understandably make it more difficult to develop a trusting relationship with one's environment. Traumatic experiences such as
domestic instability may also lead to the observed lower cognitive performance by most concretely and may be disrupting to the individual’s concentration in many aspects of one’s life. The environment in which a child lives should be safe, physically, emotionally, and psychologically. A welcoming and relaxing physical environment provide a sense of safety to a trauma survivor who is always on the lookout for danger (Guarinno & Bassuk, 2010).

Effect of trauma on thinking about self

When children go through trauma or experience a traumatic event, psychologically, they have a fragmented sense of self and are vulnerable to anxiety and depression (Terrasi & Crain De Galarce, 2017). On the other hand, children are prone to the extreme of withdrawal or serious acting-out behaviours. Children who have dynamics of complex trauma can easily be mistaken to manifestations as a willful disobedience. Defiance or in-attention may be taken or responded to as a misbehavior.

Many caregivers may not clearly understand the hateful things children who have experienced trauma believe about themselves. In effect, trauma may have harmed them once in the past, but might be continuing to inflict pain in the life of children. This is because children may have internalized the voice of their abuser. This means that, although the abuser is no longer present, the abuse continues to ache or trigger the child, thus affecting the child psychologically. The pain that the child is experiencing may even reflect in the social domain of the individual. Traumatic experiences in the life of a child may also result to cognitive distortions. The child may think that the world is not a safe place and that they do not need to trust anyone or even that things will never get better at all no matter what they do (Kahn & Aronson, 2007).
Trauma and traumatic experience affect the child’s view of self in many ways and the child may lack sense of self or may have a low self-esteem. This may result to shame and guilt that can affect the child to adulthood. Children may respond to self-recognition with a negative reaction and have a disintegrated sense of self or identity. The child may not want anything to do with peers, yet this is where children often derive identity. A child experiencing trauma may isolate him/herself. The child’s sense of self maybe lost due to the lack of connection that forms the social connection between the child and the world around them. Traumatic experiences may lead children into rigidity, where children are not very capable of forming healthy relationships among their peers. A child who becomes an adolescent and has been affected by the traumatic experience may end up not being able to venture into anything beneficial as a result of the foreshortened sense of the future. The adolescent may also lack interest in education due to the lowered tolerance of frustration (Insel & Young, 2001).

Hypervigilance

According to Terrasi and Crain de Galarce (2017), a child who has experienced early trauma will mostly be on constant alert to danger. Sometimes the child might believe they missed warning signs predicting the traumatic event. In an effort to prevent future traumas, children might be hyper-vigilant and look for warning signs that something bad is going to happen again. Perry (2006) [as cited by Bath (2008, p. 18)] observed that “traumatized children reset their normal level of arousal. Even when no external threats exist, they are in a constant state of alarm.” This can be seen in the frequent behavior of the child where they view adults as potential threat instead of people that offer comfort and love. These children are frightened all the time and expect another bad thing to happen to them anytime. This
may in turn affect their sleep pattern because of the present state of tension (Bagge et al., 2016).

Children who have gone through trauma and traumatic experiences such as rape, neglect, physical or any other kind of emotional abuse, may have difficulty in interpreting the world around them. They may also have difficulty forming relationships, interpreting verbal and non-verbal cues as well as understanding other person’s perspective. These children are often described as hyper vigilant as they are on alert for any source of danger (Bath, 2008). When a child perceives the environment as a dangerous place, they become very hyper-vigilant experiencing everyone and everything as a potential threat to their safety.

Initial reactions to trauma can include fatigue, confusion, sadness, unease, agitation, impassiveness, dissociation, confusion, physical arousal, and blunted affect. In other instances, an individual may feel obligated to find ways to deal with the painful experiences and to some extent, this might become a challenge as the individual may always struggle with overwhelming feelings of inadequacy. To numb these painful feelings and memories, individuals may end up indulging in alcohol and substance such as bhang, cocaine, tobacco among others in order to ‘feel better.’ If a person is particularly sensitive to stress or find themselves in an environment where they do not feel they have adequate control over their stress, they are likely to engage in substance abuse to cope with the painful experiences resulting from trauma (Goeders, 2004).

Briere and Elliot (1994) stated that there is a relationship between traumatic experience and later substance abuse among adolescents and adult survivors. Others may not be able to remember what happened to them or may even choose not to talk about an experience that they might have gone through (Bagge et al., 2016). All these
psychosocial effects of traumatic experiences may happen immediately or may delay and reflect later after an event of trauma.

Trauma disorients the body functioning of an individual. There are instances where individuals turn to alcohol and other substances to manage the intense flood of emotions and traumatic reminders. These substances dull the effect of the traumatic experience and the memories. The individual may feel as if this is helping to manage associated distress, but a dangerous cycle may begin. However, this interrupts the natural protective function the body was already doing. As a result, one creates a type of emotional withdrawal that can set us up to deal with increased and prolonged distress that could lead to the development of posttraumatic stress. Children who have experienced trauma will avoid digging into the details of trauma. They may avoid people, places or things that remind them of their traumatic experiences at all cost. The individual tries to avoid recollecting the trauma (Sprang, Staton-Tindall, & Clark, 2008). Typically, alcohol initially seems to release these symptoms. When one experiences a traumatic event, the brain releases some hormones that help numb the physical and emotional pain of the event. This is how the body naturally helps one cope (Peres et al., 2007).

Acting out

Trauma fractures one’s sense of connection and meaning. The individual may end up acting out which involves repetitive re-living of the painful traumatic experience even though the most prominent feature of trauma is the disbelief that comes with the traumatic experience. The individual may not be able to differentiate the past, present and the future. Traumatic experience is continually worsened as trauma masks itself in the behavior that a child portrays which can be termed as erroneous. The individual may constantly be haunted by the traumatic experience thus
the need to help the child work through their traumatic experience. Children need to be given chances to find meaning in events in which they anticipate and connect with other people in their lives. In addition, individuals need to be given voice to their painful experiences if they are to move beyond the trauma symptoms to holistic healing (Schick, 2011).

Attachment to caregiver

Haight, Kagle, and Black (2003) defined attachment as a close, enduring affective bonds that does not stop at some point but develops throughout life. Adequate attachment relationship is an important aspect when it comes to the development of a child as this forms a part of their biological heritage and enhances the potential for survival. Attachment is defined as the ability to connect mutually and positively with another person. In this case, it would be the caregiver and the child that they are responsible of (Bath, 2008). Bowlby’s attachment theory grew as a result of observing the behavior of young children who were separated from their caregivers for sometimes. There are different types of attachments and these are healthy secure attachment, in-secure attachment which includes the avoidant, ambivalent and the disorganized kind of insecure attachment. Avoidant is a type of insecure attachment where the caregiver is very inconsistent in meeting the needs of a child. This is the unavailability of the caregiver even when they can provide the needs.

Ambivalent attachment is where the caregivers meet the emotional needs of the child inconsistently to the extent that the child is unpredictably certain about their caregivers. Disorganized attachment is when the caregiver engages in frightening behavior or the caregivers themselves are frightened when they engage with the children or infant (Bartholomew & Horowitz, 1991). The caregiver is very influential when it comes to meeting the child’s psychological needs and social needs. When a
caregiver acts and responds to the traumatized child in a loving and consistent way, the child develops in a healthy way where trust is developed. For a child who is experiencing trauma, basic mistrust will develop if the caregiver is neglecting and abandoning the child in his or her care.

For the connection between the child and the caregiver to be healthy, there is a need to ensure that the kind of attachment present is that of secure attachment where the caregiver is consistent in responding to the needs of a child when the child seeks the care. This kind of connection is healthy as there is warmth and affection from the caregiver to the child (Hazan & Shaver, 1987). This can be even a simple touch or paying attention to the child as they express their needs to a trusted adult. When a child has a need, the arousal is awakened as well as the excitatory hormones in order to work. If a caregiver responds to the need of the child, the inhibitory hormone is awakened, and the child ends up relaxing and feeling secure. When the caregiver fails to respond or responds in an inconsistency manner, the inhibitory hormone never kicks in and the child is inconsistent mode of unsettlement without any relaxation or feeling of safety.

Hazan and Shaver (1987) asserted that “a toddler’s behavior such as monitoring the caregiver’s where-about, and the caregiver’s behavior, emerge with experience and appear to maximize the child's learning and safety.” (p. 197). For a child who has experienced trauma, secure attachment can be something unfamiliar to them, especially in cases where the trauma that the child is experiencing has resulted from a trusted person who took great care of the child.

A study conducted by the St. Petersburge-USA Orphanage Research Team (2008 as cited in Bakermans-Kranenburge et al., 2011) maintained that many institutions or orphanages have given their all to ensure that the children in their care
are living in a clean environment, and have access to good medical care. The effect of the rotating shifts and large number of caregivers limits the development of stable relationships between the child and the caregivers. This is because of the frequent change of their caregivers in their childhood with whom the child has not been able to establish a personal relationship. Reis (2000) argued that taking care of children is an important process that warrants careful thought and empirical scrutiny. Appelbaum (2008), in his review of Herman’s book gives an emphasis that trauma that results from a deliberate intent is more shuttering to the survivor's world view and its damage is particularly severe.

According to Lewin (1992),

In spite of the recent progress in the trauma field, relatives, friends, doctors, lawyers, police, therapist, political leaders - the people who we expect to protect us often fail to prevent abuse from happening in the first place and when it is reported, family or authorities block out what the victims are saying, greatly impeding the healing process. (pp. 6-17)

In addressing the effects of neurobiological on attachment, Insel and Young (2001) found that damage to the amygdala in early infancy is accompanied by profound changes in the formation of social bonds and emotion. "The child can control the emotions such as impulse and affect regulation which are realized when the baby has a present caregiver who is also helping this child co-regulate and be able to achieve self-regulation among other coping skills that the child can establish. When a child experiences fierce and constant threats from the caregivers, this impacts the child’s biological and social functioning."
A self-resilient parent has a greater impact in the life of a child that is in his or her care (Sanders & Hall, 2018). Some attachment types have been compromised often and can affect the life of a child. These are inefficient in regulating affective states and coping with life stressors which can lead to infant mental health. Children need to feel loved and cared for in a safe and trusting environment that empowers them. When this does not happen, children often become vulnerable to traumatic experience. Children are not able to clearly articulate how they feel and, in such instances, families, caregivers ought to provide support and motivate these children to become the powerful self and gain control.

According to Vickroy (1996) adults are portrayed as preying on children and therefore end up interfering with their innocence. She highlights that victims of trauma are mentally imprisoned and isolated by the traumatic experiences. Children who have experienced trauma are affected psychologically and socially thus the need for caregivers to help them cope with the overwhelming emotions. Caregivers can be teachers, parents, guardians, authorities, and other relevant figures in the life of a child. Caregivers are to set support system that encourages and motivates children to express their feelings, pain and disappointments ranging from the traumatic experiences while at the same time, provide ways by which the psychological and emotional well-being of such children is continuously being improved.

Children who are abused and neglected are characterized by an insecure attachment pattern to their care-givers, which prevents them from developing the ability to regulate the intensity of emotions and impulses (Cunningham, 2004). This afterward result in adoption of a range of self-regulating destructive behaviors, including disordered eating and substance misuse. These ‘destructive’ behaviors usually coexist, which further complicates diagnosis and treatment. The type of
trauma associated with neglect, violence, and relationship disruption changes the trajectory of children’s lives. It undermines children’s self-confidence and eats away at their self-esteem. It can also make them feel valueless and unlovable, and it underpins their vulnerability. These children are often labeled as disruptive, defiant, and poor learners who are at high risk of disconnecting from school (Homes et al., 2014).

A child’s two greatest needs are whom they belong to and what and how to express their needs. The caregiver comes along to develop a strong connection and an understanding of a child’s life story that encourages the child to be able to communicate their needs in the best way that they know how. Early patterns of interaction inform the way children process their thoughts and feelings throughout their life. Bath (2008) asserted that children learn to regulate their behavior by anticipating their care provider’s responses to them. If a parent or caregiver is emotionally absent, inconsistent, or neglectful, the child learns not to rely on the external environment to meet his or her needs. When the parent recognizes children’s behaviors and is consistent, the caregiver is capable of understanding the context for children behavior and can help repair the damaged sense of connection (Pizzolongo & Hunter, 2011).

Aggressive children often present as being powerful and in control; they have a tendency of blaming others for their anger. It is important to recognize that the outward presentation often hides a child who is fearful and who feels an overwhelming sense of powerlessness and lack of self-esteem. Few aggressive children feel ‘good’ about themselves or their aggression, although they work hard to hide this from themselves and others (Bagge et al., 2016). Helping children recognize that the cause of their behaviour lies in their early traumatic experiences and helping
them recognize the bio-neurological impact of these experiences, can help children make sense of the feelings that underlie their behaviour. This can also increase understanding of why they struggle to manage positive interactions, rather than becoming an ‘excuse’ for continued aggression. It is the caregiver’s understanding that help a child feel a ‘real’ sense of efficacy and an increased ability to develop healthier ways of interacting with themselves and others.

Children can recover from the incapacitating effects of trauma and the traumatic experiences., self-control, optimism, and conscientiousness, and are likely to flourish (Tough, 2016). Children who have gone through trauma show behaviors which clearly indicate that they are in a constant struggle to rely on their caregivers (Balbernie, 2001). Children need safe caregivers in their lives who understand and respond to their unique needs. They need teachers and mentors skilled at helping them adapt and change in response to their environment. They also need to learn the necessary life skills for healing and growing beyond childhood trauma. This learning can occur only in the kind of environment that possesses non cognitive qualities and is judgmental.

Caregivers who work with children who are psychologically traumatized in the care system can experience potential challenges. When these caregivers are repeatedly being exposed to the traumatic histories of those in their care, they may begin to experience secondary trauma. When there is no organizational support for these caregivers, there is lack of health work and life balance thus poor condition to this effect. Here, the caregiver may feel overwhelmed by the role and the responsibilities that awaits them and therefore suffer burn out or even compassionate fatigue (Bagge et al., 2016).
It is the caregiver’s responsibility to understand the impact that trauma has on the child. Trauma affects many aspects of a child’s life thus leading to underlying issues. The caregiver ought to minimize the child’s sense of felt safety by providing a psychologically safe setting for the child and assist the child to reduce the overwhelming emotions by developing connecting strategies. Often, ‘behavior is the language of children that have no voice.’ The caregivers and the children homes are responsible when it comes to promoting permanency in the life of children who are prone to psychological and emotional wellbeing deprivation (Herbert & Ballard, 2007)

According to Wright (2014), caregivers need to teach children how to identify and discuss their feelings by naming and validating children’s emotions. Minimizing disruptions in relationships and placements are key in ensuring and maintaining positive attachments between the caregivers and the child. There are many areas in deciding exactly what situations and behaviors constitute potentially traumatic events for children. There is great unanimity concerning some types of events, such as violent rape by a stranger, witnessing severe violence in the home or community, or being involved in a serious natural disaster. Children who have experienced trauma need an established routine which is more predictable. For children living in children homes, this may involve providing a clear sense of what they and their family can expect for instance, what is a children home? why do children come here? what happens when they leave among others. This may help the child in recovering process. Healing process cannot begin in absence of physical safety as this is critical just like emotional safety is.

A child needs to feel that the environment in which they are at is safe. This involves the assurance that the child is feeling protected, comforted, in control, heard
and reassured. For children in children orphanages, there is a greater need for the caregivers at the frontline to help children identify a safe space especially when the child experiences distress or feels threatened. In contrast, children with early trauma may not be able to identify who is a safe person or even have healthy attachments. The child requires a healthy caregiver to help in regulating the child’s physical reactions during stressful moments in order to process what happened. A safe space could also be a safe person or a place where the child can go to when they are feeling overwhelmed or triggered (Statman-Weil, 2015). At times even allowing children time to finish a responsibility or a duty that they started gives them a sense of security in the fact that the child is assured that they can accomplish something (Bagge et al., 2016).

Many are the times that caregivers assume that the child is not aware of what is going on around them. Children often fill the gap of the missing information in whatever way that makes sense to them. It is therefore important to help the child understand what happened by deliberately choosing to listen. One of the ways in which a caregiver can listen to the child is by asking three fundamental questions such as what happened, how they might be feeling and what has been the hardest part of what the child might be going through. It is important to understand that children are often better able to express the pain that they might be experiencing through play or re-enacting a bad event that happened. Another way would be allowing the child to express their pain or trauma through drawing. Giving the child a piece of paper, drawing book and a pencil can help the child to express themselves. Sand has also been a source of therapy as children are able to talk about the pain that they are going through (Bagge et al., 2016).
Children need to know the truth about the situation in ways that are appropriate for their age. This allows the child to process the pain thus the healing process is facilitated. It is important to understand that no matter how young the child is, the brain and body respond to trauma and retains memories of these experiences whether good or bad. Sometimes these memories are stored as ‘felt’ or ‘body’ memories. In some instances, similar experiences of trauma may remind the child of the pain they experienced or are experiencing. These potential reminders are known as triggers. Some of the triggers for children who have experienced trauma include but not limited to loud noises, fighting, change in routines, feelings of anger or sadness, certain smells or even loss of things or people (Bagge et al., 2016).

In an event that the child is faced with potential reminders of the trauma, children’s brains and bodies are designed to go into automatic flight, fight, or freeze response mode. These responses can be easily labeled as behavior problem that needs to be corrected. When caregivers understand trauma responses, they can help a child better understand their experiences, provide opportunities to practice regaining self-control, and use techniques to deal with difficult situations. One of the key areas of helping someone who has gone through trauma is by helping them build skills and connections. This is done by helping the child identify specific triggers, understand what is happening in their brains and bodies, ground themselves in the reality of the present situation. In addition, it helps the child develop self-soothing techniques and coping skills to manage feelings associated with past traumatic experiences (Solomon & Heide, 2005).

Hodas (2006) defined trauma informed care as the emerging efforts to address trauma in the lives of children and adults. This care involves the deliberate action to identify the trauma and the traumatic experiences to help the child with a healing
process that leads to growth. Trauma informed care also puts in consideration that the child’s history may have a great impact in the ongoing trauma therefore it seeks to explore the history of the child. The goal is to put in place some interventions that protects the child and does not worsen the situation. The intervention should at no cost inflict more pain to the child (Hodas, 2006). Children who have experienced trauma yearn to take some control over some situations and have a sense of authority. They (children) tend to have a challenging fight over power struggle as they may psychologically feel as if the parent does not value him or her hence, a conflict of will. The children become very curious about themselves, their caregivers and their surrounding thus, affecting their social interactions and begin to feel guilty about efforts to be independent as a result of the traumatic experiences that they have gone through. Children might not be able to take initiative or even to self-regulate, even when the caregiver has constantly taught them coregulation.

Cook et al. (2017) pointed that caregivers are the most influential people in a child’s life especially in the child’s development. A trauma informed caregiver is one who is aware of the emotional and psychological needs of the child and deliberately seeks to meet them regardless and is familiar of the impact of trauma thus creating a safe surrounding for the child to express their pain and worries to them as their caregivers. Adams (2010) asserted that there is a need to understand the essential elements of trauma informed care by working towards maximizing the felt safety of the child going through trauma. There are pillars or needs that a child who has gone through trauma has and desires. These needs be met to be able to cope with trauma. These needs are safety, comfortable connections, permanency, and wellbeing.
Safety and well-being

Yount (2008) illustrated that Maslow and Erikson emphasized how safety is a core developmental need for an infant and a child of any age. To Erikson, this is what he refers to as the establishment of trust verses mistrust towards the caregiver. When a child tries to communicate their needs by either crying or pointing, they are ensuring safety (Hebert & Ballard, 2007). A child may not survive where safety is not ensured. For a child who has experienced trauma of any kind, differentiating between a safe and unsafe person may become a challenge because of the painful experiences they may have gone through in the past. Children may develop mistrust towards anyone who attempts to show them care or comfort. They (children) may also develop a wall that separates them from whoever they term as unsafe.

Enhancing safety for a child involves ensuring that the child is involved in making choices, or by providing knowledge about their circumstances. This is where the child should be allowed to tell their own stories without feeling intimidated but being empowered. Giving the child control in their lives can make them feel the sense of power. However, this needs to be done in cases where the child is developmentally capable (Bath, 2008). The caregiver should increase the sense of felt safety. Some of the ways that a trauma informed caregiver should ensure a felt safety of the child under their care is by making the environment safe for the child to be able to express their pain, ensure healthy and predictable interactions and also recognizing the areas that poses a threat for the child under their care (Hebert & Ballard, 2007).

Connection

Human beings are social beings and are likely to interact with each other no matter the environment that they find themselves in. For a child who has gone through a traumatic experience, their way of connection is highly unpredictable. Healthy
relationships are part of human development. However, trauma and traumatic experiences that the child goes through interfere with comfortable connections and interactions (Sanders & Hall, 2018). In instances where the child has started the healing process with a therapist, it is the role of that therapist to ensure comfortable connection with the child. An example would be children who are experiencing complex trauma, they need adults that understand the impact that this type of trauma has in their life when it comes to building connections. This is because, without recognizing their pain, it makes it hard for the adult in this child’s life to recognize their pain through showing empathy to the child.

Sometimes the traumatic experience will affect the child’s behavior. For example, the child may play war more often or even become very irritable. Older children may involve themselves in risky behavior like hurting themselves like either cutting themselves or by committing suicide. These children’s behavior reflects the inner pain that they are going through all by themselves. The caregiver should not provide care that creates pain-based reactions but should aim at dealing with the child’s inner pain without inflicting more and more pain to this child (Perren, Schmid, Herrmann, & Wettstein, 2007). Creating appropriate safe touch and respecting the child’s boundaries should be key. Children affected by traumatic experiences need people who understand them and cares for them as they are and utilize a trauma-informed approaches that leads to the start of the healing process for these children.

Resilience and permanency

Children who have experienced trauma may often feel extreme sadness, fearful and loneliness. Caregivers should promote resilience in children by ensuring protective factors that can help the children fight the negative impacts of trauma and traumatic experiences (Pizzolongo & Hunter, 2011). Resilience is the ability to fully
adapt to adversity, trauma, tragedy, or even significant sources of stress as defined by APA (2014). Caregivers build resilience in the children by expressing their love towards the children either verbally or even through a safe touch. In addition, a caregiver can acknowledge the child’s feelings and allow him or her become independent which shows the child what giving care and empathy to other children is like.

The goal of working with a child who is going through trauma or has gone through a traumatic event, is to teach them to learn ways that they can effectively manage their affects in a healthy way. According to Van der Kolk (2005), the primary function of parents can be thought of as helping children modulate their own arousal by teaching skills that will gradually help these children modulate their own arousal. There should also be permanency of the caregiver. The caregiver taking care of the children in children’s home have a special place in the heart of these children that they are taking care of. There is an automatic connection and attachment between the child and the caregiver. Hodas (2006) stated that connection will arise as a result of the trust and the attachment that has taken time to be built between the child and the caregiver.

In instances where the child is constantly moving from one children home to another or the caregivers are constantly being changed, the child suffers the emptiness that affects his or her neurobiology. Providing psychological and social support to children and to the caregivers is a key component when it comes to taking care of a child who has gone through a traumatic experience.

Empirical Literature Review

According to a report by National Survey of Children’s Health (NSCH) in 2016, 46% of the nation’s children age 17 years and under report experiencing at least
one traumatic event (Substance Abuse and Mental Health Services Administration as cited by Salasin, 2005). Saunders and Adams (2014) pointed that depending on how traumatic experiences are defined, children in America have experienced sexual assault, physical abuse or even witnessed serious violence between caregivers. The sexual abuse is at the rate of 9-19% while physical assault is at 38-70%. Of course, these are participants who are having significant problems that may be the result of trauma experiences. These account for the high rates of reported trauma typically found in these studies.

Pfeffebaum, North, Doughty, Gurwitch, and Kyula (2003), studied the bombing of the United State embassy that happened in Nairobi Kenya. Over 5000 people were injured while 253 people were killed. The survey of 500 children showed that even among indirectly exposed children, reactions were more severe among those with history of previous trauma. This implies that individuals are more vulnerable to trauma (Cook et al., 2017). Chu and Lieberman (2010) found that children are exposed to a disproportionately increased amount of traumatic experiences. Greeson et al. (2011) carried out an explanatory study on complex trauma histories, post-traumatic stress, and related child emotional problems in a large sample of children. The results highlighted were that children with complex trauma histories experienced significant more trauma types overall than those without such histories. Another study carried out on individuals in the United Stated of America, indicated that there is a connection between childhood exposure to violence and other traumatic experiences (Bloom, & Sreedhar, 2008).

Another study was carried out by United State Department of Health and Human Science (2011) in 2010 among which 408,425 youth were in foster care in the United State. This study showed that those who enter foster care, have usually
experienced multiple traumatic events that are perpetuated by a care-giver (Garcia & Courtney, 2011). A study carried out by National Population Health Survey on 15,106 provincial household residents aged 20 years and over in Canada back in 1994 showed that childhood trauma was prevalent and increased with each successfully younger age-cohort. In the study, 54.8% were female participants while 45.2% were male. The age difference grew more pronounced as trauma exposure increased. The data suggested that childhood trauma has been on the rise over the last few decades therefore necessitating the need to facilitate early interventions so as to save the life the children before the impact worsen in the future (Thompson & Cui, 2000).

Another recent UNICEF survey done to 200 Rwandan boys and girls in 1994 found that more than half had witnessed the murder of their parents or other family members. In that survey, it revealed that nearly 75% had witnessed the slaughter of friends, neighbors, or strangers. In addition, the survey showed that as many as 42% said they had watched children kill other children, while 53% said they saw children participate in killings. Traumatic experience in this case is the war and violence that these children had witnessed. In such instances, the healing process is difficult to those that witnessed the traumatic experience as well as those who experience, both children and adults (Barricklow, 1995).

In Kenya, the ordeal of the post-election violence brought the country into a standstill as highlighted by the Commission of Inquiry into the Post-Election Violence (CIPEV). According to Waki Commission (2008), during the post-election violence in Kenya, children were exposed to various kind of trauma which affected many aspects of lives, belief system being one of them. Exposure to this form of traumatic experiences affects children’s view of the world, themselves as well as those around them (Weru, 2013).
According to Macosko (2000), the UN reported that two million out of four million people killed in conflict situations, which is a form of traumatic experience in the past decade have been children. Over ten million children have suffered severe psychological trauma from either witnessing or experiencing violence. The aftermath of Post-Election Violence included thousands of casualties. There were over 300,000 internally displaced persons, very significant, but unknown numbers of sexual violence victims as well as the destruction of property, among others. According to most of the victims and witnesses interviewed, the police were often present but were either overwhelmed or passive during the attacks. There were other instances in which families, including children were forced to watch their parents and sibling being sexually violated by gang youth. Many victims were unable to access help during and even after clashes thus, resulting into more trauma to live with in their life (Waki Commission, 2008).
Conceptual Framework

The following is the conceptual framework followed by a short description of the variables.

![Conceptual Framework Diagram]

*Figure 2.1: Conceptual framework*
Source: Author (2020)

In Fig 2.1, the study conceptually proposed that traumatic experiences result to psychosocial effects in children. The children are affected in different ways when they experience any type of trauma. Richard and William (2004) asserted that children are vulnerable to the effect of trauma and this calls for specific interventions to help children in their recovery. Children naturally look to their caregivers for assurance...
and assistance when faced by a challenging situation or even pain. In the above diagram, the figure is showing the relationship between the variables.

The independent variables are the traumatic experiences while the dependent variables are the psychosocial effects such as the negative self-thoughts, avoidance of anyone or anything that may have been a threat, poor attachment, loss of safety and even loss of danger cues. The intervening variables are the gender and the age which illustrates that the traumatic experience will affect the child differently.

There is a likely relationship between a caregiver and the children’s response to a traumatic situation. How the caregiver responds to his or her own traumatic experience will affect how he or she responds and reacts to a child’s traumatic experience. How a caregiver responds to the needs of the child such as safety, impacts how the child will respond psychologically, and socially. Permanent primary caregiver may be modeling appropriate response to the traumatic event that the child is experiencing or may be limited in responding positively to the child. Children may not respond to traumatic experiences the same way as they are all unique in their own way.

Summary

This chapter has outlined the related literature on the psychosocial effects of traumatic experiences A theoretical framework is provided to explain the relationship between traumatic experiences and the psychosocial effect in the life of a child. The researcher has also described the empirical literature as well as the conceptual framework which describes the relationship between the variables.
CHAPTER THREE
RESEARCH METHODOLOGY

Introduction

This section presents the research methodology and research design that the researcher used in assessing the psychosocial effects of traumatic experiences in children at Kings Kid Village and Our Home Child Care Center. Target population and the sample size are also discussed. This chapter presents information on sampling procedures, appropriate instruments, method of data collection as well as the ethical considerations. The areas of study in relation to the topic, which is the psychosocial effects of traumatic experience in the life of the children from the selected orphanages is also discussed.

Research Design

Kothari (2004) defined research design as a thought-out plan for collection and analysis of data in order to provide information. This research was a descriptive-research design, specifically a case of the selected orphanages of Kings Kid Village and Our Home Child Care Center in Nairobi County. Kumar (2005) asserted that descriptive research design is used to obtain information concerning the current status of the phenomena and to describe what exists with respect to conditions in a situation.

This design is most appropriate for this study because it is effective in reporting the psychosocial effects (Mugenda & Mugenda, 2003). The research involved both the quantitative and the qualitative methods to give a complete description in words as well as constructed statistics in order to explain the data.
Population

The population in this study was Kings Kid Village and Our Home Child Care Center children. These two children homes are situated in Kasarani Constituency-Nairobi County. The researcher sampled children who were between the ages of 11-18 years.

Target Population

Mugenda and Mugenda (2003) defined target population as the population that has been identified by the researcher in his or her research with an aim of obtaining findings that are meant to be generalized. The target population is crucial as it forms the sample of the study. The target population of this study was children from Kings Kid Village Children Home and Our Home Child Care Center who are between ages 11 years to 18 years. Kings Kid Village Children Home has 57 children while Our Home Child Care Center has 41 children thus the target population was 98.

Most of these were the children who are living in the children home under the care of their caregivers. These children orphanage forms the best study sample as they are very well structured and have well laid ground rules of enrolling children to their center. The other reason for selecting this population was the fact that the home had caregivers who were available and easily accessible which was an advantage.

Sample Size

This study used the population of children who are an integral part of Kings Kid Village and Our Home Child Care Center. The entire population of Kings Kid Village is 57 while that of Our Home Childcare Center is 41. The total population of both homes is therefore 98. The total population forms the sample size for the present study.
Sampling Techniques

The study sampled the entire study population. The main reason for using this method is because the population was small and manageable. The researcher focused on the boys and the girls from the selected orphanages. There are many children orphanages in Nairobi County. The researcher chose the Kings Kid Village and Our Home Childcare Center because these orphanages have established enrollment procedure and they enroll children at risk in their care.

Inclusion and Exclusion Criteria

The inclusion criteria in the study were the participants that are residents at Kings Kid Village and Our Home Childcare center.

Data Collection Instruments

The method of data collection was issuing of questionnaires to both boys and girls between ages 11 to 18 years who are living in the selected children orphanages. A questionnaire is a research instrument and is comprised of a (multi) set of questions (Glazer & Rubinstein, 2014). The researcher used structured questions to gather information from the selected sample. The researcher involved a research assistant who was available to give clarifications to the participants.

The questionnaire had a socio-demographic section as well as a section that formed the basis of the research topic which is the psychosocial effects of traumatic experiences in children living in the selected children’s home and the research questions as well. The researcher gave the questionnaires to the participants with the help of a research assistant who had knowledge in trauma.

This instrument was structured because of the research questions of this study. With the participants being children, the researcher ensured that the questionnaire is simplified and child friendly for it to be more effective. In the instances where some
of the participants did not understand English, the research assistant explained the questions to the participants and ensured utmost confidentiality of the participants.

Primary Data

Primary data source is comprised of the use of questionnaires in this study. This enhanced quick analysis and faster conclusion of results. The participants were served with questions and were given a chance to fill and then the questionnaires were collected later. The delivery of these questionnaires was done through hand delivery, for convenience purpose.

Data Collection Procedures

Before issuing the questionnaire to the participants in the childrens’ homes, the researcher sought permission from the Kings Kid Village directors in order to ensure that the participants were protected. The researcher further sought clearance from National Commission for Science, Technology, and Innovation (NACOSTI).

Upon approval, the researcher was able to gather the information from the participants. Issuing the questionnaire required more hands therefore, the researcher welcomed research assistant on board to help in giving the questionnaires to the participants. The research assistant was taken through a brief training which included informing them the need for the participant’s assent before participating in the research. The researcher and the research assistant met the participants at their own convenient time, especially when they were not on schedule.

Pretesting

Pretesting is aimed at testing the validity and the reliability of the research instrument. The pretest was conducted at Faith House Girls’ Ministries. This home was selected for pretesting due to its similarity to the Kings Kid Village and Our Home Child Care Center on the enrollment style, availability of the caregivers as well
as the convenience to the researcher and the assistant. Mugenda and Mugenda (2003) asserted that 10% of the population is adequate for pre-testing. A total of 10 participants were selected for pretesting.

Pretesting was conducted early enough to ensure efficient planning, especially when it comes to the realization of how much time would be needed for distributing the questionnaires. The data was collected at the same time to ensure validity and consistent research outcome that would not affect the research findings negatively.

Data Analysis Plan

Data analysis refers to the process of systematically applying techniques to evaluate the collected data and organizing these in such a manner that they answer the research questions (Kothari, 2004). The researcher read through all the data and organized comments from the questionnaires into similar experiences or concerns, depending on the research objectives. The raw data was organized to extract useful information. The data was analyzed by means of statistical techniques to investigate the variables and their effects.

The study used descriptive statistics to identify the psychosocial effects of traumatic experiences. Descriptive statistics enables the researcher to present collected data in a logical and organized form. The researcher used the Statistical Package for Social Sciences (SPSS® version 22) to analyze the quantitative data using both descriptive and inferential statistics.

The qualitative data was presented in verbatim as the responses from the field exercise, specifically the questionnaires. Pearson’s correlation test was used to determine if there was a relationship between the variables.
Ethical Considerations

Ethic is what guides the researcher when conducting the research as well as protecting the participants. The researcher sought clearance from Daystar University Research and Ethics Board (ERB) and was also given permission by the Head of Psychology and Counseling Department at Daystar University, School of Human and Social Science. The researcher also got permission from the National Commission for Science, Technology, and Innovation (NACOSTI) in order to be allowed to conduct the research.

The sample of the study comprised of young people who are below 18 years. Children participated in the research only when the guardian had written a consent prior to the child’s participation. This implied that the participants’ guardians were issued with a written informed consent form, before the children participated in the study. The participants also gave their assent before the study.

The participants were notified that all the information that they shared with the researchers would be anonymous and that destruction of data would be done after the analysis is completed and findings obtained. The participants were included in the study upon ascertaining that they were willing to participate (assent) in the study. This was by signing of the informed consent forms presented to them by the researcher and the research assistant. In addition to the already mentioned, the researcher made the following important ethical considerations:

Voluntary participation: The participants were assured that they would freely decline to participate in the study as it was voluntary.

Compensation: The researcher informed the participants that there would be no form of compensation upon participation in the study.
Benefits: The researcher informed the participants that there were no direct benefits that would result from participating in the study. However, indirectly, the results of the study will be beneficial to relevant government agencies.

Risks: The participants were informed that they would not be exposed to any risk during the study. However, in cases of overwhelming emotions, the respondents were assured of debriefing.

Confidentiality: The researcher informed the participants that their identity would not be used for any other reason rather than for study purpose. Further, the questionnaires would be anonymous, and data would be stored in a personal computer encrypted with a code. The participants were also informed that the physical questionnaires would be destroyed after December 2020.

Data ownership: The data collected will be owned by the researcher for the sole purpose of working towards the MA degree. The data shall not be shared with any unauthorized person. The researcher ensured that she was the one who collected the data from the field.

Summary

This chapter has discussed the method that the researcher used to carry out the research. These included the descriptive design as the research design. The study population and target population were discussed. Pretesting and data collection procedures has also been considered. Data analysis as well as ethical considerations have been discussed.
CHAPTER FOUR

DATA PRESENTATION, ANALYSIS, AND INTERPRETATION

Introduction

This chapter presents data presentation, analysis of the findings as well as interpretation of the results. The response rate is presented, followed by instrument pretesting results that covered reliability test results. Demographics characteristics of the children from Kings Kid Village Children Home and Our Home Child Care Center who were the participants of the study and results on each of the specific research objectives was also presented. Descriptive statistics were applied to conduct analysis of the data collected. Presentation of the research findings has been presented in figures and tables and the summary of the key findings has also been presented.

Analysis and Interpretation

Response rate represents the fraction of the participants who actually took part in the study. A total of 98 questionnaires were distributed to the children from Kings Kid Village Children Home and Our Home Child Care Center aged between 11 to 18 years who were the participants of the study in order to collect the required information. Out of these, 61 questionnaires were completed, returned, and were fit for analysis, which represents a general response rate of 62.24%. A response rate of above 50% is adequate to conduct statistical analysis according to Mugenda and Mugenda (2003). The results are presented as shown in Figure 4.1.
Cronbach’s Alpha value of 0.7 was adopted in ensuring reliability of the instrument whereby the study measured internal consistency of the questionnaires that were obtained for pretesting. This is in accordance with Mugenda and Mugenda (2003) who recommended the Cronbach’s Alpha value of 0.7 as the threshold for internal consistency. The variables examined in this study (traumatic experiences among children and psychosocial effects) all had alpha coefficient values higher than 0.7 i.e. $\alpha > 0.7$ implying that the instrument was reliable for data collection. The results are as indicated in Table 4.1.

**Table 4.1: Reliability Test**

<table>
<thead>
<tr>
<th>Scale</th>
<th>Cronbach’s Alpha</th>
<th>Number of Items</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Traumatic experiences</td>
<td>0.781</td>
<td>13</td>
<td>Reliable</td>
</tr>
<tr>
<td>Psychosocial effects</td>
<td>0.803</td>
<td>8</td>
<td>Reliable</td>
</tr>
</tbody>
</table>

Demographics Characteristics of the Participants

The children from Kings Kid Village Children Home and Our Home Child Care Center aged between 11 to 18 years who were the participants of the study were examined in order to establish their demographic features. The demographic
characteristics of the participants are therefore presented in this section specifically their age, gender as well as highest level of education.

Age of the participants

The study established the age of the participants of the study in order to establish the role age plays in the relationship between traumatic experiences and psychosocial effects. As shown in Figure 4.2, (24)40% were aged between 16-18 years while a further (16)26% were aged between 14-16 years. Further, (13)21% of the participants of the study were aged between 12-14 years and only (8)13% were aged between 11-12 years. This shows that participants who are between the age of 16-18 years represented the highest percentage in the study.

![Figure 4.2: Age of the Participants](image)

Gender of the participants

The gender composition of the sample was examined. Exploring gender in this study was important because the researcher wanted to establish if a specific gender was more affected by traumatic experiences than the other. As shown in Table 4.2 male participants of the study were represented by 54% while females were 46%. This shows that most of the participants of the study were male.
Table 4.2: Gender of the Participants

<table>
<thead>
<tr>
<th>Gender</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>33</td>
<td>54.1</td>
</tr>
<tr>
<td>Female</td>
<td>28</td>
<td>45.9</td>
</tr>
</tbody>
</table>

Participants’ highest level of education

The highest level of education of the participants sampled by this study was also assessed. As shown in Figure 4.3 children who are in primary school were represented by 56% while 44% were in secondary school. This shows that most of the participants of the study were in primary school.

Figure 4.3: Highest Level of Education

Traumatic Experiences that Children suffer

The first objective of this study was to determine the traumatic experiences that children in Kings Kid Village and Our Home Child Care Center experience. The participants sampled by this study were therefore asked to respond to various statements regarding traumatic experiences in terms of abuse, abandonment, negligence, and violence based on different scales. This section therefore presents the results on the different types of trauma experienced by the children sampled by the study.

First, the study sought to determine the different abuses that children in Kings Kid Village and Our Home Child Care Center experienced. The participants sampled
by this study were therefore asked to respond to various statements regarding abuse based on a scale of 1-4 where: 1= Never true, 2= Not always true, 3= Always true and 4= Very often true. This section therefore presents the results using frequencies, percentages and mean for the respective abuse statements as indicated by the participants. The first statement established whether someone threatened to hurt or tell lies about the participants unless they did something sexual like watch sexual things, do sexual things, or draw sexual things. Majority of the sampled participants as represented by 57% and frequency of 35 indicated that it was true followed by 21% and frequency of 13 who indicated it was very often true. On whether people said hurtful or abusive things to the participants, the results showed that a large proportion of the participants of the study, 34% and frequency of 21, indicated that it was always true while 26% indicated that it was very often true.

Another statement determined whether participants experienced physical abuse, the results showed that a large proportion of the sample, 46% and frequency of 28 indicated that it was always true followed by 21% who indicated it was very often the case while 19% and frequency of 12 indicated that it was not always true. A mean of 3.1 showed that a large proportion of the sample indicated that they experienced physical abuse. On whether participants were experiencing emotional abuse, the results showed that a large proportion of the sample 48% and frequency of 29 indicated that it was very often true followed by 41% and frequency of 25 who indicated that it was always true. A mean of 3.52 showed that a large proportion of the sample indicated that they experienced emotional abuse.

The findings in this section as shown by the mean values of the specific types of abuse imply that majority of the sampled participants indicated that they frequently
experienced different forms of abuse such as sexual threats, verbal abuse, physical abuse and emotional abuse. The results are as shown in Table 4.3.

**Table 4.3: Types of Abuse Experienced by Participants**

<table>
<thead>
<tr>
<th>Statement</th>
<th>Never true</th>
<th>Not always true</th>
<th>Always true</th>
<th>Very often true</th>
</tr>
</thead>
<tbody>
<tr>
<td>Threats and sexual harassment</td>
<td>9.8% (6)</td>
<td>11.5% (7)</td>
<td>57.4% (35)</td>
<td>21.3% (13)</td>
</tr>
<tr>
<td>Verbal abuse</td>
<td>19.7% (12)</td>
<td>19.7% (12)</td>
<td>34.4% (21)</td>
<td>26.2% (16)</td>
</tr>
<tr>
<td>Physical abuse</td>
<td>13.1% (8)</td>
<td>19.7% (12)</td>
<td>45.9% (28)</td>
<td>21.3% (13)</td>
</tr>
<tr>
<td>Emotional abuse</td>
<td>8.2% (5)</td>
<td>3.3% (2)</td>
<td>41% (25)</td>
<td>47.5% (29)</td>
</tr>
</tbody>
</table>

Abandonment and negligence of children

The study also determined the different abandonment and negligence traumas that children in Kings Kid Village and Our Home Child Care Center experienced. The participants sampled by this study were therefore asked to respond to various statements regarding abandonment and negligence based on a scale of 1-5 where: 1= strongly agree, 2= agree, 3= Not sure, 4= disagree and 5= strongly disagree.

The first statement examined whether participants have enough for basic needs like food, clothes, health and others all the time whereby the results showed that a large proportion of the sample as represented by 46% and frequency=28 disagreed followed by 34% of the participants who strongly disagreed. The mean of 4.08 showed that a large proportion of the sample disagreed that they had enough for basic needs like food, clothes, health, and others. On whether the caregiver took good care of the participants, results showed that a large proportion of the participants of the study as shown by 28% and frequency=17 strongly disagreed followed by 26% and frequency of 16 who disagreed. Only 13% of the participants agreed that the caregiver
did take good care of them. The mean value was 3.98 which was an indication that majority of the participants disagreed that the caregiver did take good care of them.

Another statement examined whether participants felt loved and well thought of whereby results indicated that a large proportion, 43% and frequency =26, disagreed while a further 25% and frequency=13 strongly disagreed. Only 3% of the participants strongly agreed that they felt loved and well thought of. On whether participants’ parents were happy that they were born been born and if parents took good care of them, results showed that a large proportion of the sample as represented by 43% and frequency of 28 strongly disagreed while a further 37% and frequency of 22 disagreed. A mean of 4.12 was an indication that majority of the participants disagreed that their parents were happy that participants had been born and that the parent had taken good care of them.

A different statement examined whether participants knew that there is someone to take care of them and to fully protect them, majority as represented by 63% and frequency of 37 strongly disagreed while a further 20% and frequency of 12 disagreed. Regarding the statement that people that care stay for long in life, the large proportion of the participants as shown by 46% and frequency of 28 strongly disagreed while a further 37.7%, frequency 23 disagreed. A mean of 4.06 was an indication that majority of the participants disagreed that people that care stayed for long in their lives. The findings in this section showed that majority of the participants admitted having experienced abandonment and negligence from both parents and caretakers. This section presents the results for the various statements on abandonment and negligence as shown in Table 4.4.
Table 4.4: Abandonment and Negligence

<table>
<thead>
<tr>
<th></th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Not sure</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I have enough for basic needs; food, clothes, health, and others</td>
<td>3.3% (2)</td>
<td>0.00%</td>
<td>16.4%</td>
<td>45.9%</td>
<td>34.4% (21)</td>
</tr>
<tr>
<td>My caregiver does take good care of me</td>
<td>13.1% (8)</td>
<td>13.1% (8)</td>
<td>19.7% (12)</td>
<td>26.2% (16)</td>
<td>27.9% (17)</td>
</tr>
<tr>
<td>I feel loved and well thought of</td>
<td>3.3% (2)</td>
<td>8.2% (5)</td>
<td>22.3% (13)</td>
<td>42.6% (26)</td>
<td>24.6% (15)</td>
</tr>
<tr>
<td>My parents were happy that I was born, and they did take good care of me.</td>
<td>4.2% (2)</td>
<td>7.8% (5)</td>
<td>6% (4)</td>
<td>37.1% (23)</td>
<td>42.9% (27)</td>
</tr>
<tr>
<td>I know that there is someone to take care of me and to fully protect me</td>
<td>0%</td>
<td>1.5% (2)</td>
<td>16.4% (10)</td>
<td>19.7% (12)</td>
<td>62.5% (37)</td>
</tr>
<tr>
<td>People that care for me stay for long in my life</td>
<td>1.1% (1)</td>
<td>3.4% (2)</td>
<td>11.5% (7)</td>
<td>37.7% (23)</td>
<td>46.3% (28)</td>
</tr>
</tbody>
</table>

Violence towards children

The study further determined the different types of violence experienced by children in Kings Kid Village and Our Home Child Care Center. Accordingly, the participants were asked to indicate their agreement or otherwise on various statements regarding different types of violence.

The first statement examined whether the participant had seen people in their family and friends being beaten, physically injured or even killed whereby the results of the study showed that majority of the participants, 55.7% and frequency=34 agreed while 44.3% and frequency =27 disagreed. On whether the participant had been a victim of being kicked, scolded, punished, or chased away in a threatening manner, majority of the participants, 54.1% and frequency=33 agreed while 45.9% and frequency =28 disagreed. Another statement enquired whether people in the family hit the participant so hard that it almost left him/her with bruises or marks on his/her
body whereby majority of the participants as shown by 69% agreed while 31% disagreed. The findings in this section showed that the participants sampled by the study admitted to experiencing violence of some sort from their family. The results for the various statements on violence towards children is as shown in Table 4.5.

<table>
<thead>
<tr>
<th>Statement on violence</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>I have seen people in my family and friends been beaten, physically injured, or even killed</td>
<td>Yes</td>
<td>34</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>27</td>
</tr>
<tr>
<td>I have been a victim of being kicked, scolded, punished, chased away in a threatening manner</td>
<td>Yes</td>
<td>33</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>28</td>
</tr>
<tr>
<td>People in my family hit me so hard that it almost leaves me with bruises or marks on my body</td>
<td>Yes</td>
<td>42</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>19</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>61</td>
</tr>
</tbody>
</table>

Psychosocial Effects of Traumatic Experience in Children

The second objective of the study was to establish the psychological and social effects of traumatic experience in children living in Kings Kid Village and Our Home Child Care Center. The participants sampled by this study were asked to respond to various statements regarding psychosocial effects of traumatic experience based on a scale of 1-3 whereby 1= yes, 2= No and 3=not sure.

Initially, the study examined whether sexual abuse influences the loss of sense of self whereby majority of the participants of the study indicated yes as
represented by 60.7% and frequency =37 while 24.6% and frequency=15 were not sure. Only 14.8% and frequency=9 disagreed that sexual abuse influences the loss of sense of self. A mean of 1.64 provided a confirmation of the results whereas a standard deviation of 0.86 showed low variation in the replies. On whether lack of permanent caregiver results into poor attachment, the findings showed that majority of the participants as shown by 52.5% and frequency=32 indicated yes while 37.7% and frequency=23 were not sure. Only 9.8% and frequency=6 of the participants disagreed that lack of permanent caregiver results into poor attachment.

A different statement sought to find out whether being a victim of violence affects participant’s association with others whereby majority of the participants as shown by 73.8% and frequency =45 agreed, 18% and frequency=11 were not sure while only 8.2% and frequency =5 disagreed. The results were confirmed by a mean of 1.44. The findings as illustrated in this section implied that majority of the participants sampled by the study agreed that traumatic experience in children caused various psychosocial effects such as loss of sense of self, poor attachment, and poor association with others. This section presents the results on psychosocial effects of traumatic experience as shown in Table 4.6.

Table 4.6: Psychosocial Effects of Traumatic Experience in Children

<table>
<thead>
<tr>
<th>Statement</th>
<th>Yes</th>
<th>No</th>
<th>Not sure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexual abuse influences the loss of sense of self</td>
<td>60.7%(37)</td>
<td>14.8%(9)</td>
<td>24.6%(15)</td>
</tr>
<tr>
<td>Lack of permanent caregiver results into poor attachment</td>
<td>52.5%(32)</td>
<td>9.8%(6)</td>
<td>37.7%(23)</td>
</tr>
<tr>
<td>Being a victim of violence affects our association with others</td>
<td>73.8%(45)</td>
<td>8.2%(5)</td>
<td>18%(11)</td>
</tr>
</tbody>
</table>
Relationship between Psychosocial Effects and Traumatic Experiences

The third objective of this study was to determine the relationship between the psychosocial effects and the traumatic experiences in children living in Kings Kid Village and Our Home Childcare Center. In this regard, various statements were made on the subject of the relationship between the psychosocial effects and the traumatic experiences in children and participants were required to provide their rating based on a rating of 1-3 where 1 is low, 2 is moderate and 3 is high. The first statement sought to determine whether the participant had been avoiding people and things or going into situations that remind them of something bad that happened to them and results showed that majority of the participants, represented by 57% and frequency 34 indicated high extent while a further 41% indicated moderate extent and only 2.7% indicated low extent. The next statement enquired whether the participant was often very startled/scared easily. The findings showed that majority of the participants as represented by 54% and frequency of 33 indicated high extents while 39% indicated moderate extent and only 7% and frequency of 4 indicated low extent.

On whether the participants often felt that people do not like him/her because they are not good enough, majority of the participants, 59% and frequency of 36 indicated high extent while 36% and frequency of 22 indicated moderate extent. Only 5% of the participants of the study indicated low extent. Regarding the statement that the participants did not know how to react or what to do in times of danger, majority as represented by 56% and frequency of 34 indicated high extent followed by 41% who indicated moderate extent.

Finally, on whether the participants had ever gone through some bad experiences that at some point these experiences were reappearing as if they are still happening afresh, majority of them, 59% and frequency 36 indicated high extent
while 36% and frequency of 22 indicated moderate extent. The results in this section point to the fact that there is a general relationship between traumatic experiences and psychological effects among children. The results are presented in Table 4.7.

**Table 4.7: Relationship between Psychosocial Effects and the Traumatic Experiences**

<table>
<thead>
<tr>
<th>Low</th>
<th>Moderate</th>
<th>High</th>
<th>Mean</th>
<th>Std. Dev</th>
</tr>
</thead>
<tbody>
<tr>
<td>I have been avoiding people and things or going into situations that remind me of something bad that happened to me</td>
<td>2.6% (2)</td>
<td>41.00% (25)</td>
<td>56.5% (34)</td>
<td>2.46</td>
</tr>
<tr>
<td>I am often very startled/scared easily</td>
<td>6.60% (4)</td>
<td>39.30% (24)</td>
<td>54.10% (33)</td>
<td>2.48</td>
</tr>
<tr>
<td>I often feel that people do not like me because I am not good enough</td>
<td>4.90% (3)</td>
<td>36.10% (22)</td>
<td>59.00% (36)</td>
<td>2.54</td>
</tr>
<tr>
<td>I do not know how to react or what to do in times of danger</td>
<td>3% (2)</td>
<td>41% (25)</td>
<td>56% (34)</td>
<td>2.46</td>
</tr>
<tr>
<td>I have ever gone through some bad experiences that at some point these experiences were reappearing as if they are still happening afresh.</td>
<td>4.90% (3)</td>
<td>36.10% (22)</td>
<td>59.00% (36)</td>
<td>2.54</td>
</tr>
</tbody>
</table>

Psychosocial Effects of Traumatic Experiences in Children

The study sought to establish the psychosocial effects of traumatic experiences in children living in orphanages. To do this, the researcher conducted a Pearson moment correlation between the independent and dependent variables of the study. Findings from the study revealed that there was a strong significant relationship between psychosocial effects of traumatic experiences and children living in orphanages.

Specifically, as shown from the study, it was found out that lack of parental care causes loss of sense of self with a correlation value of $r = -0.477^{**}$ at $p < 0.001$. 
The lack of parental care also leads to poor attachment. This is derived from a correlation value of $r = -0.413^{**}$ at $p < 0.001$.

As shown from the study, there is a relationship between lack of basic needs and dissociation. This is shown by a correlation of $r = -0.375^{**}$ at $p < 0.003$. From the study, one factor stood out. The lack of parental care is a precursor to various challenges in the children as they grow up. Findings of the analysis are presented in the Table 4.8.

Table 4.8: Psychosocial Effects of Traumatic Experiences

<table>
<thead>
<tr>
<th></th>
<th>Loss of sense of self</th>
<th>Negative self thought</th>
<th>Poor Attachment</th>
<th>Dissociation</th>
<th>Lack of danger cues</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Emotional Abuse</strong></td>
<td>Pearson Correlation</td>
<td>.062</td>
<td>-.085</td>
<td>-.013</td>
<td>-.026</td>
</tr>
<tr>
<td></td>
<td>Sig. (2-tailed)</td>
<td>.637</td>
<td>.513</td>
<td>.921</td>
<td>.841</td>
</tr>
<tr>
<td><strong>Lack of basic needs</strong></td>
<td>Pearson Correlation</td>
<td>-.230</td>
<td>-.131</td>
<td>-.245</td>
<td>-.375^{**}</td>
</tr>
<tr>
<td></td>
<td>Sig. (2-tailed)</td>
<td>.074</td>
<td>.314</td>
<td>.057</td>
<td>.003</td>
</tr>
<tr>
<td><strong>Lack of Parental Care</strong></td>
<td>Pearson Correlation</td>
<td>-.477^{**}</td>
<td>-.329^{**}</td>
<td>-.413^{**}</td>
<td>-.425^{**}</td>
</tr>
<tr>
<td></td>
<td>Sig. (2-tailed)</td>
<td>.000</td>
<td>.010</td>
<td>.001</td>
<td>.001</td>
</tr>
<tr>
<td><strong>Lack of Protection</strong></td>
<td>Pearson Correlation</td>
<td>-.059</td>
<td>-.025</td>
<td>-.020</td>
<td>.049</td>
</tr>
<tr>
<td></td>
<td>Sig. (2-tailed)</td>
<td>.654</td>
<td>.849</td>
<td>.879</td>
<td>.707</td>
</tr>
</tbody>
</table>

**Note:** Correlation is significant at the 0.01 level (2-tailed).
Summary of Key Findings

1. Children sampled in the study experienced different forms of abuse which included sexual threats, verbal abuse, physical abuse emotional abuse to varying regularities.

2. Children have experienced varying traumatic experiences of different levels of abandonment and negligence from both parents and caretakers who are primary or secondary caregivers.

3. The participants sampled in the study admitted having experienced violence of some sort from their families. Traumatic experiences caused them various psychosocial effects such as loss of sense of self, poor attachment, and poor association with others.

4. Negative psychosocial effects among the children were as a result of the traumatic experiences they suffered. Specifically, the descriptive results showed that as a result of such traumatic experiences as abuse, violence, abandonment and negligence, the children were vulnerable to avoiding people and things or going into situations that reminded them of something bad that happened to them. The children were often very startled/scared easily, and they often felt that people do not like them because they are not good enough and they did not know how to react or what to do in times of danger.

5. Children indicated that they had suffered from post-traumatic experiences and that they were going through some bad experiences that at some point these experiences were reappearing as if they are still happening afresh in their minds despite having experienced some of the traumatic events in the early past. The study therefore established a general negative relationship between traumatic
experiences and psychological effects among children living in Kings Kid Village and Our Home Childcare Center.

Summary

The findings, analysis in addition to interpretation of the findings has been discussed which commenced with findings on the response rate and reliability results. Findings on demographic characteristics of the participants sampled by the study has been presented. These has been followed by descriptive results of each of the specific objectives of the study which have been presented using tables as well as figures. The three key areas that the descriptive statistics focused on were the traumatic experiences among children living in Kings Kid Village and Our Home Childcare Centre, the psychosocial effects of the traumatic experiences and the relationship between the two variables. The key findings of this chapter and summary have also been presented.
CHAPTER FIVE

DISCUSSIONS, CONCLUSIONS, AND RECOMMENDATIONS

Introduction

This chapter presents a discussion of key findings, conclusions, and recommendations. The conclusions and recommendations made by the study focused were based on the findings of the study whose main objective was to find out the psychosocial effects of traumatic experiences in the children living in the selected children orphanages guided by the following specific objectives: to determine the traumatic experiences that children in Kings Kid Village and Our Home Child Care Center experience, to establish the psychological and social effects of traumatic experience in children living in Kings Kid Village and Our Home Child Care Center, and to determine the relationship between the psychosocial effects and the traumatic experiences in children living in Kings Kid Village and Our Home Childcare Center.

Discussions of Key Findings

This section presents the key findings and discussions based on the specific objectives in line with the empirical literature reviewed. The key findings presented are focused on the specific objectives of the study which were to determine the traumatic experiences that children in Kings Kid Village and Our Home Child Care Center experience, to establish the psychological and social effects of traumatic experience in children living in Kings Kid Village and Our Home Child Care Center, and to determine the relationship between the psychosocial effects and the traumatic experiences in children living in Kings Kid Village and Our Home Childcare Center. Discussion of the findings is done per objective.
Traumatic experiences that children suffer

From the findings, children in the selected orphanages suffered different kinds of traumatic experiences such as abuse, abandonment and negligence and violence. Regarding abuse, as shown in the study, it was established that children in the selected orphanages experienced different forms of abuse such as sexual threats, verbal abuse, and physical abuse emotional abuse to varying frequency.

Children had experienced varying levels of abandonment and negligence from both parents and caregivers. It was also established that the children in the selected orphanages admitted to having experienced violence of some sort from their families which included physical assault that left bruises and permanent scars on their bodies, extreme dressing-down by their families and even threats. The results concur with the argument by Maas, Herrenkohl, and Sousa (2008), that sexual, emotional, and physical abuse appear to increase the likelihood of later violence and the child may suffer long term consequences of abuse, and neglect.

Psychosocial effects of traumatic experience in children

The second objective of the study was to establish the psychological and social effects of traumatic experience in children living in Kings Kid Village and Our Home Child Care Center. It was established that majority of the children in the selected orphanages agreed that traumatic experiences caused them various psychosocial effects such as loss of sense of self, poor attachment, and poor association with others. It was also established that children in the selected orphanages suffered harm in their belief system, their ability to self-regulate was affected, they were unable to identify and express emotions. Their feelings of emotional safety and stability into adulthood were affected. The findings concur with those of a study by Van der Kolk (2003) which indicated that children who have experienced trauma are affected in the sense
that they have altered thoughts about themselves and others, how they feel and how they regulate their biologic systems.

Relationship between psychosocial effects and traumatic experiences

Some of the negative psychosocial effects among the children were because of the traumatic experiences they suffered. Specifically, the descriptive results established negative effects of traumatic experiences such as abuse, violence, and abandonment and negligence on the psychosocial effects of the children in the selected orphanages. Some of the negative psychosocial effects the children in the selected orphanages suffered as a result of the traumatic experiences includes vulnerability to avoid people and things or going into situations that reminded them of something bad that happened to them, often being startled/scared easily and often feeling that people don’t like them because they are not good enough. This findings concurs with the study by Willis and Nagel (2015) which pointed that children with traumatic experiences are affected in an immense way especially their attention where they are rarely able to concentrate due to the trauma memories that they continuously relive as well as the violent environment around them.

There was a negative general relationship between traumatic experiences and psychological effects among children in the selected orphanages. A study by Dyregrov, Gupta, Gjestad, and Mukanoheli (2000) indicated that children are vulnerable to the effect of trauma and traumatic experiences. These painful experiences predispose the children thus suffer great impact from the negative psychosocial factors. When these children live in threatening environment, they suffer traumatic reminders and frequent arousals of the traumas they have gone through.
Conclusion

In conclusion, based on the findings discussed as shown from the study, children in the sampled orphanages have suffered different kinds of traumatic experiences such as abuse, abandonment, and negligence as well as violence. In this regard, the study concluded:

1. That children in the sampled orphanages have suffered sexual threats, verbal, physical and emotional abuse, physical assault that leaves bruises and permanent scars on their bodies, reprimand and even murder threats from members of their family.

2. Children in the selected orphanages agreed to have gone through traumatic experiences that have resulted into various psychosocial effects. These are loss of sense of self, poor attachment and poor association with others, negative belief system, low ability to self-regulate, and inability to identify and express emotions.

3. That negative psychosocial effects among the children were as a result of the traumatic experiences they suffered. In this regard, the study concluded that the negative psychosocial factors such as vulnerability to avoid people and things or often being startled/scared easily as well as feeling of dislike are as a result of traumatic experiences.

Recommendations

Based on the findings and conclusions, the study made the following recommendations:

1. The study recommends the children’s home and caregivers in orphanages to find ways to eliminate any form of abuse, be it verbal, physical or emotional
against children in order to avoid continuous trauma in the children that may result to negative psychosocial effects.

2. The study also recommends that the children home and caregivers properly attend and provide for the various needs of the children to purposely avoid continuous traumatic experiences in the life of children.

3. Another recommendation made by the study is that family and caregivers especially in orphanages should eliminate any form of violence meted on children such as harsh punishments, sexual threats, physical assault, reprimands and even murder threats as these may plunge these children into trauma.

4. The study also recommends that the caregivers be given basic skills on trauma informed care in order to eliminate various forms of trauma that may cause children various negative psychosocial effects such as loss of sense of self, poor attachment and poor associations. This is as a result of the study that established a negative influence of traumatic experiences on psychosocial factors.

Recommendations for Further Research

Another study could also be carried out to investigate the other factors that are responsible for the negative psychosocial factors among children besides traumatic experiences since the study findings indicated that only a small percent (40.3) of the variation in psychosocial factors among children is accounted by abuse, abandonment, negligence and violence. Additionally, this study sampled children from Kings Kid Village and Our Home Child Care Center orphanages which might not be representative of the whole population of children’s home and other children who are susceptible to trauma. Similar studies could be carried out using more children’s
homes to cover a wide geographical area because children are unique in the way they respond to various traumatic experiences.
REFERENCES


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APPENDICES

Appendix A: Assent Form

Dear Participants,

The following is an assent form that is comprised of a list of questions that seeks your assent to participate in the study. The study seeks to identify the psychosocial effects of traumatic experiences in children living in selected orphanages. You are invited to willingly participate in the study, and to show your willingness to participate.

I, the undersigned confirm that:

1. I will not benefit directly from participating in the study.
2. The process of confidentiality, keeping a record of the information that I share and conditions for breaching of confidentiality will be explained to me.
3. I understand that I am free to withdraw from the study anytime without any penalty or explanation of why I withdraw.
4. In case of injury during the research study and participation in which I am part of, the researcher or the research assistants will not be held accountable.
5. The use of data in research and sharing my information will be explained to me.
6. I understand that the conditions to participation in the research and will be given time to ask questions about the research and my participation.
7. I alongside with the researcher, voluntarily agree to sign and date this assent having understood the information as it is given and indicating that I am willingly participating in the study. Also, by signing, I indicate that I know that the study is voluntary with no compensation whatsoever.

Thank you.

Margaret Wangui
Appendix B: Questionnaire

Thank you for agreeing to participate in this process. My name is Margaret Wangui Waithera and I am studying for a Master of Arts in Counseling Psychology at Daystar University. I am conducting a research geared into identifying the psychosocial effects of traumatic experiences in children. The questionnaire consists of 8 questions whose aim is to give more information/data. The process will take to fifteen minutes of your time to complete. Please answer that which most closely represents your experience. All the information shared will be kept anonymous and no one will be identifiable in the research. Please do not put your name.

Thank you.

SECTION A: Demographic Information

Code: ________________________

Please tick (√) where appropriate:

1. Age in years?
   - 11-12
   - 12-14
   - 14-16
   - 16-18

2. Gender?
   - Male
   - Female

3. What is your highest level of education (class/grade) are you in? Select one
   - Primary
   - Secondary
SECTION B:

This section focuses on traumatic experiences in children.

Part 1: Abuse

1. Please put a tick (✓) where appropriate:

<table>
<thead>
<tr>
<th></th>
<th>Never true</th>
<th>Not always true</th>
<th>Always true</th>
<th>Very often true</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A</strong></td>
<td>Someone threatened to hurt me or tell lies about me unless I did something sexual with them like watch sexual things, do sexual things, draw sexual things</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>B</strong></td>
<td>People say hurtful or abusive things to me</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>C</strong></td>
<td>I get hit so many times for reasons that I am not aware of.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>D</strong></td>
<td>I feel hopeless and helpless.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
SECTION C: Abandonment and negligence

1. For the following please put a tick (√) where appropriate.

<table>
<thead>
<tr>
<th></th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Not sure</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>I have enough for basic needs ie food, clothes, health and others</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>My caregiver does take good care of me</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>I feel loved and well thought of</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D</td>
<td>My parents were happy that I was born, and they did take good care of me</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E</td>
<td>I know that there is someone to take care of me and to fully protect me</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>People that care for me stay for long in my life</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

SECTION D:
This focuses on the relationship between the traumatic experience and the psychosocial effects.

1. In the following question, put a tick (√) on the most appropriate.

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Not Sure</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Sexual abuse influences the loss of sense of self</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>Lack of permanent caregiver results into poor attachment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>Being a victim of violence affects our association with others</td>
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2. In a scale of 1-3 where 1=low, 2=moderate and 3=high, show the extent to which the following affects you by a tick (√)

a. I have been avoiding people and things or going into situations that remind me of something bad that happened to me

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<th>2</th>
<th>3</th>
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b. I am often very startled/scared easily
c. I often feel that people do not like me because I am not good enough

d. I do not know how to react or what to do in times of danger

e. I have ever gone through some bad experiences that at some point these experiences were reappearing as if they are still happening afresh.
SECTION E: Violence

a. I have seen people in my family and friends been beaten, physically injured or even killed

Yes □ No □

b. I have been a victim of been kicked, scolded, punished, chased away in a threatening manner

Yes □ No □

c. People in my family hit me so hard that it almost leaves me with bruises or marks on my body.

Yes □ No □
30th September 2019

National Commission for Science, Technology and Innovation  
P. O. Box 30623, 00100  
Nairobi  
KENYA

Dear Sir/Madam,

RE: WAITHERA MARGARET WANGUI (11-0901)

The above named is a student in the Master of Arts, Counseling Psychology at Daystar University Nairobi Campus. She is about to complete her coursework for the master’s program and is required to do research as part of her final requirements.

The topic of study is 'Psychosocial effects of traumatic experiences in children living in orphanages: A selected case of Kings Kids Village and Our Home Child Care Centre in Nairobi County'. Her proposal has been passed and approved by the Department of Psychology & Counseling and Daystar University Ethics Review Board.

She is hereby authorized by the University to carry out her study by collecting data from the field. She requires your authorization to facilitate the same.

Thank you in advance for your willing to give this opportunity. We are truly grateful for your partnership in this, and for your organization’s contribution in the education of Daystar University students.

If you have any queries, please do not hesitate to contact me.

Yours faithfully,

[Signature]

Dr. Susan Muriungi  
HEAD, PSYCHOLOGY & COUNSELING

[Reduced to last two lines of letter]
Appendix D: Ethical Clearance

Dear Walthera,

RE: PSYCHOSOCIAL EFFECTS OF TRAUMATIC EXPERIENCES IN CHILDREN LIVING IN ORPHANAGES: A SELECTED CASE OF KINGS-KID VILLAGE AND OUR HOME CHILD CARE CENTER IN NAIROBI COUNTY

This is to inform you that Daystar University Ethics Review Board has reviewed and approved your above research proposal. Your application approval number is DU-ERB-00329. The approval period is 12th September, 2019 – 11th September, 2020.

This approval is subject to compliance with the following requirements:

i. Only approved documents including informed consents, study instruments, MTA will be used.
ii. All changes including amendments, deviations, and violations are submitted for review and approval by Daystar University Ethics Review Board.
iii. Death and life-threatening problems and serious adverse events or unexpected adverse events whether related or unrelated to the study must be reported to Daystar University Ethics Review Board within 72 hours of notification.
iv. Any changes, anticipated or otherwise that may increase the risks or affect the safety or welfare of study participants and others or affect the integrity of the research must be reported to Daystar University Ethics Review Board within 72 hours.

v. Clearance for export of biological specimens must be obtained from relevant institutions.
vi. Submission of a request for renewal of approval at least 60 days prior to expiry of the approval period. Attach a comprehensive progress report to support the renewal.

vii. Submission of an executive summary report within 90 days upon completion of the study to Daystar University Ethics Review Board.

Prior to commencing your study, you will be expected to obtain a research license from National Commission for Science, Technology and Innovation (NACOSTI) https://org.nacosti.go.ke and also obtain other clearances needed.

Yours sincerely,

Pity Kihabi
Secretary, ERB
Appendix E: Research Permit

This is to certify that Ms. Margaret Waithera of Daystar University, has been licensed to conduct research in Nairobi on the topic: PSYCHOSOCIAL EFFECTS OF TRAUMATIC EXPERIENCES IN CHILDREN LIVING IN ORPHANAGES: A SELECTED CASE OF KINGS KID VILLAGE AND OUR HOME CHILD CARE CENTER IN NAIROBI COUNTY for the period ending: 04/October/2020.

License No: NACOSTI/P/19/1954

Ref No: 868723

Applicant Identification Number

Date of Issue: 04 October 2019

Director General
NATIONAL COMMISSION FOR SCIENCE, TECHNOLOGY & INNOVATION

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Appendix F: Plagiarism Report

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