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An Evaluation of the Effectiveness of Psychosocial Support Services Provided to Trauma-Exposed Children Aged 8 To 15 Years in Selected Rehabilitation Centres In Nairobi, Kenya

by

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A thesis presented to the School of Applied Human Sciences

of

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MASTER OF ARTS
in Child Development

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APPROVAL

AN EVALUATION OF THE EFFECTIVENESS OF PSYCHOSOCIAL SUPPORT SERVICES PROVIDED TO TRAUMA-EXPOSED CHILDREN AGED 8 TO 15 YEARS IN SELECTED REHABILITATION CENTRES IN NAIROBI, KENYA.

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In accordance with Daystar University policies, this thesis is accepted in partial fulfilment of the requirements for the Master of Arts degree.

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DECLARATION

AN EVALUATION OF THE EFFECTIVENESS OF PSYCHOSOCIAL SUPPORT SERVICES PROVIDED TO TRAUMA-EXPOSED CHILDREN AGED 8 TO 15 YEARS IN SELECTED REHABILITATION CENTRES IN NAIROBI, KENYA

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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: _____

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LIST OF ABBREVIATIONS AND ACRONYMS

NACOSTI	National Commission for Science, Technology and Innovation
PSS	Psychosocial Support Services
UNICEF	United Nations Children's Fund

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ABSTRACT

This study sought to evaluate the effectiveness of psychosocial support services provided to trauma-exposed children aged 8-15 years in selected rehabilitation centres in Nairobi, Kenya. The objectives of the study were to establish the types of trauma exposure experienced by children, assess the prevalence of trauma observed among children, and evaluate the effectiveness of the psychosocial support services (PSS) offered to children aged 8-15 years in the selected rehabilitation centres. The selected centres for the study were Kwetu Home of Peace and Children's Garden Home and School. Erik Erikson's psychosocial development and Abraham Maslow's hierarchy of needs theories guided the study. A descriptive study design was used to explain the phenomena of PSS provided. Purposive and simple random sampling techniques were used to select study respondents. The quantitative data was analysed using the Statistical Package for Social Sciences (SPSS®), version 22, and qualitative data were thematically analysed. The study revealed that children experienced acute and chronic trauma as a result of abuse and neglect. The study further established the prevalence of abuse ranging from emotional (34.3%), physical (27.1%), and neglect (24.3%), with parents and guardians as the main perpetrators. PSS provision in these centres was effective because, before PSS provision, the children had poor anger management (46.2%), fear of expression (46.2%), and were violent (38.5%). However, after the PSS provision, they were jovial, social with others, and had self-control, as shown by 30.7%. Therefore, the study concluded that PSS offered through counselling and psychosocial support in rehabilitation centres positively transforms children's lives. The study recommends sensitizing caregivers and law enforcers on protecting children's rights through the National and County Children's Departments

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DEDICATION

This work is dedicated to my beloved mother, Jane Ochieng, for journeying with me and affirming me through it all. Her strength is mine, my strength is hers and this strength comes from the Almighty God.

This work is also dedicated to any student whose health situation tries to hold them back as it has for me. You are loved and you will prevail!

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CHAPTER ONE

INTRODUCTION AND BACKGROUND TO THE STUDY

Introduction

This chapter captures a background on the impact of psychosocial support on cases of trauma in children aged between eight and 15 years old. The chapter also outlines the problem statement concerning the study and the purpose of the study. The study's research objectives, rationale, significance, limitations & delimitations, assumptions, and scope are also discussed in-depth as part of the introduction and background to the study. This provides more details on the psychosocial impact of trauma on children living in the selected rehabilitation centres of the study.

Background to the Study

Trauma has been defined as a neglected illness in the modern world (Sakran et al., 2012). It is triggered when a person faces traumatic events such as exposure to death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence (Kleber, 2019). It is an area of mental health that still poses a significant health concern across the world, particularly when it comes to the health and well-being of children. Traumatic experiences can harm the lives of children as well as their ability to interact with other people (Daniels et al., 2013). At some point in the lives of children, they may experience traumatic events. In some instances, children grow up in healthy and functional families and may fail to experience trauma in their early childhood. Nonetheless, some children tend to face difficulties in life, which leaves them at an intersection of traumatic experiences. A child who has suffered from trauma may feel overwhelmed even as an adult, thus making it necessary to address the issue of trauma in children (Schimmenti & Caretti, 2016).

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Trauma acts as a breakage in the connection between families and the world (Jones, 2019). Psychologically, this massive loss of connection can be manifested in the later stages of a child's life, thus it is best understood as a spectrum of mental disorders. Globally, children continue to be victims of maltreatment. The effects of trauma on children have lifelong consequences affecting the way the child comes to understand himself and his surroundings (Cristobal et al., 2017).

In recent years, it has been noted that globally, children have been experiencing the worst possible forms of atrocities, a situation that poses a substantial threat since these incidences are on the rise (Benner et al., 2015). Unfortunately, a large number of these cases are not reported or documented because they are either viewed as culturally acceptable, not perceived as being abusive, or simply tactfully condoned. This challenge has been heightened by the fact that some children are too young or vulnerable to reveal their experiences or protect their safety, child protection services are not readily accessible, and the legal system may fail to respond (United Nations Children's Fund [UNICEF], 2014).

Among the industrialized countries, the USA has one of the worst records for child abuse and neglect, losing on average almost five children daily. According to the 2017 child maltreatment report published by the Children's Bureau (2017), there has been an increase in child abuse referrals to four million from three-point six million. The report indicated that 17.2% were victims of physical abuse, 8.4% were victims of sexual abuse, 6.9% were victims of psychological maltreatment, and 5.3% were victims of neglect. Overall, girls made up 50.9% of the victims, boys were 48.6%, and 0.5% of the victims were unknown. Most of the risk factors contributing to this situation emanate from the caregivers and they include domestic abuse, alcohol abuse,

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and drug abuse. In this view, neglect and physical abuse have been identified as the most common forms of child abuse.

Data highlighted that all over the world, children are exposed to and subjected to traumatic experiences (Colman et al., 2016). Often, these adverse experiences were perpetrated by people they trust from their homes, churches, schools, and communities. Importantly, Van der Kolk (2017) noted that the effects of traumatic experiences manifested differently in children, with some not being affected while others are severely affected. The onset of trauma depends on a child's perception of their experience. How children experience trauma and how they express their lingering distress largely depends on their age and stage of development (McLaughlin & Lambert, 2017). For children aged eight to 15 years, their trauma may manifest in various ways including withdrawal or aggressive behaviour, difficulties concentrating and learning, sleep disturbances, re-enactment or retelling, as well as psychosomatic pains and aches (Kuhlman et al., 2015).

Psychosocial interventions provided to children should seek to ensure that the basic needs of a child are met first (American Psychiatric Association, 2013; National Academies of Sciences, Engineering, and Medicine, 2016). For children who have suffered from trauma, this includes social and psychological needs. Maslow's (1954) hierarchy of needs reveals that individuals must first achieve their basic physiological and safety needs before moving to acquire other essential needs for growing toward a path of self-actualization. Children who have experienced traumatic events should be allowed to express their feelings voluntarily and training should be given to caregivers to ensure that they listen to and understand the reactions of the child.

In Africa, the state of affairs is not much different from the continent, reporting rampant maltreatment of children. The continent has a population of around 1.3

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billion, with the majority of these people being in the young age group (Worldometers, 2020). Compared to other regions of the world, data on the prevalence of child abuse is scanty, and this can be attributed to the lack of documentation and reporting in some nations, harmful cultural practices, the challenge of unregistered births, affected vulnerable children (orphans, street children, and disabled children), and children in armed conflict (Ministry of Labour and Social Protection, 2020; UNICEF, 2015). In addition, child abuse is viewed as something that may inflict physical harm or injury to the child, hence psychological violence is not seen as a type of child abuse.

The Kenya Violence Against Children Survey 2019 was conducted across 47 counties to assess the prevalence, nature, and consequences of various forms of violence against children and showed that 45.9% of females and 56.1% of males experienced childhood violence in the country (Ministry of Labour and Social Protection, 2020). This survey highlighted that sexual violence was experienced by 13.5% of females and 2.4% of males before the age of 18, physical violence was experienced by 36.8% of females and 40.5% of males before the age of 18, and emotional violence was experienced by 12.3% of females and 6.3% of males ages before the age of 18. Most of the risk factors that are contributing to this situation emanate from witnessing violence in the home and food insecurity. The common perpetrators of childhood violence are parents, caregivers, and adult relatives.

According to Dyregrov et al. (2015), a traumatic event in the life of a child threatens their life and may result in exposure to victimization in early childhood. Traumatic experiences range from any form of abuse including physical, sexual, emotional, or psychological, to neglect, violence, abandonment, war, accidents, lack of a permanent safe person, and the presence of an unsafe caregiver (Saunders & Adams, 2014).

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Additionally, a child who has suffered from trauma or has been exposed to any form of a traumatic event sometimes avoids situations and people that they view as a threat. Given that these children are exposed to psychosocial threats, they may find it difficult to form and build relationships because they feel lonely and alienated, and may not take part in activities that give them a sense of fulfilment. Such children may be set on a path of frustration and feelings of despair and hopelessness (Wright, 2016).

The psychosocial effects that individuals are exposed to at a young age include loss of sense of self, loss of safety, hypervigilance, and negative self-thought. Some children may have an image of the traumatic event in their minds and this might continuously interrupt their thoughts (Walkley & Cox, 2013). There exists a close relationship between traumatic effects and psychosocial impacts, as depicted in this study. Saxe et al. (2015) established that children develop distinct features of personality changes, including changes in identity formation and the ability to relate to those in their surroundings. Furthermore, children who have suffered from trauma are susceptible to repeated harm, which could be self-inflicted or arise from their interactions with other people. Past studies have demonstrated that residency in an area with lower socio-economic status is associated with an increased risk of traumatic experiences. This necessitates the need to address the need to provide psychosocial support to children who have suffered from trauma.

Statement of the Problem

The 2010 Constitution of Kenya (Article 53) recognized the need for all children to be protected from abuse, neglect, harmful cultural practices, all forms of violence, inhumane treatment and punishment, and hazardous or exploitative labour (National Council for Law Reporting, 2010). It affirmed that children have basic rights

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including the right to education, nutrition, shelter, health care, and parental care. Atwoli et al. (2014) indicated that all children in Kenya are potentially at risk of trauma in the form of violence, exploitation, and abuse, however, some groups are more vulnerable than others due to their gender, social status, or geographical location. Trauma greatly affects the development of a child and leads to disruptions in giving care, hence there is a need to address the psychological and social effects of trauma as depicted in the life of the child. As attested by Kiraly and Humphreys (2015), children without parental care lack the protective environment and supervision that adult care normally provides. Children in large families may also lack parental attention and can become victims of neglect. Although girls and boys are both subjected to trauma resulting from rights violations due to socio-cultural factors, cultural practices, and economic constraints, girls are particularly vulnerable to trauma from violence, sexual abuse, and harmful practices (Mbwayo et al., 2020).

The Cradle and Undugu Society of Kenya divided Kenyan street children into four categories: children who worked and lived on the street full-time in groups; children who worked on the streets by day but returned home to their families in the evenings; children who are on the streets occasionally such as evenings, weekends, or school holidays; and lastly the category of “street families” (children whose parents are also in the streets) (The New Humanitarian, 2007).

Although these studies were relevant in their own right, they do not give information on whether psychosocial support services (PSS) are provided for these children or not. Secondly, they did not indicate whether the PSS provided to these children was beneficial to them or not. It also did not give an overview of the competence required by the PSS providers. As such, this study was necessary to provide a better understanding of these unanswered questions.

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Purpose of the Study

The purpose of this study was to investigate PSS provided to trauma-exposed children aged 8-15 years in selected rehabilitation centres in Nairobi, Kenya.

Objectives of the Study

The following were the objectives of this study:

1. Establish the types of trauma exposure experienced by children aged 8-15 years before being in the selected rehabilitation centres in Nairobi, Kenya.
2. Assess the prevalence of trauma observed among children aged 8-15 years in the selected rehabilitation centres in Nairobi, Kenya.
3. Evaluate the effectiveness of the PSS offered to children aged 8-15 years in the selected rehabilitation centres in Nairobi, Kenya.

Rationale for the Study

Any form of trauma to a child can have lifelong consequences on their holistic development. Toxic stress response occurs when a child experiences strong, frequent, or prolonged adversity such as physical or emotional abuse, chronic neglect, caregiver substance abuse or mental illness, exposure to violence, the accumulated burdens of family economic hardship, or the absence of adequate adult support (Franke, 2014). Some of these lifelong consequences include impaired physical and mental health, poor school performance, as well as job and relationship difficulties, which can have direct or indirect long-term effects on the social and economic progression of a country (Cristobal et al., 2017). This study examines the types of trauma children aged 8-15 years experience in rehabilitation centres.

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In Kenya, the National Psychosocial Framework is a structured framework used to guide how to implement effective psychosocial support to children by caregivers and the community (Ministry of Labour and Social Protection, State Department for Social Protection, 2020). Ironically, five years down the line, the National Council for Children's Services in Kenya (2015) observed that the prevalence of childhood mental illness is on the rise. This is because adverse childhood experiences, overall access to child psychiatric care, and psychosocial services are extremely limited.

Research Questions

1. What were the types of trauma exposure experienced by children aged 8-15 years before being in the selected rehabilitation centres in Nairobi, Kenya?
2. What was the prevalence of trauma observed among children aged 8-15 years in the selected rehabilitation centres in Nairobi, Kenya?
3. What was the effectiveness of the PSS offered to children aged 8-15 years in the selected rehabilitation centres in Nairobi?

Significance of the Study

The outcome of this study would help local communities, partners, county governments, donors, and non-governmental organisations to tackle the issue of children going through lifelong trauma and ensure the implementation of better measures and PSS to deal with the after-effects of the trauma. Further, the study would benefit scholars and researchers in the future who may want to undertake a similar study. Policymakers may find the findings of this study beneficial in making proper evaluations of trauma experienced by children aged 8-15 in rehabilitation centres. The study could also ensure that current policies are best guided toward providing maximum support to children in rehabilitation centres.

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Assumptions of the Study

The study assumed that the psychosocial support offered to children aged between 8-15 years at rehabilitation centres does not sufficiently deal with the effects of trauma. This assumption proved false as the PSS offered to the children aged between 8-15 years at rehabilitation centres by social workers, the resident counsellor, and the careleavers sufficiently dealt with the effects of trauma.

The study was based on the assumption that children who have been subjected to violence, abuse, or neglect are victims of trauma. This assumption proved true as the children who were subjected to violence, abuse, or neglect were victims of trauma.

Furthermore, the study assumed that a certain level of cognitive maturity was required to process traumatic events. This assumption proved true as a certain level of cognitive maturity was required to process traumatic events.

Another assumption of this study was that participants were affected by the psychosocial effects of trauma. This assumption proved true as the participants were affected by the psychosocial effects of trauma.

Scope of the Study

The present study focused on selected centres that provide hope for a future for street children in Nairobi County. These selected rehabilitation centres rescue children from the streets and rehabilitate them from the traumas they may have faced. In the centres, the children are in a warm nurturing environment that meets both their psychological needs as well as their security and safety needs. The selected centres also provide them access to education and spiritual development.

The selected centres for this study have children in the targeted age range of the study (8 to 15 years old). Each of these centres has dedicated staff that provides the children

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with the necessary PSS needed. The selected centres for the study were Kwetu Home of Peace (2021) and Children's Garden Home and School (n.d.). The study focused on the PSS providers and the children to ensure that no harm comes to them from the study. It also focused on the data of the children aged 8-15 years old at the selected rehabilitation centres of the study.

Limitations and Delimitations of the Study

The researcher anticipated COVID-19 restrictions as a limitation. However, this did not affect the study as the researcher followed the stipulated health guidelines and ensured that all precautions were undertaken during the study. Secondly, the children at the selected rehabilitation centres, who may have been exposed to tremendous trauma, may be unwilling to share this information with an outsider or have not processed the trauma. As such, the researcher interviewed the caregivers of the children in these centres such as social workers, the resident counsellor, as well as the careleavers regarding the PSS offered to the children.

Another limitation was that the researcher would not be allowed to obtain information from these centres as it could be used for exploitation purposes and not to benefit the children. The researcher had institutional approval, approval from relevant ethical boards, and consent from the respondents of this study before commencing data collection.

Furthermore, the respondents to be interviewed may not have been forthcoming with information relevant to the study. The researcher reiterated a commitment to maintain confidentiality and protect the privacy of respondents. The data collection tool was a questionnaire worded in English, but because some of the respondents were more comfortable expressing themselves in sheng (a slang form of the Kiswahili language),

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the researcher employed the services of an interpreter in the centre to help in understanding accurately what was being relayed. Additionally, the researcher simplified the questionnaire so that the questions would be easily understood by the respondents.

Definition of Terms

Acute trauma: This type of trauma mainly results from a single distressing event such as an accident, rape, assault, or natural disaster (LeBouthillier et al., 2015). The event is extreme enough to threaten a person's emotional or physical security. It (the event) creates a lasting impression on the person's mind. In this study, the term 'acute trauma' referred to children at the rehabilitation centres who had been exposed to a single distressing event before joining the centres.

Careleavers: Refers to an adult who spent their childhood away from their family in the care system such as foster care, children's homes, or by state intervention (Care Leavers' Association, 2014; St. Christopher's, 2019). In this study, the term was used concerning children who resided in rehabilitation centres and consequently left to pursue their lives outside the centres. They continued to engage with the rehabilitation centres as adult persons who guide and provide hope for a better life by modelling positive behaviour for the children.

Child: According to the Office of the High Commissioner for Human Rights (2021), a child refers to a human being who has not attained the age of 18 years. In this study, a child denoted a human being aged 8 to 15 years.

Chronic trauma: Chronic trauma happens when a person is exposed to prolonged distressing and traumatic events over an extended period (LeBouthillier et al., 2015). Chronic trauma may result from a long-term serious illness, sexual abuse, domestic

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violence, bullying, and exposure to extreme situations such as war. In this study, 'chronic trauma' referred to children at the rehabilitation centre who had been exposed to prolonged distressing events before being in the centres.

Complex trauma: LeBouthillier et al. (2015) established that complex trauma is a result of exposure to varied and multiple traumatic events or experiences. The events are generally within the context of an interpersonal relationship. It may give a person a feeling of being trapped and often has a severe impact on the person's mind. It may be seen in individuals who have been victims of childhood abuse, neglect, domestic violence, family disputes, and other repetitive situations such as civil unrest. The study regarded complex trauma as children at the rehabilitation centre who had been exposed to multiple traumatic events before being in the centre.

Houseparents/caregivers: These are persons responsible for the provision of daily care to the children living in selected rehabilitation centres (The Houseparent Network, 2022). The daily care includes, but is not limited to, attending to meals, laundry, recreation, church, and ensuring a clean-living environment. Concerning the study, the term referred to adult persons at the selected rehabilitation centres that provide daily holistic care to the children, which includes, but is not limited to, ensuring a clean and calm environment, provision of nutritious meals, access to recreational and church activities, and ensuring clean clothing and beddings.

Psychosocial: Refers to a child's inner world and relationship with his or her environment (Save the Children, 2011). This study viewed psychosocial as subjective experiences of a child that inform how they see their surroundings and the people around them. These experiences affect their feelings, thoughts, and consequent behaviour.

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Psychosocial support: According to OVC Support (2016), psychosocial support refers to assistance that builds internal and external resources for children and their families to cope with adversity as well as build resilience in children. In this study, the term referred to necessary activities provided to children at rehabilitation centres that help them realize and utilize their innate capabilities to positively impact their lives and that of others. These activities attend to their psychological, socio-emotional, spiritual, and physical needs.

Trauma: This is a psychological, emotional response to an event or an experience that is deeply distressing or disturbing (Boals, 2018). Trauma, in this study, is related to damage to a child's mind as a result of one or more distressing events causing overwhelming amounts of stress that exceed the child's ability to cope with the emotions involved, gradually resulting in serious and long-lasting negative repercussions.

Traumatic experience: It is a powerful and often overwhelming event in an individual's life that leaves one in a helpless or hopeless situation (Dalenberg et al., 2017). In this study, the term 'traumatic experience' described experiences that are viewed as traumatic for example violence, sexual abuse, and neglect.

Trauma severity: Refers to the degree of distress that trauma survivors experience after a traumatic event (De Bellis & Zisk, 2014). The study regarded trauma severity as the nature and frequency of symptoms exhibited by children in rehabilitation centres following exposure to trauma.

Summary

This chapter has provided a detailed background of the study, a statement of the problem, the study purpose, research objectives, and research questions. Furthermore,

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the rationale for the study, scope, limitations and delimitations, and definition of key terms were discussed. The next chapter discusses the literature review.

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CHAPTER TWO

LITERATURE REVIEW

Introduction

This chapter presents a systematic assessment of the psychosocial support for children who have suffered trauma, with a focus on rehabilitation centres. The study adopted an extensive review of the most updated and credible primary sources of data concerning childhood trauma and psychosocial support provided for children living in rehabilitation centres. Children living in rehabilitation centres are affected by traumatic experiences, which include sexual abuse, physical abuse, emotional abuse, and neglect. The chapter presents a discussion of the epidemiology of trauma in children and a review of the psychosocial support for children living in rehabilitation centres. It also discusses the theoretical and conceptual frameworks of the study to expound on the relationship between trauma and psychosocial support in children aged between 8 and 15 years in rehabilitation centres.

Theoretical Framework

This section of the literature review presents the theories on which this study was based. It involves an examination and contextualization of key concepts for the present study. The study was based on Erik Erikson's theory of psychosocial development and Abraham Maslow's theory of the hierarchy of needs. Erickson's theory was relevant because it sheds light on the existing relationship between trauma and the psychosocial support offered to children. Similarly, Maslow's theory was relevant as it informs on the relationship that exists between PSS and trauma recovery.

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Psychosocial Development Theory

The psychosocial development theory was developed by Erik Erikson in his work, childhood and society, in 1950 (Cherry, 2020). He highlighted the different phases in which a child grows into an individual who positively impacts and contributes to the social, historical, and interpersonal experiences faced during the process of socialization (Maree, 2021). These stages include transitioning through development in a specific order, with age and the contribution of culture.

Erikson's eight psychosocial stages are (basic) trust vs (basic) mistrust (0 - 18 months), autonomy vs shame and doubt (2 - 3 years), initiative vs guilt (3 - 5 years), industry vs inferiority (6 - 11 years), identity vs role confusion (12 - 18 years), intimacy vs self-absorption (19 – 40 years), generatively vs stagnation (40 to 65), and, lastly, integrity vs despair (65 to death) (Cherry, 2020). According to Syed and McLean (2017), the psychosocial crisis may also be referred to as a developmental task and helps to better understand the different psychological issues that may affect individuals at various stages as they develop. These have been highlighted in Table 2.1.

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Table 2.1: Stages of Psychosocial Development

Stage	Psychosocial Crisis/Task	What happens at this stage
1	Trust vs Mistrust	If needs are dependably met, infants develop a sense of basic trust.
2	Autonomy vs Shame/Doubt	Toddlers learn to exercise their will and do things for themselves, or they doubt their abilities.
3	Initiative vs Guilt	Preschoolers learn to initiate tasks and carry out plans, or they feel guilty about efforts to be independent.
4	Industry vs Inferiority	Children learn the pleasure of applying themselves to tasks, or they feel inferior.
5	Identity vs Confusion	Teenagers work at refining a sense of self by testing roles and then integrating them to form a single identity, or they become confused about who they are.
6	Intimacy vs Self-absorption	Young adults struggle to form close relationships and gain the capacity for intimate love, or they feel socially isolated.
7	Generatively vs Stagnation	The middle-aged discover a sense of contributing to the world, usually through family and work, or they may feel a lack of purpose.
8	Integrity vs Despair	When reflecting on his or her life, the older adult may feel a sense of satisfaction or failure.

Source: HQ Psychology Notes (2019)

Trust (basic) vs mistrust (basic) is a stage of development that occurs for children who are between the ages of 0 - 18 months. As indicated by Erikson, at this stage, children learn whether those around them, particularly the mother, are dependable in meeting their needs or not (Evers, 2018). As noted by McLeod (2018), if their needs are always being met, they develop a sense of hope and trust in others and their surroundings. However, if their needs are neglected and/or randomly met, they develop a sense of fear and mistrust of others and their surroundings.

Evers (2018) noted that trauma in children can happen in the womb and/or after birth. A mother's negative well-being such as poor nutrition, taking alcohol and/or drugs, and a hostile environment trickles down to the baby in utero. When a baby is born into this situation and his or her needs are not met, it causes toxic stress upon the baby. Consequently, this will lead to poor appetite, loss of weight, excessive screaming and crying, emotional dysregulation, cognitive delays, and disorganized

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attachment (Evers, 2018; McLeod, 2018; National Child Traumatic Stress Network (NCTSN), 2018). Nevertheless, trauma in children varies in intensity and severity and, therefore, cannot be the same for every child. As such, when protective factors are provided for the child, it can aid them to build resilience. The factors include the presence of a positive, caring, and protective parent or caregiver to develop a positive attachment (National Child Traumatic Stress Network, 2018).

Autonomy vs shame and doubt is a stage of development that occurs for children who are between the ages of 2 - 3 years. As indicated by Erikson, at this stage, children are learning how to physically interact with their environment as their fine and gross motor functioning develops (Evers, 2018). They learn how to crawl, touch things, and pick up boundaries among many other milestones. Cortical Chauvinism (2018) noted that when children are at this stage and are encouraged, they develop a sense of will that they are capable. However, when they are met with hostility and criticism for their efforts, they are faced with feelings of shame and doubt about their capabilities. Trauma for children at this stage is manifested by irrational and impulsive behaviour, fear and/or refusal to try doing things, inability to adhere to proper boundaries, as well as hypersensitivity when the parent or caregiver is around them (Wurdeman, 2015). However, if positive coping strategies are introduced to the child, they can regain their sense of autonomy.

Initiative vs guilt is a stage of development that occurs in children who are between the ages of 3 - 5 years. As pointed out by Erikson, children build on skills learned in the previous stage and show more initiative in their learning and social skills at this stage (Erskine, 2019). When children are at this stage, they develop a sense of purpose as they explore their surroundings. When they are met with positive feedback and encouragement for their efforts, they develop a sense of initiative. However,

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when they are met with a lack of guidance, cruel jokes aimed at them, and severe punishment, they will be faced with guilt for their actions (Erskine, 2019). This guilt will be manifested in hyper-responsiveness, anxiety, and low self-esteem (Evers, 2018; National Child Traumatic Stress Network, 2018).

Industry vs inferiority is a stage of development that occurs for children who are between the ages of 6 - 11 years. Erikson established that at this stage, children attempt to engage themselves in various tasks which are typically normal developmental milestones (McAdams & Zapata-Gietl, 2015). As posited by Orenstein and Lewis (2020), this is the stage where the experiences of a child expand and increase due to exposure to other individuals, places, as well as new information. Children who experience traumatic events exhibit changes that affect their ability to cope in a normal and acceptable developmental style.

Identity vs role confusion is a stage of development that occurs in children who are between the ages of 12 - 18 years, and as shown by Erikson, during this stage, children seek to find a sense of self in their journey of self-discovery(McLeod, 2022). The World Health Organization (WHO) (2022) asserted that this period is met with various physical, mental, emotional, and social changes as they transit from childhood to adulthood, also referred to as adolescence. As a result of these changes, children make a more conscious effort to answer the major question they face, “who am I?” (Block, 2011).

Successful navigation of this crisis (who am I) helps children to have healthy emotional and psychological well-being through their relationships with others (Ragelienė, 2016). Consequently, As attested by Kasinath (2013), this leads them to have a positive outlook on life and themselves, thus exhibiting moratorium and identity achievement. On the flip side, unsuccessful navigation of this crisis may

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cause children to not only have unhealthy relationships but also a negative outlook on life and themselves (Cherry, 2020). Moreover, Zhang (2015) noted that traumatic experiences in early adolescence cause children to have role confusion and face challenges of identity diffusion, identity foreclosure, and negative identity. Nevertheless, Oshri et al. (as cited in Truskauskaite-Kuneviciene et al., 2020) posited that a positive support system can deescalate the negative effects of trauma on the child.

Erikson's industry vs inferiority and identity vs role confusion stages best inform this study because they cover the targeted age range of children in the study. The psychosocial development theory has various strengths that demonstrate its use in this study and will be discussed herein. Firstly, the theory shows that a child passes through different developmental stages, hence the need to be able to manoeuvre each stage effectively to live a healthy life (Cherry, 2020). Secondly, according to McLeod (2018), the theory demonstrates the importance of early childhood experiences in the development of growth for every person. It also emphasizes the importance of social relationships and their effect on the development of children (Rubin & McDonald, (2018). Furthermore, Erikson's theory practically embraces children as actively trying to negotiate through traumatic experiences constructively. This theory has been adopted in other studies to evaluate and support the study of psychopathology (Klimstra & Denissen, 2017). Importantly, as indicated by Knight (2017), Erikson's theory of psychosocial development has been integral in the assessment of psychosocial perspectives that can assist individuals to evaluate the formation of relationships.

Critics have questioned the validity of Erikson's psychosocial development theory by asking if each of the crises is measured on a single or two continua and how the ratios

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can be operationally defined and measured by representing the extent to which a crisis has been resolved (Maree, 2021). Additionally, Cherry (2020) argued that the theory does not give exact detail on the type of experiences that are necessary at each stage for it to be successfully resolved. Lastly, the theory does not explain the implications for an individual throughout their lifespan regarding whether or not they solve the crisis at various stages (McLeod, 2018).

Erikson's theory was suitable for this study as it sheds light on the relationship that exists between trauma and the psychosocial support offered to children. The theory also illustrates the impact of traumatic events on the normal growth and development of children.

Maslow's Theory of Hierarchy of Needs

Cherry (2020) noted that the theory of the hierarchy of needs was developed by Abraham Maslow and published in his 1943 work (the theory of motivation) and, consequently, in his later 1954 work (motivation and personality). Maslow posited that human beings have an inborn desire to achieve their fullest potential and attainment of their needs (Block, 2011). According to Maslow, human needs can be organized in a hierarchy ranging from more concrete needs such as water and food to abstract concepts such as personal fulfilment (Taormina & Gao, 2013). These needs are illustrated in a pyramid format with the low-level/basic needs at the bottom and the complex needs at the pinnacle. He further asserted that the low-level/basic needs were deficiency needs, necessary for one to be a functioning individual (McLeod, 2022). The complex needs, as attested by Noltemeyer et al. (2021), were referred to as growth needs, necessary for growth as a person. If deficiency needs are not met, one cannot achieve growth needs. Maslow asserted that humans are motivated by five

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basic categories of needs namely physiological, safety, love and belonging, esteem, and self-actualization (Taormina & Gao, 2013).

Physiological needs are considered to be the most essential for survival such as food, water, air, sleep, shelter, and clothing (Aruma & Hanachor, 2017). For example, if a child does not get adequate sleep or food the day before attending school, the child may be very tired and hungry in class and not pay attention to what is being taught. McLeod (2022) established that once the physiological needs have been met, safety and security needs are next to be attended to. Safety does not only refer to a shelter where a person resides, but also emotional safety. For example, an adequate shelter can instantly become unsafe through instances of domestic violence or defilement of minors in the home. Psychologically, such a home may be deemed unsafe for minors and adults. Security refers to the continuity of social aspects such as employment for financial security to necessitate the maintenance of basic needs. According to Bishop (2016), even in early childhood, children need a safe and predictable environment and normally react with anxiety and fear if these needs are not met. This study evaluated the types of trauma children aged 8-15 years go through before being taken to rehabilitation centres. Trauma is always a result of not living in a safe and conducive environment.

Following the acquisition of the first two needs is the need for love and belonging. Human beings are social beings and face difficulties when they are isolated from others. Children, for example, need a family to belong to that they can depend on, a group of friends to learn from and play with, and, most of all, they need to be loved. As social beings, humans seek to love and be loved, to be part of a social group, to be accepted, and to have a sense of belonging (Hopper, 2020). The everyday experiences of feeling loved and loving others, even pets, positively influence one's well-being

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and, according to Oravecz et al. (2020), experiences that give one optimism and a sense of purpose.

Upon achieving feelings of love and belongingness, the next need to be met is esteem needs. Maslow postulated that human beings can achieve these needs through the feelings they have about themselves as well as those valued by others (Hopper, 2020). In line with this, Britto et al. (2017) noted that the nurturing of children and their environment plays a huge role in fulfilling their esteem needs by impacting how they approach tasks, try new things, and process feedback from their caregivers, among others. When a child is met with high criticism on the mentioned issues, the child may manifest low self-confidence and feelings of hopelessness and inferiority. This study covers the types of trauma the children go through when faced with criticism and esteem needs.

Finally, when previous needs have been met, comes the need for self-actualization. This is a growing need and is at the pinnacle of the pyramid (McLeod, 2022). At this level, human beings are motivated to achieve their highest potential in all they do and be their ideal self. Extracurricular activities in school help children to discover their talents to be the best they can be by their standards. For example, children who have talent in playing lawn tennis will spend extra time training and learning from coaches or a tennis player they admire. Self-actualization refers to any person striving to live to their full potential in all they do. A summary of Maslow's hierarchy of needs is highlighted in Figure 2.1.

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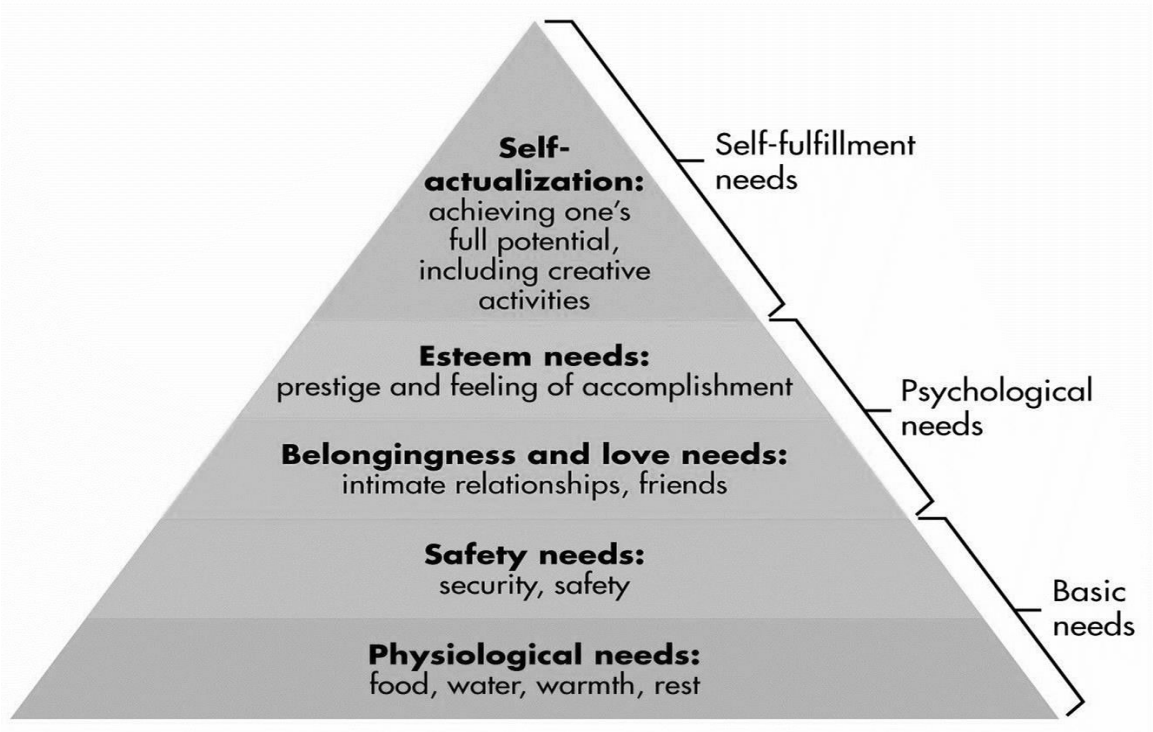

Figure 2.1: Maslow's Hierarchy of Needs
Source: McLeod (2022)

Maslow's hierarchy of needs was developed to provide an understanding of the drive behind the motivations of human beings. The theory's simplicity made it easy to comprehend and relate to. It also gives importance to relationships, both interpersonal and intrapersonal, at every stage necessary for individuals. The environment in which an individual is plays a huge role in his or her development and motivations as well. Lastly, at every stage, the motivations of individuals change as each need is met and as they strive to meet other needs (McLeod, 2022).

However, despite the many acknowledgements of the theory, it also received criticism. Although the theory postulates the importance of relationships for human beings, it was criticized for giving individuality a higher preference. Secondly, critics noted that the theory does not consider the aspects of culture and cultural diversity. Furthermore, the theory was developed as a rigid step-by-step process on how beings may achieve their full potential (McLeod, 2022). Therefore, in the 1970s, Maslow

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updated his theory to include cognitive needs, aesthetic needs, and transcendence, which led to the hierarchy of needs having eight stages.

Human beings are social beings always motivated to achieve their ideal selves. They are curious about their environment and seek knowledge and understanding along the way. This nature of human beings refers to their cognitive needs (McLeod, 2022). In their interactions, human beings have an appreciation of beauty and continue to search for it through nature, art, sculptures, and even biological marvels such as pregnancy and birth, to name a few. McLeod (2022) noted that these are aesthetic needs. Above self-actualization is the need for transcendence. Verboven (2020) noted that transcendence is the understanding that one is part of a bigger whole and acts accordingly. Verboven further noted that it is not easy to achieve, especially in the case of children, but as they continue to develop aspects of love and kindness, for example, it gets clearer.

With the expanded hierarchy of needs, the stages are not rigid and can even overlap each other making them tailored to different individuals based on their aspirations and motivations regarding growth needs. However, deficiency needs continue to remain a crucial element to be met in fueling human beings' motivation. An illustration of Maslow's revised hierarchy of needs is presented in Figure 2.2.

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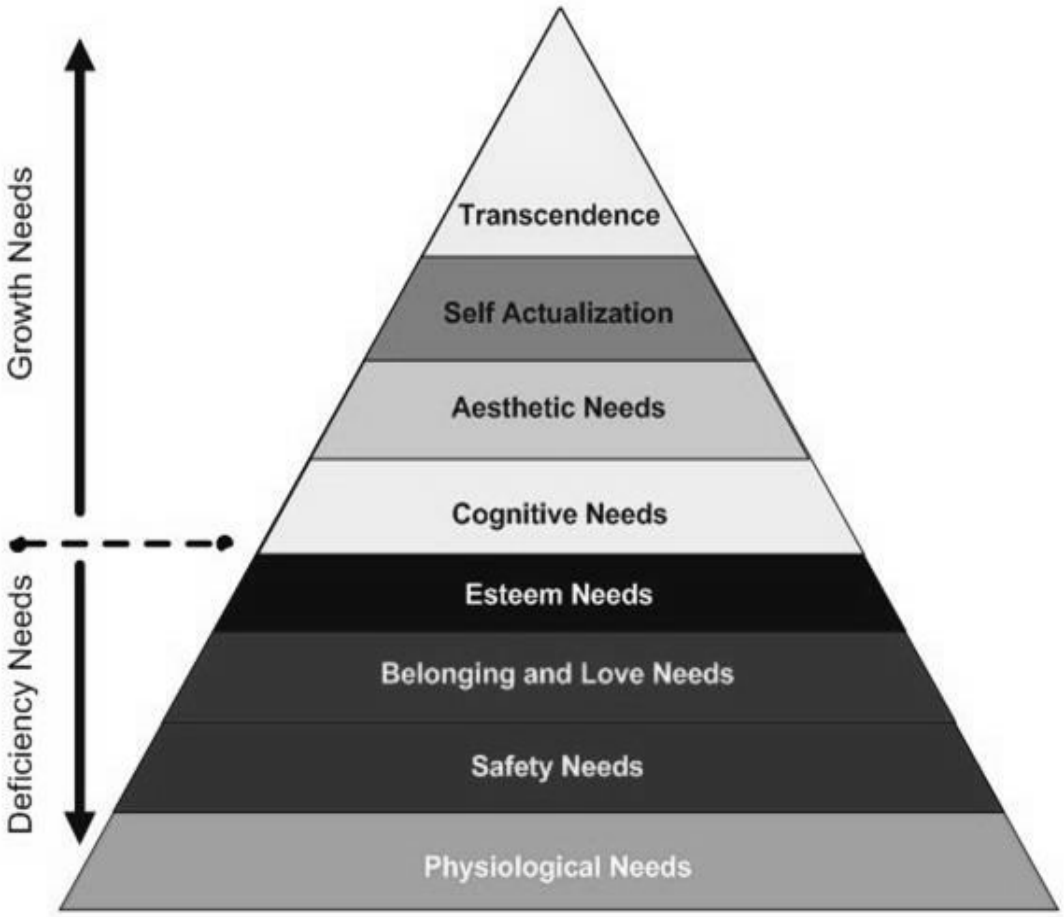

Figure 2.2: Maslow's Expanded Hierarchy of Needs
Source: McLeod (2022).

In summation, Maslow's hierarchy of needs was appropriate for this study since it enlightens on the relationship that exists between PSS and trauma recovery. The theory also illustrates the need for psychosocial support for children who have experienced traumatic events and are not able to adequately fulfil their basic human needs because of extreme circumstances such as violence, extreme poverty, different forms of child abuse, and emotional neglect.

The selected rehabilitation centres in this study provide the children with the necessary deficiency needs for healthy growth and development. The children in both centres are assured of food, drink, and clothing. The PSS providers also support the

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children to achieve their needs of belonging and love as well as build positive self-esteem.

General Literature Review

In recent years, studies on trauma have emerged as one of the most important new topics in humanities studies (Daniels et al., 2013). In the USA, it is estimated that 26% of children and adolescents experience or witness a traumatic experience before the age of four years, while others experience chaos in the home setting (de Arellano et al., 2014). Notably, children are exposed to distinct traumatic events and what may be traumatizing to one child may not traumatize another child. Consequently, it is necessary to employ different techniques when addressing traumatic experiences in children. Recognizing the impacts of trauma on the development of a child is crucial for the provision of support and understanding the essential needs for a child to heal.

Masten and Tellegen (2012) identified three primary developmental tasks in the social and psychological development of a child: attachment, initiative, and self-regulation. Traumatic events or experiences can occur in a variety of ways in a child's life. Trauma results in a psychological loss that is not easy to appreciate, especially since it happens gradually over time (Kauffman & Landrum, 2013). It is important to have a proper understanding of childhood trauma as well as the challenges involved, even when this information is found in different studies.

In a study drawing a comparison between the levels of exposure to trauma amongst Kenyan and South African children, the findings revealed that 80% of these individuals had been exposed to traumatic events or experiences at least once in their lives (Hanche-Olsen et al., 2012). As stated by Tossani (2013), a traumatic event is characterized by painful negative emotion that impedes the coping mechanism of

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children. Examples of traumatic events include violence, neglect, losing a loved one, sexual abuse, and mistreatment. Shackman et al. (2011) noted that children who have gone through traumatic experiences or events may develop negative psychosocial effects on themselves. From their perspective, they might believe that the event or experience occurred because of something they did or failed to do. Nonetheless, this should not be the case as children cannot be blamed for the trauma they go through (Cohen et al., 2016). A caregiver's presence in a child's life is crucial since it aids the child to learn new skills, which enable them to cope with the social environment through the development of a sense of industriousness.

When children encounter painful events, it brings about trauma, which could lead to psychosocial effects in their life. In their early life, children are exposed to different forms of mistreatment that result in trauma even in their future adult life. For instance, children may be exposed to sexual abuse, physical abuse, emotional abuse, and negligence from their elders. If a child experiences trauma, and psychosocial support is not offered, challenges arise and this exposes the child to other risks that may have a negative influence on their well-being.

Types of Traumas

Children suffer different types of traumas that emanate from child abuse as discussed in this section.

Acute trauma

This is a form of trauma that results from a single event or incident. Perusini et al. (2016) asserted that acute traumatic stress is a terrifying experience for the individual, which might lead to a lot of fear or hopelessness in return. Acute trauma is commonly experienced by any individual who witnesses traumatic violence or any other event

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causing pain. A good example is when a person is travelling and comes across an accident. It might take some time before the individual can comfortably travel in a car again without experiencing any triggers or fearing that they might encounter an accident (Kassam-Adams, 2014).

Children are often exposed to traumatizing events and, in some instances, they may develop symptoms or urgency that requires to be addressed to deliver them from painful experiences. In other situations, symptoms might comprise erratic nightmares and flashbacks that a child is not accustomed to. In other incidences, children might end up escaping anything that serves as a reminder about a past traumatic experience. Parents, teachers, care workers, psychology specialists, and other adults can assist children through the process of healing and growing by ensuring that they are dependable persons whom the child can identify with and easily reach out for assistance in handling difficult circumstances (Marsac et al., 2014).

Chronic trauma

This kind of trauma occurs in a repeated and extended pattern. According to Levy et al. (2019), chronic trauma results when individuals experience many repeated traumatic events such as neglect or violence for an extended period and, at some point, they might end up showing different reactions to the experiences. Among children, some of the chronic traumatic experiences include domestic violence, sexual abuse, and mistreatment. The devastation of the continuous trauma leaves the child victims coping in both a reactionary and defensive manner to protect themselves (Skywood Recovery, 2018). Consequently, this may lead to problems such as anxiety, impaired memories, fatigue, anger, and poor sleep as well as behavioural manifestations such as substance abuse, risky sexual behaviour, and violence. These

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problems and manifestations may continue into adulthood, hence the need for psychological aid and/or psychosocial support to be provided.

Complex developmental trauma

In this type of trauma, an individual may experience trauma that goes beyond acute and chronic trauma. Typically, complex developmental trauma arises from chronic and acute trauma. When a child is unpredictably and uncontrollably exposed to danger at an early age, it affects their psychological functioning. Terrasi and Crain De Galarce (2017) posited that children who encounter this kind of trauma are likely to display unique and unpredictable behaviour. Additionally, when the caregiver is absent or is not efficiently responding to a child, the child lacks essential nurturing, thus they might experience the negative effects of complex developmental trauma. The child may start feeling abandoned and neglected, which may leave them in a hopeless situation.

Complex developmental trauma negatively impacts a child's life, given that it affects key areas of developmental milestones. Some of these milestones include the child's touch, hunger, and executive functioning, which may interfere with the proper functioning of the brain and control of impulses. A study by Lanius et al. (2010), which focused on neuro-biological functioning, revealed the impact of chronic fear on brain development and the influence it has on the mode of interaction between people. Even when the brain dictates the thoughts and behaviour of an individual, chronic fear impacts the ability to respond to a threat.

D'Andrea et al. (2011) asserted that multiple exposures to trauma can have a great impact on the intensity of the psychological functioning of an individual. They demonstrated that stress also results in physical harm and has a high likelihood of

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exposing individuals to mental health problems as well as the ability of children to recognize, regulate, and express emotions. A safe and nurturing environment allows a child to connect with the care provider, which aids in the growth and development of his or her brain even in a stressful environment. It enables an individual to learn how to control their feelings as well as develop a model needed to deal with psychological stress in the future. Children should be able to recognize their temperaments and traumatic events. In this view, children learn by being able to identify and express their emotional states. Eventually, this helps them learn how to control their emotions and internal experiences (Van der Kolk, 2017).

Prevalence and Impact of Childhood Trauma

Childhood trauma is linked to a variety of negative psychological outcomes such as depression, guilt, shame, dissociation, emotion dysregulation, and low self-esteem (Kohrt, 2014). Children who undergo traumatic experiences often display interpersonal issues, possibly related to deficits in emotion regulation and in their ability to relate to other people or engage in relationships healthily (Kempke et al., 2013). Childhood trauma, potentially arbitrated by this range of psychological consequences, is in turn linked to an even broader variety of problematic behaviours including hyperactivity, aggression, and lack of attention (Álvarez et al., 2011). As suggested by Watson et al. (2014), most of the symptoms and behaviours that are displayed by children with a history of trauma interfere with their ability to achieve success academically and socially. Consequently, Hovens et al. (2012) indicated that these childhood struggles can trigger children to have negative views of themselves and other people.

Notably, the extent to which trauma affects the lives and wellness of child victims is dependent on the prevalence at which it occurs. According to Wamser-Nanney and

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Vandenberg (2013), 32% to 80% of children have experienced child maltreatment. The World Health Organization (2020) estimated that more than one billion children aged between two and 17 years around the world experience neglect and physical, sexual, or emotional abuse yearly. The incidence of trauma is relatively higher in children who are involved in child welfare, with around 68% to 92% having experienced maltreatment (Cyr et al., 2012). However, the prevalence of childhood trauma is less recognized among teenagers involved in the juvenile justice system. Dierkhising et al. (2013) reported that 70% to 93% of teenagers who are involved in the juvenile justice system have been exposed to trauma. As attested by Greeson et al. (2011), dysregulation of behaviour and emotion by children who have undergone traumatic experiences predisposes them to involvement with the juvenile justice system and misdemeanour.

In the African continent, it is approximated that more than half of children experience different forms of child abuse, including neglect and physical, sexual, emotional, and psychological abuse. Child maltreatment has been documented in various East-African families including Tanzania and Kenya (Schneider et al., 2018). Studies in this region have reported that children and adolescents experience child abuse regularly. The ability to approximate the national and continental magnitude of child abuse is limited. This is attributed to the fact that the majority of research that has been carried out has concentrated either on adults or population groups and not specifically on children or adolescents, preventing independent estimates of the magnitude of the problem facing children in the continent (Schneider et al., 2018).

Additionally, previous studies in this area of study (child maltreatment) were conducted in different countries or different regions of Kenya using distinct definitions, for instance, sexual abuse (Cicchetti & Toth, 2015). This has made it

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difficult to generalize the findings of one study to Kenya or Africa in its entirety to get an overall depiction. Furthermore, past studies have ignored some cases of child abuse such as sexual violence against the boy child, or have underrepresented it because of the cultural factors that lower reporting by boys. Therefore, it can be argued that most of these studies have only been successful in raising awareness of the existence of the problem of child maltreatment (Cicchetti & Toth, 2015).

Psychosocial Effects of Trauma on Children

Literature on the responses to trauma highlighted that children who encounter traumatic experiences appear to have a high 'dose effect" and worse psychological outcomes. According to Snyder et al. (2012), experiencing trauma at an early age predisposes children to other health risks. Trauma affects every child differently in terms of psychological and social aspects. The extent of the impact that trauma has on every child relies on various factors including age, a child's previous experiences of trauma, a child's perception of danger, and a child being the witness or victim. The following section discusses the psychosocial effects of trauma in children.

Effects of trauma on brain development

Traumatic events and experiences can have serious repercussions on the normal development of the brain, its chemistry, and the coordination of the nervous system. Carrion and Wong (2012) established that the body responds to trauma in a certain manner and this response is controlled by a natural alert system whose purpose is to assess threats and maintain the safety of the body. Trauma affects the brain's balance by causing disruptions in the homeostasis processes in multiple areas (McLean, 2016). These areas are specifically designed to respond to any kind of threat or attack.

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As attested by Kesby et al. (2011), even though the brain develops continuously throughout life, traumatic experiences have a huge impact on its development.

According to Music (2016), comprehensive developmental experience is essential in the determination of the functional status of a mature brain. When it comes to understanding the responses of children, it is important to first understand trauma, brain, and human development, and their interrelation (Luby et al., 2013). As noted by Blair and Raver (2016), a physiological change to the developing brain in response to trauma results in perceptive delays and losses in the emotional, social, and physical development of a child. They trigger behavioural and emotional responses that impede the child's learning and engagement (Lester et al., 2013). When a child is exposed to a traumatic experience, their brain finds it difficult to process information, thus the child might develop sensory issues or difficulties. A child may avoid anything or anyone that serves as a reminder of the trauma they suffered. Burke et al. (2011) explained that trauma interferes with the learning ability of children, exposing them to more adverse childhood experiences.

Effect of trauma on emotional safety and stability

At an early age, children go through different overwhelming life experiences and events. This affects their affective, cognitive, behavioural, and psychological components, posing a challenge to their well-being (Turner, 2012). The presence of an adult who can be trusted enhances practices that are child-oriented to influence the child's feelings of safety and security as they receive the help they need (Sullivan et al., 2016).

The experience of trauma is overwhelming for a child and this instils intense fear in them. Klain and White (2013) established that past experiences may make it harder to

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build a trusting relationship with one's surroundings. Traumatic experiences such as domestic instability might also result in lower cognitive performance by disrupting a child's concentration in most aspects of his or her life. These traumatic experiences affect the child emotionally as it causes them to dissociate themselves from other people, have low self-esteem, and develop both anxiety and agitation. The environment in which children live should be safe in terms of physical, emotional, and psychological safety. A physical environment that is relaxing and welcoming provides a sense of safety to trauma victims who are constantly on the lookout for danger (Buss et al., 2015).

Effect of trauma on the belief system

A child's belief system can be affected by trauma through an alteration of the child's worldview. Usually, belief systems emerge from the words the child has constantly heard either being said to them or being called. A child's belief system may also originate from a painful experience. To some extent, a child's belief system is shaped by traumatic experiences. Children might start seeing the world through the lens of newly formed beliefs. Behaviour and emotions are influenced by thoughts about life. Among children, the belief system influences their feelings thereby affecting their behaviour toward others (Berkowski & MacDonald, 2014). It is, therefore, necessary to alter the experiences of a child by giving them words of affirmation that will gradually change their belief system (Hardy et al., 2016).

Effect of trauma on thinking about self

Steele and Malchiodi (2012) noted that trauma fragments the psychological sense of self, and survivors of trauma are susceptible to depression and anxiety. Conversely, children are vulnerable to extremes of withdrawal or negative behaviours such as

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acting out. A child who has suffered complex trauma can be easily mistaken for one who is willfully disobedient (Shannon et al., 2014). Being inattentive or showing defiance may be viewed as negative behaviour. Furthermore, a caregiver may not have a clear understanding of the hateful things they have suffered from trauma beliefs about themselves. Although trauma may occur in the early childhood stages, it continues to inflict pain in a child's life because the child might internalize the voice of the abuser (Valdez & Lilly, 2016). This implies that even though the abuser is no longer present, the abuse still lingers or triggers the child. Swannell et al. (2012) found that the pain a child experiences might even be reflected in the social domain of the person. Moreover, a traumatic event in the early life of a child may cause cognitive distortions. A child may be of the view that the world is not a safe place and that there is no need to trust anyone (Slone & Mann, 2016).

Hypervigilance

Hypervigilance can be described as a state of heightened alertness. An individual who is in a state of hypervigilance is extremely sensitive to their surroundings. Therefore, an individual who has experienced trauma at an early age will always be alert to danger. In some instances, a child might think that they missed warning signs foreshadowing the traumatic event. To avert future trauma, children might display hypervigilance by looking for indicators that something bad is going to happen again. Wilkinson (2016) observed that children who have suffered from trauma were in a constant state of alarm even when there was no external threat. This can affect their sleeping pattern due to the present state of tension. Children who have been abused or neglected may find it difficult to comprehend the world around them. They may also experience challenges in forming relationships, understanding the other person's point of view, and interpreting verbal and non-verbal cues (Dye, 2018).

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The caregiver plays an integral role when it comes to meeting the psychological and social needs of a child (Cook et al., 2017). When a caregiver acts and responds to a child who has suffered from trauma consistently and lovingly, the child will develop a healthy relationship based on trust. Neglecting and abandoning a traumatized child results in the development of basic mistrust. For there to be a healthy relationship between the caregiver and child, it is necessary to ensure that there is consistency in the responses to a child's needs (Kinniburgh et al., 2017).

Divaris et al. (2012) indicated that if a child has a need, excitatory hormones are awakened to perform their function. When the caregiver responds to the child's needs, the inhibitory hormone is stimulated and, in the end, the child feels secure and relaxed. On the other hand, if the caregiver fails to respond or responds inconsistently to a child's needs, the inhibitory hormone is never awakened and the child feels unsettled, without any relaxation or sense of safety (Betancourt et al., 2013). A secure attachment with a child who has experienced trauma might be unfamiliar to the child, particularly in situations where the trauma emanates from a trusted person who took care of them.

According to Bakermans-Kranenburg et al. (2011), many orphanages and children's homes have taken strategic measures to ensure that every child under their care lives in a clean environment and has access to high-quality medical care. Nonetheless, the impact of a large number of caregivers and rotating shifts limits the development of stable relationships between children and their caregivers. Regular changes mean that children will not be able to establish a personal relationship with a caregiver.

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The greatest concerns of a child at an early age are whom they belong to and how to express their needs. As noted by Divaris et al. (2012), a strong connection with a child is based on a caregiver's understanding of the life story of the child, which encourages them to communicate their needs in the best way that they can. The thought processes and feelings of children are informed by early patterns of interaction. Kinniburgh et al. (2017) explained that children learn to regulate their behaviour by anticipating how their care provider will respond to them. If a caregiver is inconsistent, emotionally absent, or neglectful, the child learns not to depend on the external environment to meet his or her needs.

A caregiver who is consistent and recognizes the behaviour of children is capable of understanding the context of their behaviour and can aid in repairing the damaged sense of attachment (Music, 2016). As asserted by Tough (2016), children can recover from the undermining effects of trauma, allowing optimism, conscientiousness, and self-control to flourish. Traumatized children exhibit behaviours that clearly illustrate that they are in a continuous struggle to depend on their caregivers.

Children should have safe caregivers who have a proper understanding of their unique needs and respond to them consistently. Caregivers should act as mentors and teachers by assisting them to adapt and change in response to their surroundings (Divaris et al., 2012). Furthermore, they should have basic knowledge and essential life skills for healing and growth beyond traumatic experiences during childhood. It is also their responsibility to understand the effects that trauma has on children. Trauma has an impact on various aspects of a child's life which results in underlying issues. In this regard, the caregiver has to maximize a child's sense of feeling safe through the provision of a setting that is psychologically safe and helps them to minimize the

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overwhelming emotions through the development of connection strategies (Tough, 2016).

When it comes to orphanages and children's homes, as attested by Schneiderman et al. (2012), caregivers are responsible for the promotion of permanency in the life of children who are susceptible to deprivation of emotional, social, and psychological wellness. Caregivers should educate children on how to recognize and discuss their feelings by validating and naming their emotions (Wright, 2016). To maintain a positive attachment between children and caregivers, it is important to minimize disruptions in relationships and placements.

Traumatized children need an established routine that is predictable (Brunzell et al., 2016). In the case of children living in children's homes, this may entail providing a sense of what is expected, for example, what is a children's home? What are the reasons for children coming there? What happens when one leaves the home? This might be crucial in helping the child through the process of recovery. For healing to occur, physical and emotional safety needs to be present. Caregivers in children's homes need to help children identify a safe space particularly if a child feels threatened or experiences distress. A safe space could be a safe person or a place where the child can retreat when they feel triggered or overwhelmed (Lawson & Quinn, 2013). As highlighted by Wilkinson (2016), sometimes simple actions such as allowing a child to complete a duty or responsibility gives them a sense of security since they are assured that they can accomplish something.

According to Lawson and Quinn (2013), children can recover from the incapacitating impacts of trauma and traumatic experiences through optimism, conscientiousness, and self-control. Children who have experienced trauma exhibit behaviours that demonstrate a constant struggle to rely on their caregivers. Children must have safe

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caregivers who understand and respond to the unique needs in their lives. They need mentors and teachers who have the competencies to help them adapt and change in response to their environment. In addition, children need to learn essential life skills for healing and growing beyond trauma. This form of learning can only take place in an environment that possesses non-cognitive qualities (Lawson & Quinn, 2013).

Caregivers have to recognize the effect that trauma has on the child. Trauma has an impact on various aspects of a child's life, hence leading to underlying issues. It is the caregiver's responsibility to minimize the child's sense of safety by creating a psychologically safe environment and helping the child minimize overwhelming emotions by developing connecting strategies. In children's homes, caregivers have a responsibility when it comes to the promotion of permanency of the life of children who are susceptible to deprivation of emotional and psychological wellness (Lawson & Quinn, 2013).

Schneiderman et al., (2012) stated that children have a right to know the truth about a situation in a manner that is suitable for their age. This enables them to process the pain, thereby facilitating the process of healing. A caregiver who is knowledgeable about trauma is aware of the social and psychological needs of children and intentionally strives to meet them. Additionally, the caregiver is familiar with the psychosocial effects of trauma, creating a safe environment for the child to express their worries and pain. Trauma-informed care works toward ensuring that a child who is experiencing trauma feels safe and comfortable (Brown et al., 2012).

Children's bodies and brains are designed in such a way that if a child faces potential reminders of the trauma, they go into an automatic fight, flight, or freeze mode of response. These responses can be easily misinterpreted as behavioural issues that need to be corrected. However, if caregivers understand trauma responses, they can assist a

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child to have a better understanding of their experiences, use coping mechanisms to deal with difficult scenarios, and offer opportunities to practice regaining self-control (Brown et al., 2012). One of the primary areas of helping a child who has undergone trauma is assisting them to build connections and develop skills. This can be done by assisting the child to recognize specific triggers, ground themselves in the reality of the current situation, and comprehend what is going on in their bodies and brains. Furthermore, it enables the child to build coping skills and self-soothing mechanisms to manage feelings linked to traumatic experiences in the past.

Empirical Literature Review

In a study to enhance a better understanding of the global scale of violence against children, Hillis et al. (2016) conducted a study based on data from population-based surveys and scientific literature that included data for 96 countries. The study revealed that over half of the world's children (one billion) aged between two and 17 years old experienced violence every year. In 2015, a minimum of 50% of children in Asia, Africa, and Northern America experienced violence. In 2016, approximately 64% of children in Asia, 56% in Northern America, 50% in Africa, 34% in Latin America, and 12% in Europe were victims of violence. This was before the COVID-19 pandemic.

The COVID-19 pandemic has led to the loss of jobs, life, and education steeped in fear, anxiety, and anger, leading to intimate partner violence, family violence, and child maltreatment all occurring at high rates on a global scale. As such, the COVID-19 pandemic increased the levels of child maltreatment and trauma globally. A joint global 2020 study by UNICEF and Save the Children showed that approximately 150 million children live in multidimensional poverty without access to education, health care, housing, nutrition, sanitation, or water (UNICEF, 2020).

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Countrywide school closures affected more than 1.6 billion children and youth, and six to seven million children under five may have suffered from wasting or acute malnutrition. Overall, the COVID-19 pandemic increased the number of children who have been left hungry, isolated, abused, and anxious. To mitigate the spread of the pandemic, countries initiated lockdowns, national curfews, and discontinuation of services in healthcare and education. Studies show that these measures also exposed children and adolescents to increased risk of family violence, mental illness of parents, social isolation, limited access to healthcare services, child maltreatment by physical and sexual abuse, malnutrition, as well as emotional and psychological challenges (Fegert et al., 2020; Kuehn, 2020; Lawson et al., 2020; Pereda & Díaz-Faes, 2020).

Samara et al. (2020) posited that children in conflict settings such as Palestine and Syria face toxic stress, which disrupts the development of the brain and other organs and increases psychopathology as well as cognitive and emotional impairment with lifelong effects. Moreover, these children experience high rates of mental disorders including post-traumatic stress disorder or separation anxiety disorder, depression, emotional dysregulation, suicidal ideations, anxiety, behavioural problems, and functional impairment. These disorders are manifested through enuresis, nightmares, hypervigilance, grief, phobia, stuttering, learning disabilities, and aggression, among others. Therefore, these children must be supported in healing from the effect of toxic stress to break the cycle of violence. Consequently, access to well-trained primary and mental healthcare will be of great impact on the well-being of these children (Samara et al., 2020).

The national survey of children's exposure to violence was conducted in 2011 to map childhood exposure to various forms of violence in the USA. The survey was

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conducted via telephone and consisted of 4,503 participants aged one month to 17 years (Finkelhor et al., 2013). In the previous year, 41.2% of the participants experienced physical assault, 10.1% experienced an assault-related injury, 12.7% experienced sexual abuse, and 13.7% experienced maltreatment by a caregiver. These types of abuse on children have severe negative consequences on their development.

According to Saunders and Adams (2014), a significant number of children have experienced physical abuse, sexual assault, bereavement, or serious violence between caregivers. The participants in these studies may have had significant problems that may have resulted from traumatic experiences or events. Moreover, McLaughlin et al. (2013) conducted a national survey of adolescents aged 13 through 17 years in the USA, with 6,483 adolescent-parent pairs participants. The study showed that children living with caregivers were more exposed to interpersonal violence and other potentially traumatic experiences and not only did they live in fear but also developed distress disorders. The survey findings revealed a connection between exposure to trauma in early childhood and other traumatic experiences to psychological well-being. Kilpatrick et al. (2013) highlighted that over the past few decades, childhood trauma has been on the rise, thus necessitating the need to facilitate early interventions to help children recover before the impact becomes worse in the future.

A study by Santino et al. (2021) highlighted how children have been and continue to be used as instruments of war on a global scale, whereby their rights and welfare are disregarded by their involvement in armed groups (voluntarily or not). In Somalia, children may join armed groups either voluntarily to access physiological, safety, and security needs for survival or involuntarily by forced recruitments and abductions in public spaces. They are used for roles such as spies, sex slaves, cooks, suicide

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bombing, carrying loads, or guarding the army's camps by armed groups such as Al Shabaab.

In 2018, the Somali population between zero and 14 years of age was estimated to be 46.57% of the total population, whereby almost half of the society was under 15 years of age (Santino et al., 2021). Children seeking to find their identity and belonging remain easy prey to armed groups for indoctrination and radicalization. Consequently, children born into conflict are exposed to poly-victimization through multiple forms of trauma. The children in Somalia continue to live in fear and grief as they witness and experience heinous acts of violence against their families, friends, and community every day.

Violent post-election conflict continues to have negative lifelong effects on a child. A study by Wayoro (2018) highlighted these effects in Côte d'Ivoire between the 2002-2007 conflict and post-war household surveys in 2008 as per UNICEF 2009 data. In 2002, 10% of children suffered chronic malnutrition, 3,000 children faced forced involvement with armed groups, and 750,000 fled to safe areas and became internally displaced people; 51,037 of these persons were children. In 2008, families in Côte d'Ivoire faced food insecurity (27% of rural households were food insecure, while 12% were severely food insecure), malnutrition (17.5% of children under five in the north suffered from acute malnutrition out of which 4% (22,000 children) suffered from severe acute malnutrition), and crippled access to education and healthcare since over 80% of the health personnel and trained teachers fled to more secure areas in the country. Further hardship has been met by the illness of parents, sudden loss of household income, displacement, looting, loss of assets, the death of breadwinners, and disease in Côte d'Ivoire (Wayoro, 2018).

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In 1998, following the bombing of the USA embassy in Nairobi, Kenya, a study was conducted to evaluate the children who had been exposed to trauma (Pfeffebaum et al., 2003). The study, which involved 500 children revealed that even among children who were indirectly exposed to the incident, reactions were more severe for those individuals who had a previous history of trauma. In Kenya, the 2007 post-election violence brought the entire country to a halt. The Waki Commission (2008) revealed that during this period, children were exposed to different types of traumas, which had effects on various aspects of their lives. Exposure to this kind of traumatic experience impact how children view the world, themselves, and the people around them (Njuguna, 2012).

To further portray the devastating effects of post-election violence on children in Kenya, Mbwayo et al. (2020) conducted a study on 2,482 schoolchildren aged 11-17 years old in both rural and urban settings. The study indicated that these school children had witnessed people being shot at, beaten up, or killed (46.9%) or had heard about the violent death or serious injury of a loved one (42.0%). Some of the victims were not able to access help during and after the clashes, implying that they had to live with more trauma in their lives.

Conceptual Framework

A conceptual framework represents a researcher's understanding of how the variables in the study connect and shed light on a specific phenomenon (Adom et al., 2018). The conceptual framework for this study is illustrated in Figure 2.3, with arrows highlighting the relationship between the variables.

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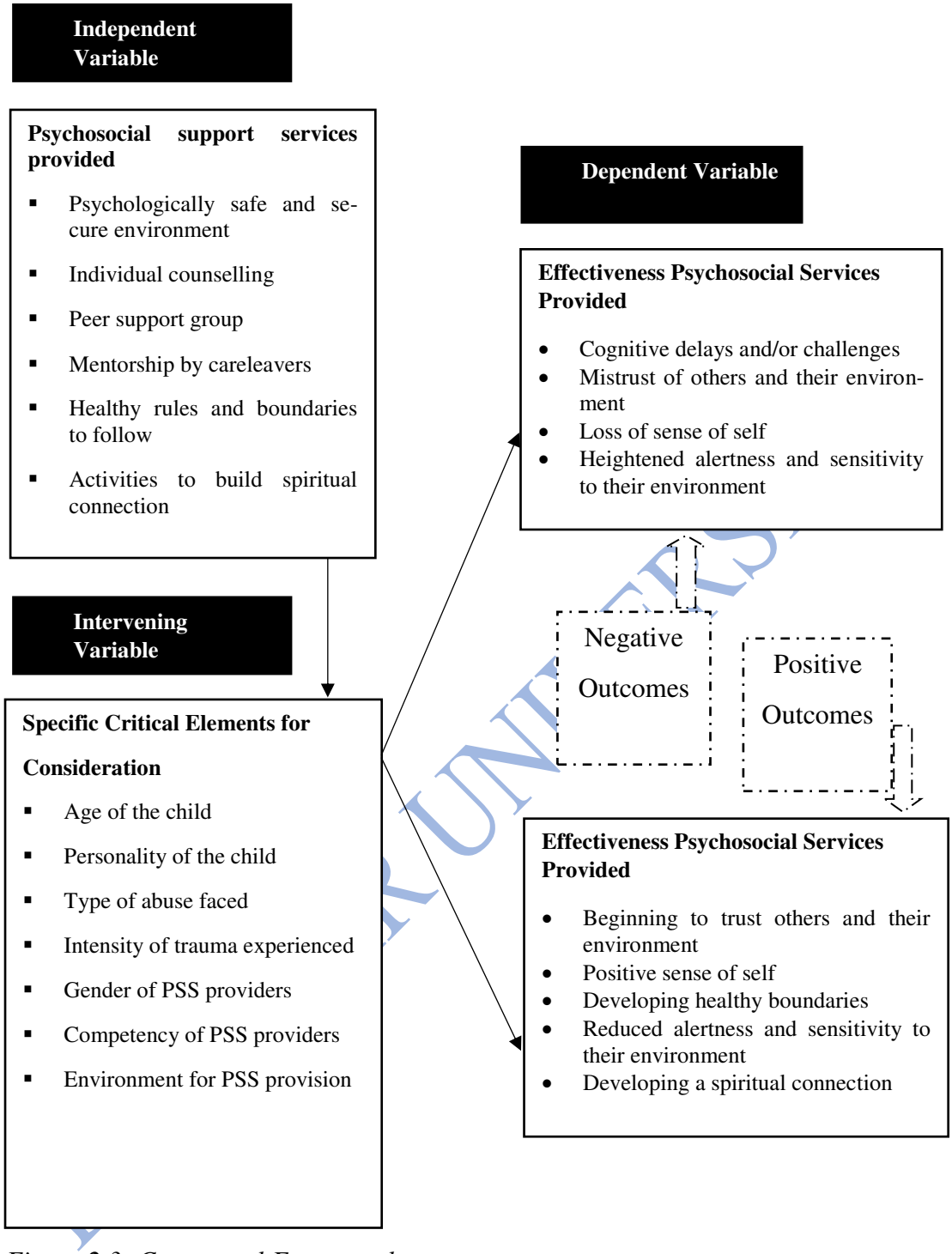

Figure 2.3: Conceptual Framework
Source: Author (2022)

Discussion of the Conceptual Framework

Figure 2.3 depicts the relationship between the independent variable and the dependent variable of the study, the PSS and the effectiveness of psychosocial services provided respectively, with consideration of the specific critical elements that

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make up the intervening variable of the study. When PSS is properly provided and by qualified persons then a positive outcome for the child is realistic. PSS should be provided by taking into consideration specific critical elements to holistically mitigate the psychosocial effects of trauma. These specific critical elements include the age of the child, the personality of the child, the type of abuse faced, the intensity of trauma experienced, the gender of PSS providers, the competency of PSS providers, and the environment for PSS provision. The consideration of these specific critical elements makes up the intervening variable of the study.

Summary

This chapter has discussed related literature on the psychosocial effects of trauma and how children require psychosocial support. A theoretical model was outlined to explain the relationship between trauma and the psychosocial effect on a child's life. Furthermore, the chapter has presented empirical literature and the conceptual framework, which illustrated the connection between the study variables. The ensuing chapter discusses the research methodology for the study.

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CHAPTER THREE

RESEARCH METHODOLOGY

Introduction

This chapter presents a discussion of the research methodology and research design that was adopted when investigating the PSS provided to trauma-exposed children aged 8 to 15 years in selected rehabilitation centres in Nairobi. It also outlines the target population and sample size for this study. In this chapter, the sampling procedures, data collection instruments and techniques, data analysis, and ethical considerations are discussed. Additionally, the chapter discusses the areas of study on the subject, which is the psychosocial impact of trauma exposure on the lives of children in the selected rehabilitation centres.

Research Design

Rahi (2017) defined research design as a systematic plan that is adopted in the collection and analysis of data to derive necessary information. This study utilized a descriptive research design. According to Siedlecki (2020), a descriptive research design is appropriate when a study is seeking information related to the current status of a phenomenon and describing the present state of the conditions in a situation.

This study sought to understand how children are affected by trauma from the abuse they may have faced and how PSS helped them to overcome these effects. A descriptive research design is best suited for this study as it looked at how children develop trauma and how PSS services offered to them help to overcome the negative effects of trauma. The study used both qualitative and quantitative methods to deliver a comprehensive description in words and calculated statistics to expound the data.

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Study Population

This study focused on selected rehabilitation centres providing street children access to their deficiency needs that were lacking in their lives. One of the selected centres has 2 sites; a 'dropping in' site and a rehabilitation site/boarding school. The other selected centre also has 2 sites; a home and a school. Firstly, Kwetu Home of Peace was established in 1995 with 2 sites, Kwetu Home of Peace Madaraka and Ruai. Secondly, the Children's Garden Home and School were established in 2001 with 2 sites, Children's Garden Home and School Home and School.

At Kwetu Home of Peace, the children reside at the drop-in site for three to six months before being transferred to the rehabilitation centres. This transfer is based on the initiative of the children to make positive changes for themselves. At the respective rehabilitation centre, children reside for one year or one and a half years. At Children's Garden Home and School, the children reside full-time at the home and also have access to school.

At these rehabilitation centres, social workers and counsellors proceed with further rehabilitation and reintegration. The careleavers of both centres are from the rehabilitation centres. They continue to interact with these centres as mentors to these children. The researcher considered the children's ages, degree of trauma exposure, and their demeanour upon arrival at the drop-in site and the home. This was supported by accurate records by the administration of the respective centres. The records also included accounts of the social workers and counsellors regarding the children.

At Kwetu Home of Peace, 96 children were attended to at both sites from January to October 2021. At Children's Garden Home and School, 264 children were attended to

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at both sites from January to October 2021. The study population of these two sites is presented in Table 3.1.

Table 3.1: Study Population of Relevant Persons of the Study

Rehabilitation Centre	Number of Psychosocial Support Service Providers per Site		Population of Psychosocial Support Service Providers per Site	Population of Children per Site
Children's Garden Home and School	CGHS Home	22	49	355
	CGHS School	27		
Kwetu Home of Peace	Madaraka	10	40	96
	Ruai	30		
Total			89	451

Target Population

According to Asiamah et al. (2017), the target population refers to the population that a researcher has identified intending to obtain generalizable results. The selected rehabilitation centres were based in Nairobi, dealt with street children, and had been in existence for more than 10 years.

At Kwetu Home of Peace, 70 children aged 8-13 were attended to at both sites from January to October 2021. At Children's Garden Home and School, 290 children aged 8-13 were attended to at both sites from January to October 2021. The total number of 360 children in the targeted age range of the study formed part of the targeted population. The children in these centres are provided PSS by social workers, counsellors, and careleavers. These persons are an integral element as they also form part of the study's target population.

The researcher sampled relevant persons from the total population of PSS providers to the children in the targeted age range of the study in the selected rehabilitation centres. These persons consisted of social workers, counsellors, and careleavers in

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each of the selected rehabilitation centres of this study. These persons were 30 in total as highlighted in Table 3.2.

Table 3.2: Target Population of Relevant Persons of the Study

		Children's Garden Home and School		Kwetu Home of Peace		Sub Total		Total
		CGHS Home	CGHS School	Madaraka	Ruai			
PSS Providers	Social Workers	2	0	3	1		6	30
	Counsellors	2	0	4	4		10	
	Careleavers	5	5	2	2		14	
Children	Sex of Children	M	F	M	F	M	F	360
		146	144	70	0	216	144	
	Sub Total				70		360	
	Total							390

Sample Size

Sample size refers to the percentage of the population selected for the study (Oladipo et al., 2015). The study's sample size was derived by factoring in the relevance of the group to the study, the relevance of information that may be brought to the study, and accessibility to the group with support from the selected rehabilitation centres' respective administrations. A simple random sampling technique was used to derive the sample size from a population of 360 children. The sample size was arrived at using the stratified Fishers exact test formula (Jung, 2014), expressed as follows:

$n=Np(1-p)$

N=360: population size.

p=0.5: anticipated population.

n=90: sample size

A sample size of data files of 90 children aged 8-15 years from the two rehabilitation centres of the study was selected.

Sampling Techniques

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This research utilized a purposive sampling technique, which is used in qualitative research for the identification and selection of information-rich cases for the most effective use of limited resources (Palinkas et al., 2015). The purposive sampling technique was used to sample 13 PSS providers from the target population in the selected rehabilitation centres. These persons consisted of social workers, counsellors, and careleavers in each of the selected rehabilitation centres of this study.

Purposive sampling was ideal for this study as all the persons in the sample size provide psychosocial support to the children at the selected rehabilitation centres. As such, the study focused on the social workers, counsellors, and careleavers who attend to trauma-exposed children of the target age range at the selected rehabilitation centres. The specific quality considered for the PSS providers was that they had to be employees at the centre and have holistic interaction with the children daily.

Inclusion and Exclusion Criteria

The inclusion criteria of the study included obtaining the data of trauma-exposed children aged 8 to 15 years at each of the selected rehabilitation centres in the study. The rehabilitation centres had to be in existence for more than ten years to provide adequate data. The inclusion criteria in this research were the data from trauma-exposed children within the targeted age group of the study at each of the selected rehabilitation centres. The selected PSS providers and careleavers had to be working in the selected rehabilitation centres of the study, which formed the sample size. The specific quality considered for the PSS providers was that they had to be employees at the centre, well-trained in PSS provision, and have holistic interaction with the children daily.

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The exclusion criteria in this research did not include the data from trauma-exposed children outside the targeted age group of the study at each of the selected rehabilitation centres. PSS providers and careleavers working in the selected rehabilitation centres of the study that did not form the sample size were excluded. The PSS providers who did not meet the specific quality considered were also excluded from the study.

Data Collection Instruments

Data was collected via a prepared interview schedule by the researcher to conduct in-depth face-to-face semi-structured interviews with the respondents that make up the sample size of the study. An interview schedule refers to a list of structured questions prepared to serve as a guide for interviewers when collecting information or data about a specific topic or issue (Luenendonk, 2019). The interview schedule was prepared with the following considerations: it was in line with the objectives of the study, clear and concise, operationalized and easily understood by respondents, properly coded and analysed, free from bias, and, finally, piloted and tested before the interview (Oladipo et al., 2015).

The interview schedule was preferred for this study as it helped the researcher establish rapport with the respondents and set the tone of the interview. Secondly, it gave the researcher flexibility for real-time clarifications and maintained the proper flow of the interview. Thirdly, it assured all respondents that ethical considerations were adhered to by the researcher to protect them and ensure the study's credibility.

Types of Data

Primary data was collected from the careleavers in each of the selected rehabilitation centres of this study as they were able to provide a first-hand evaluation of the

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effectiveness of the PSS provided to them while in the home. This data was qualitatively collected using interviews. The study respondents were offered an opportunity to take part in face-to-face interviews, where primary qualitative data was gathered.

The study also collected secondary data. This type of data was previously collected and stored safely in the form of databases and records (Ajayi, 2017). The researcher requested relevant files on child abuse records of children in the targeted age range of the study from the selected rehabilitation centres. This data was collected quantitatively, whereby the researcher sought specific data on the demeanour of the children when they arrived at the drop-in site, the type of PSS provided to these children at the rehabilitation site, as well as the considerations made by the selected rehabilitation centres regarding the PSS providers. The data collected was recorded on an excel sheet for further analysis. It (data) underwent thematic analysis, which is an appropriate mode of analysis to better understand experiences across a data set (Kiger & Vaipor, 2020). It excluded data regarding children outside of the study's targeted age range, hence providing further validation and strength to the value of the data received from the interviews.

Data Collection Procedures

Before commencing the study, the researcher sought relevant and necessary permits. These included a letter of introduction from Daystar University to each of the rehabilitation centres, a permit from the Daystar University Ethics and Review Board (DU-ERB), clearance from the National Commission for Science, Technology and Innovation (NACOSTI), and signed consent from the rehabilitation centres. Once the research was approved, the researcher collected information from the respondents.

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The researcher recruited a research assistant for support in conducting this study. The research assistant was taken through a brief training, which included an overview of the objectives of the study, the interview schedule and questions, as well as the crucial need for informed consent before taking part in the research. In case the respondents did not have a proper understanding of the English language, the assistant explained the questions to them and made sure that their confidentiality was maintained.

The researcher applied the necessary ethical considerations when collecting data for the study (Oladipo et al., 2015). Firstly, the respondents and their relevant contact information were availed to the researcher through the selected rehabilitation centres' respective administrations. Secondly, all respondents of the study were informed of the purpose of the study as well as their role in providing the relevant data required. Thirdly, the respondents were informed that data was to be collected via in-depth face-to-face semi-structured interviews and that the interviews were to be recorded. Fourthly, the respondents had to give consent to the interviews and/or audio recordings before their commencement. They were not coerced, cheated, or pressured to participate in this study. The same applied to audio recordings. Finally, the respondents were assured of confidentiality and that the audio recordings would only be utilised for this study.

The secondary data available at the selected rehabilitation centres were also subjected to ethical considerations in its handling. The audio recording of the interviews was utilized upon the consent of the respondent, who was not only assured of confidentiality but also that the audio recordings were only utilised for this study (Oladipo et al., 2015).

Pretesting

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Pretesting is when the data collection research tools are tested to evaluate their reliability and validity (Hurst et al., 2015). The researcher conducted a pretesting at Cheryl's Children's Home based in Dagoretti, Nairobi County. The researcher tested the effectiveness of the tool to be used in the study. The interviews were conducted in English and the questions were clear to the respondents with minimal clarifications. The research assistant conducted in-depth interviews with the PSS providers in the institution under study. However, the respondents' feedback was that the interviews ended abruptly without taking their views on the topic into consideration or how the interview process was for them.

Based on the feedback, the researcher added new sections to the interview questions. The sections added were participant challenges and recommendations. The sections gave room for the respondent to relay the challenges faced when providing PSS to the children, and some recommendations to enhance the provision of PSS to the children. With this new approach, the researcher conducted another pretesting and respondents felt more at ease after the interviews, which showed the importance of these sections to the interviewer, the respondent, and the quality of the output received for the study.

Data Analysis Plan

Data analysis is defined as the process of systematically applying methods to assess the gathered data and organizing it in such a way that it provides answers to the research questions (Ridder, 2014). The raw data was organized to derive useful information. The data was analysed utilizing statistical techniques to explore the variables and their impact. The researcher used descriptive statistics to enable the presentation of data in an organized and logical form. The Statistical Package for the Social Sciences (SPSS®), version 22, was used to analyse the quantitative data using both inferential and descriptive statistics. Accurate transcription of the audio

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recordings was captured from data collected from the sample size. Furthermore, the qualitative data was acquired via short notes taken from the audio recordings, hence capturing the emerging themes of the study.

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Ethical Considerations

The researcher was typically guided by ethics when collecting data to protect the study respondents. The researcher sought relevant and necessary permits, which included a letter of introduction from Daystar University to the rehabilitation centres, clearance from the DU-ERB and NACOSTI, and signed consent forms from the respective selected rehabilitation centres of the study.

The sample size of the study included all PSS providers in the selected rehabilitation centres for children in the targeted age range of the study. The respondents were duly notified by the selected rehabilitation centres' administration and consequently availed to the researcher. The respondents who took part in the study did so voluntarily, meaning that they had the freedom to refuse to participate and, therefore, were not coerced, threatened, or cheated to participate in the study (NACOSTI as cited in Oladipo et al., 2015).

Accordingly, the respondents were required to provide informed consent to participate in the study. They were only included in the study once they had provided consent that they were willing to take part in this research. Informed consent required the respondents to be informed about the purpose and importance of the study, any risks of harm or discomfort they may experience, the expected duration of the study, and the procedures involved as well as any benefits they received (Oso & Onen as cited in Oladipo et al., 2015).

The study ensured to provide privacy and confidentiality of respondents as well as the data collected. By guaranteeing privacy, respondents were assured protection when participating and also retained the validity of the study (Oladipo et al., 2015). By guaranteeing their confidentiality, all the information shared and data collected during

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the research would remain confidential and not passed to a third party without their consent (Oso & Onen as cited in Oladipo et al., 2015), and the data would be destroyed after the analysis (Tripathy, 2013). By having the respondents be the caregivers and not the children, the study did not harm the children at the selected rehabilitation centres.

Summary

This chapter has provided a thorough overview of the research design suitable for the study. A descriptive research design was found appropriate as it accommodates both qualitative and quantitative data. The target population was determined as well as the sample size. Purpose sampling was used to calculate the sample size used for the study. This chapter has also outlined the inclusive and exclusive criteria for the target population. Street children, PSS providers, and careleavers were the main respondents. The chapter has described the tools used to collect both qualitative and quantitative data. Furthermore, it has included data analysis approaches used and their effectiveness. Pretesting and ethical consideration sections are also described. Pretesting showed how the data collection tools were tested before the main data collection procedure, while the ethical consideration section outlined the varied ethical standards considered for this study.

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CHAPTER FOUR

DATA PRESENTATION, ANALYSIS AND INTERPRETATION

Introduction

This chapter looks into the analysis, interpretation, and presentation of the data gathered in this study. Primary data was collected from PSS providers using interviews, while secondary data was collected from files of children aged 8-15 years who were at the selected rehabilitation centres between January to October 2021. The study utilized a thematic analysis technique to analyze the qualitative data, where repeated patterns across the data set were identified, analyzed, and reported. Further, the children's file data was quantified and SPSS software was used in the analysis. The data was analysed based on the objectives of the study and findings were presented under the following major headings: response rate, demographic information, types of abuse experienced, the prevalence of trauma, and PSS offered to children.

Data Analysis and Interpretation

Response Rate

Psychosocial support service providers from the two selected rehabilitation centres were interviewed as follows: two counsellors, three social workers, and eight careleavers. In addition, secondary data was collected from files of 70 children, as shown in Table 4.1.

Table 4.1: Response Rate

Sample Size (n)	Response	Per cent
90	70	77.7
13	13	100

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All the targeted PSS service providers (100%) were interviewed. The high response rate for primary data collection was attributed to the use of research assistants, who helped the respondents to understand the tool and answer all the questions required. Furthermore, the use of KOBO Collect (an online tool installed on the phone) and semi-structured in-depth face-to-face interviews, and the researcher's follow-up activities contributed to the high response rate.

The results (Table 4.1) reveal a response rate of 77.7% for the secondary information. The selected rehabilitation centres were willing to provide the files of children who had left the rehabilitation centre in the year 2021, which aided in data collection. However, one of the institutions denied access to 20 children's files, which the researcher had targeted, resulting in a 77.7% response rate. Saleh and Bista (2017) argued that effective studies need to have an average of a 57% response rate for the survey or study to be regarded as relevant. This study had a 77.7% response rate and thus was reasonable for completing the data analysis process.

Social - Demographic Information for PSS Providers

This section sought to establish information on the respondent`s demographic characteristics. Specifically, the researcher focused on the gender of the respondents, their highest level of academic qualification, and their age.

Gender of the PSS providers

The study aimed to determine the gender category of the respondents. This was done to ensure the fair engagement of PSS providers in terms of their gender. The findings are tabulated in Table 4.2.

Table 4.2: Gender of the PSS Providers

Gender	Frequency	Per cent
Male	7	53.8
Female	6	46.2

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Total	13	100.00

The results in Table 4.2 show that most of the respondents were males (53.8%), whereas 46.2% were females. This implies that most of the PSS providers at rehabilitation centres are men, which could have been the case since the institutions under study mostly had male children.

Highest level of academic qualification of the PSS providers

The academic qualification of an individual is associated with the ability to respond to various issues and how to solve them. Because of establishing the respondent's ability to respond to research questions, respondents were requested to indicate their educational qualifications. Results are presented in Table 4.3.

Table 4.3: Level of Education

Education level	Frequency	Per cent
Secondary education level	1	7.7
Diploma education level	9	69.2
Bachelors education level	2	15.4
Masters education level	1	7.7
Total	13	100.0

From the results in Table 4.3, most of the respondents (69.2%) had a Diploma, 15.4% had a Bachelor's Degree, 7.7% were holders of a Master's Degree, and 7.7% had secondary education qualifications. These results imply that the PSS providers had the right academic qualification to respond to the questions that the study sought to answer.

Age category of the PSS providers

Different age groups are perceived to hold different opinions on various issues. To ensure that the study collected a wide range of opinions from different age groups, PSS providers were requested to indicate their age category. Table 4.4 portrays the findings.

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Table 4.4: Age of the PSS Providers

Age of the Respondent	Frequency	Per cent
20 – 25 years	8	61.5
26 – 31 years	1	7.7
32 – 37 years	2	15.4
44 + years old	2	15.4
Total	13	100.0

From the findings (Table 4.4), most of the respondents (61.5%) were aged between 20 and 25 years, 15.4% were aged between 32 to 37 years, 15.4% were above 44 years old, and 7.7% were between 26 and 31 years. These findings indicate that the respondents were drawn from all the age categories, implying that the study was well-informed, and opinions and ideas of different age groups were well-taken care of.

Social - Demographic Information for Children

Age of the children

The study focused on children who were between the age of 8 to 15 years old. The age of the children was extracted from the secondary data collected and analysed, as depicted in Table 4.5.

Table 4.5: Age of the Children

Age of the Respondent	Frequency	Percentage
8 Years	5	7.1
9 Years	2	2.9
10 Years	9	12.9
11 Years	8	11.4
12 Years	16	22.9
13 Years	18	25.7
14 Years	11	15.7
15 Years	1	1.4
Total	70	100.0

Table 4.5 shows that most of the respondents (25.7%) whose ages were extracted from their files were 13 years old, 22.9% were 12 years old, and 15.7% were 14 years old. However, it was evident that only 1.4% of the respondents were aged 15 years, while 2.9% were aged 9 years old. These results imply that although all children whose files were extracted had an age range between 8 and 15 years old, the majority

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of the children in the institution were aged 10 - 14 years old. This further suggests that the majority of the children whose data was accessed were in the early and middle adolescence stage.

Children's gender

The study aimed to determine the gender category of the children. This was done because of ensuring the fair engagement of children in terms of their gender. Table 4.6 shows the findings.

Table 4.6: Children's Gender

Gender	Frequency	Per cent
Male	53	75.7
Female	17	24.3
Total	70	100.00

The results in Table 4.6 reveal that the majority of the children (75.7%) were males, whereas 24.3% were females. This indicates that the majority of the children in rehabilitation centres were males. However, it is notable that one of the rehabilitation centres visited was taking care of boys, hence the higher number of males.

Types of Abuse Experienced by Children Before Being in the Rehabilitation Centres

The study examined the types of abuse experienced by children aged 8-15 years old before being in the rehabilitation centre. The data from the secondary sources were analyzed and Figure 4.1 illustrates the summary of the findings.

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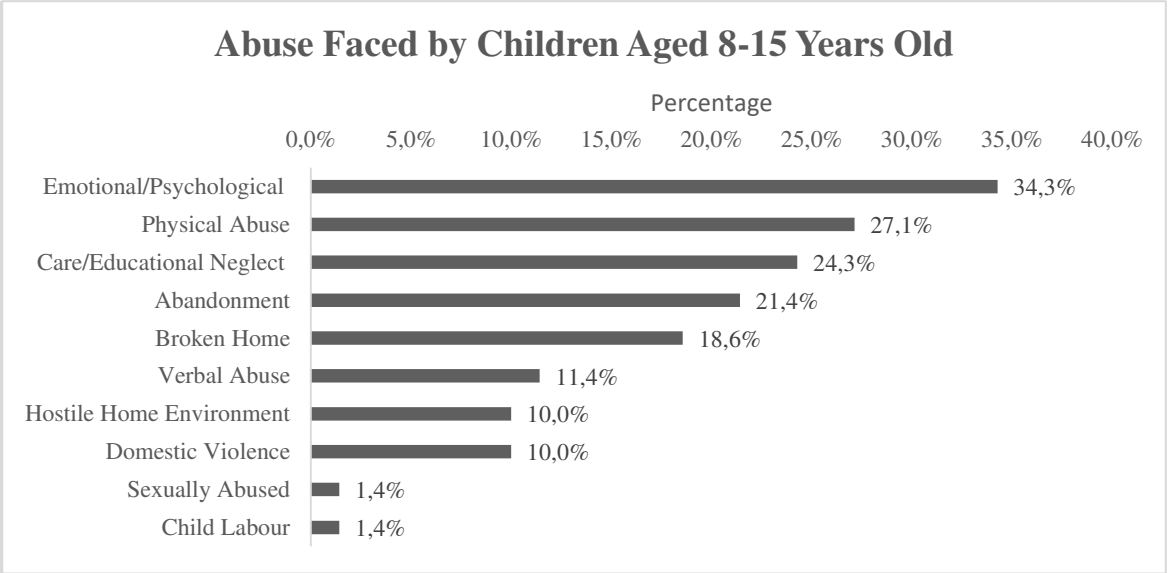

Figure 4.1: Abuse Faced by Children Aged 8-15 Years Old

From the analysis (Figure 4.1), the study established that 34.3% of children were emotionally/psychologically abused before being in the rehabilitation centre. This was followed closely by physical abuse, as shown by 27.1%, and child neglect, as shown by 24.3%. Some children were also abused verbally and sexually, as shown by 11.4% and 1.4% respectively. These findings were in agreement with one of the social workers who said as follows: Abuse Faced by Children Aged 8-15 Years Old

Children face different types of abuse before being in the rehabilitation centre, child neglect, physical abuse, psychological, and sexual abuse are the most common abuse reported by children.

The finding from PSS providers also revealed that physical abuse, psychological, child neglect, and sexual abuse are the main types of abuse that children face before being in the rehabilitation centre. These findings imply that children in the rehabilitation centres have experienced some form of abuse and neglect before entry into those institutions. A counsellor said the following:

Some parents do not care about their child, they beat the child, neglect them, and some are not even taken to school….

A social worker from the institution added,

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Children are forced to work by their parents, which denies them the opportunity to go to school. Some parent beat their children, which makes them run to the streets.

Perpetrators of child abuse

Furthermore, the study aimed to determine the perpetrators of child abuse before being in the rehabilitation centre. The secondary data were analyzed and the results are depicted in Table 4.7.

Table 4.7: Perpetrators of Child Abuse

Perpetrators	Frequency (n=70)	Percent (n=70)
Father	39	55.7
Mother	39	55.7
Step Father	12	17.1
Step Mother	10	14.3
Grand Mother	1	1.4
Step grandmother	2	2.9
Aunt	4	5.7
Uncle	1	1.4

From the findings in Table 4.7, it is evident that both father and mother were the main perpetrators of child abuse as indicated by 39(55.7%) responses. This was followed by 12(17.1%) stepfathers and 10(14.3%) stepmothers as perpetrators of abuse of children. The study also revealed that other relatives, including aunties, uncles, and grandmothers, who acted as guardians were perpetrators of abuse to children, leading to their entry into rehabilitation centres. This was further corroborated by the findings from the PSS providers. In this study, the PSS providers interviewed also said that fathers, mothers, and guardians were the main abusers. For instance, one of the counsellors interviewed said as follows:

Some of the parents, guardians, and caregivers beat their children and neglect them while others sexually abuse them forcing the children to go to the streets.

The findings of this study reveal that parents and extended family members are the main perpetrators of abuse toward children. This implies that children found it

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difficult to stay in homes that meted violence against them and thus opted to move to the streets or rehabilitation centres.

Reasons for going to streets

The study sought to understand the reasons that made the children go to the streets. The data from the children's files were analyzed and Figure 4.2 summarizes the results.

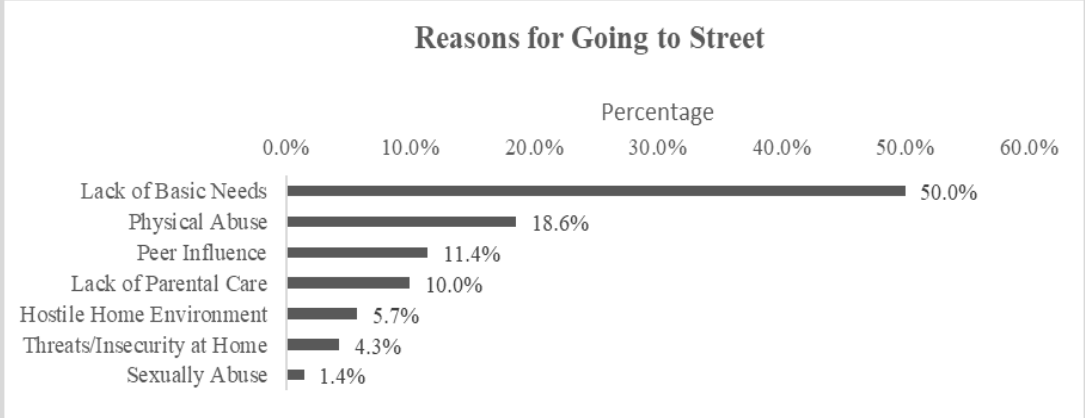

Figure 4.2: Reasons for Going to the Streets

The results revealed that half (50.0%) of the children went to the streets due to a lack of basic needs at home, 18.6% went to the street after physical abuse, and 11.4% went to the streets as a result of peer influence. Further, 10.0% of the children did not get parental care, making them go to the street. Hostile home environment, the threat to children at home, and sexual abuse made some children go to the street, as shown by 5.7%, 4.3%, and 1.4% respectively.

In addition, PSS providers said that child neglect resulted from family separation, lack of basic needs, and physical abuse of the children at home, making children go to the streets. One of the careleavers interviewed said the following:

There was no food, no education fees, I was being beaten and our house was locked for not paying the rent, this forced me to the streets.

Furthermore, according to a counsellor,

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Some of the children have dropped out of school because of a lack of basic needs at home and others are forced to the street due to a lack of food and shelter at home.

These results imply that lack of basic needs was a major contributor to children going to the streets. The home environment was characterized by poverty, physical abuse, and other forms of abuse that necessitated children going to the streets.

Life on the streets

The study sought to determine the kind of life children experienced on the streets. Findings were analysed and portrayed in Table 4.8.

Table 4.8: Life on the Streets

Life on the Streets	Frequency (n=70)	Per cent
Begging for money/food	58	82.9
Collecting and selling scrap (bottles, plastics, and tins, among others)	41	58.6
Using drugs *(glue, bhangi, tobacco, msii, 'cigarettes', chavis, miraa, piere, mlela, mowaiti, and chetis)*	29	41.4
Carrying luggage	11	15.7
Gambling (betting)	1	1.4
Stealing (pickpocketing)	1	1.4
Collecting and selling firewood	1	1.4
Collecting food from the Dandora dumpsite	1	1.4
Sexually abused by other boys	1	1.4
Wiping car windows and screens	1	1.4

The findings (Table 4.8) revealed that the majority (82.9%) of the children aged 8-15 years old on the street were begging for money and food for their survival. In addition, the children collect and sell scraps such as metal, bottles, plastics, and tins to earn little coins for their survival, as shown by 58.6%. The study findings also revealed that 41.4% of the children on the street use more than three drugs and the most commonly used drugs are *glue, bhangi, tobacco, msii, chavis, miraa, piere, mlela*, and *mowaiti*. Others on the streets carry luggage and collect and sell firewood to earn their daily bread. While on the street, some of the children involve themselves in sexual activities, stealing, and gambling, as indicated by 1.4% respectively. These

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findings were in line with those of the careleavers, who revealed that street children engage in maladaptive behaviours such as stealing, sexual business, violence, using and selling drugs, begging for money and food, and collecting scrap metals for sales. One of the careleavers interviewed said the following:

While on the street, most children engage in drug abuse, fornication, theft, child labour, harassment, and foul language.

Prevalence of Trauma Observed among Children Aged 8-15 Years Old in the Rehabilitation Centres

The study aimed to establish the prevalence of trauma among children in the selected rehabilitation centres. The PSS providers interviewed were asked to classify the type of trauma experienced by children before being recruited into the rehabilitation centre. When interviewed by the researcher, the counsellors classified the trauma children faced at home as acute or chronic, basing their categorization on their subjective criterion without the use of psychometric tests. According to one of the counsellors,

Some of the children we admit at the rehabilitation centres face different challenges such as sexual abuse, lack of food, and beating while on the street resulting in acute trauma.

Some children experienced single distressing events in their homes leaving them faced with acute trauma. These included physical and emotional/psychological abuse as well as neglect. The counsellors spoke of cases faced by the children such as beatings, displacement by their parents in conflict, verbal abuse, educational neglect, and a lack of parental love and care.

Some parents don't care about their children and they chase them from home, traumatizing the child (a counsellor).

Other children experienced prolonged distressing events, leaving them faced with chronic trauma. These events included physical and emotional/psychological abuse as

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well as sexual abuse. The counsellors spoke of cases faced by the children such as feeling unwanted and unloved, sexual abuse by male guardians, corporal punishment, and fear of being abused.

One of the counsellors said as follows:

Some of the children at home are exposed to highly stressful events such as daily beating, domestic violence, and neglect for a long period, resulting in chronic trauma.

Another counsellor added the following:

If a child witnesses an event which is overwhelming like parents fighting or an accident this may result in acute trauma for the child.

These traumatic events, both acute and chronic, limit the child's fulfilment of their necessary deficiency needs at home, thus leading them to the streets (Noltemeyer et al., 2021). The counsellors highlighted that although the type of trauma depended on the experience of the child, mostly acute or chronic trauma was observed

Furthermore, the researcher noted that the children sought refuge in the streets but were instead exposed to even more traumatic events. Such events include frequent beatings by bigger boys and law enforcement agencies. Social workers and careleavers at the selected rehabilitation centres noted that children manifest traumatic experiences, mostly from those who faced physical abuse. According to a careleaver,

On the street, the bigger boys beat other smaller boys and girls and even sexually abuse them. It's always harsh on the street and all manner of abuse happens.

Reasons for going to a rehabilitation centre

The study aimed to establish the reasons that made street children go to rehabilitation centres. From the secondary data analysis, the results revealed that most street children go to selected rehabilitation centres to access education, basic needs, and care and protection. The careleavers interviewed said that some of the children take

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themselves to the rehabilitation centres, while others are taken by police officers, rescue mission officers, and referrals from other organizations as well as individuals. One of the counsellors interviewed said the following:

Realized that the rehabilitation centre is an avenue to solving their basic needs, protection from external harassment, and reunification with the family.

Child's first contact at rehabilitation centres

The PSS providers were asked to describe the first contact with children at the rehabilitation centres. The study revealed that most children are always unfriendly and dirty, some carry the drug substance, are phobic due to a new encounter, and other children provide fake names. To create a good rapport with the children, the PSS providers become friendly and have a general talk with the children. The PSS providers also use recreational activities, athletics, and indoor games to create a good rapport with the children.

Psychosocial Support Services Offered to Children Aged 8-15 Years Old in the Rehabilitation Centres

The caregiver plays an integral role when it comes to meeting the psychological and social needs of a child (Cook et al., 2017). When a caregiver acts and responds to a child who has experienced any type of trauma, the child develops a healthy relationship based on trust. This study revealed that children at the selected rehabilitation centres receive counselling, psychosocial support, and rehabilitation. One of the careleavers interviewed said as follows:

...at the rehabilitation centre, a child receives individual and group counselling, a loving environment, spiritual development through church and devotions, activities like games, activities like games and clubs, and education.

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Additionally, the careleavers said that children receive guidance and counselling, life skills programs, spiritual support, and co-curriculum activities such as brass band, theatre, acting, and sports while at the rehabilitation centre. While providing PSS, the providers consider the age, physical appearance, communication skills, and behaviour of the child. According to a careleaver,

With PSS providers, children get parental love missed when growing up, receive education, and learn from other children, counselling helped her/her to forgive their parents and be more responsible people.

The study also sought to determine whether the children are always ready to accept the PSS offered. The data from careleavers was analyzed and Table 4.9 presents the results.

Table 4.9: Children Ready to Accept the PSS Offered

Response	Frequency	Per cent
Yes	3	37.5
No	5	62.5
Total	8	100.00

As per the findings in Table 4.9, 62.5% of the respondents said that children at rehabilitation centres are not always ready to accept the PSS offered, while 37.5% said that the children are always ready to accept the PSS offered. A careleaver said the following:

Since it is part of the rehabilitation program the children have no option but to accept the PSS offered.

Another careleaver said as follows:

... life at the rehabilitation centre is better than life on the streets hence the children accept the PSS offered.

On the other hand, a careleaver said that children at rehabilitation centres were not ready to accept the PSS offered because of their age difference and stigmatization from other children. According to a careleaver,

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You were used to getting street food which included chips and chicken but when you get to a rehabilitation centre you eat maize and beans.

Another careleaver added the following:

... some escape, because of stigmatization by other children.

The study also noted that children are not always ready to accept the PSS because it is not the environment they are used to before, hence find it hard to adapt. This finding implies that PSS is not readily accepted at the rehabilitation centres due to other intervening factors such as the previous experiences children had on the streets. Furthermore, it seems like adjusting to the lifestyle of the rehabilitation centres affects children, leading to their resistance to PSS.

Impact of PSS offered at the selected rehabilitation centres

The study aimed to establish the impact of the PSS offered at the selected rehabilitation centres. The careleavers interviewed said that the PSS offered was helpful and transformed their lives by giving them a second opportunity in life. One of the careleavers narrated as follows:

Going to church, sports and drama made me know other people and made me a better person.

In addition, the careleavers indicated that the PSS made them resilient to challenges, responsible persons, and wise decision-makers, and are no longer easily influenced by society. The services also made them have a good relationship with Christ as well as other people in the community. One of the careleavers said the following:

Through the rehabilitation centres, I developed a positive sense of self and I was exposed to hidden God-given talents.

According to another careleaver,

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... I am a role model and have learned to make my own decisions and face difficulties after leaving the rehabilitation centre.

Another careleaver added as follows:

I am able now to get the parental love missed when growing up, receive an education, and learn from other children, counselling helped me to forgive my parents and be a more responsible person.

These findings imply that PSS made an impact on the lives of careleavers, thus it has the potential of impacting children in the rehabilitation centres positively.

The study aimed to determine the emotional and behavioural changes that were observed in children by PSS providers before and after PSS provision, as shown in Table 4.10.

Table 4.10: Children's Emotional and Behavioral Changes Before PSS

Before	Percent (n=13)
Fear of Expression	46.2
Poor anger management	46.2
Violent	38.5
Silent/Quiet	38.5
Lonely	30.7
Used Abusive Language	23.1
Very Judgmental	7.7
Lack of respect	7.7
Unfriendly to other Children	7.7
Unhappy while with other children	7.7

Results in Table 4.10 reveal that before the PSS was provided, most children had poor anger management, fear of expression, and were violent, as shown by 46.2%, 46.2%, and 38.5% respectively. Others were quiet, feel lonely, and used abusive language, as shown by 38.5%, 30.7%, and 23.1% respectively. Other children were noted to be very judgmental, unfriendly with other children, unhappy, and lacked respect for the other children and PSS providers, as shown by 7.7% in each category. Table 4.11 demonstrates children's emotional and behavioural changes after PSS.

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Table 4.11: Children's Emotional and Behavioral Changes After PSS

After	Percent (n=13)
Self-control	30.7
Social with other children and PSS providers	30.7
Happy/Jovial with other children and PSS providers	30.7
Respond politely	15.3
More friendly with other children and PSS providers	15.3
Talkative	15.3
Have respect	15.3
Able to manage anger	7.7
A positive attitude about life	7.7
More responsible.	7.7

After the provision of PSS, a great change is always noted in most children's lives. The study established that most children after receiving the PSS become social with other children and PSS providers, jovial, and have self-control, as shown by 30.7%. They (15.3%) respond politely to people and are more friendly with other children and PSS providers, talkative, and have respect. After receiving the PSS, children can manage their anger, have a positive attitude about life, and become responsible (7.7%).

A social worker said the following:

Once a child has been received at the centre, most don't disclose their information, they are unfriendly, unresponsive and don't interact with others, however after receiving the PSS sometimes they open up to a counsellor, become obedient, respectful, happy, interact and engage with others.

These results imply that PSS in the rehabilitation centres was effective in helping manage children's behaviour toward a positive change. Positive results were attained after children underwent and received these services.

Challenges experienced in the provision of PSS

The study also sought to establish the challenges experienced in the provision of PSS at the rehabilitation centre. Table 4.12 summarizes the results.

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Table 4.12: Children Ready to Accept the PSS Offered

Challenges	Frequency	Per cent
No interest in the program and do not want to be engaged	8	61.5
Children do not speak the truth as they are unwilling to disclose their information	7	53.8
Budget to meet the basic needs of the children	3	23.1
Lack of enough resources such as labour, counselling materials	2	15.4
The uncooperative family set up especially broken families	1	7.7

From the results in Table 4.12, most of the respondents (61.5%) said that children had no interest in the program and did not want to be engaged, hence follow-up becomes a challenge. Of the respondents, 53.8% said that most children did not speak the truth as they are unwilling to disclose their information, which makes it difficult to offer the PSS. Lack of enough resources to offer PSS effectively to the children and an inadequate budget to keep the basic needs of the children have also established challenges, as shown by 15.4% and 23.1% respectively. The study also revealed that an uncooperative family setup, especially broken families where the father and mother are reluctant to reunite, poses a challenge as well.

According to a counsellor,

> *Relapsing back to the street, uncooperative families, drop-out from schools, funding, provision of handouts in the street, and lack of resources are the major challenges while offering the PSS.*

The PSS providers were requested to give their opinion on ways to enhance the provision of PSS to the children. From the interviews with the PSS providers, the following was recommended: an increase in funding for the centres, family empowerment, and training for PSS providers and caregivers to educate them on how to deal with the children and how to attend to their emotional and mental needs. A counsellor said as follows:

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No handouts should be given in the streets and local administration should be active in issues referring to the family.

Summary of Key Findings

Socio-Demographic Information of Respondents in the Study

The study established that the majority (53.8%) of the PSS providers were males and, in terms of education, 92.3% had a minimum Diploma education level. Most (61.5%) of PSS providers were between the age of 20 - 25 years. Further, it was established that 15.4% of the PSS providers were aged between 32 to 37 years, and another (15.4%) of the PSS providers were above 44 years old.

Children's data was collected from 70 files with all the children being between 8-15 years. Most (25.7%) of the children whose files were extracted were 13 years old. In terms of gender, most of the children (75.7%) were males, and the high number of boys was attributed to the fact that one of the institutions visited took care of boys only.

Types of Trauma-Exposure Experienced Before Being in the Rehabilitation Centres

The study revealed that most of the children (34.3%) at rehabilitation centres were emotionally abused before being in the rehabilitation centre. This was followed closely by physical abuse at 27.1% (n=70) and child neglect at 24.3%. There was also evidence of verbal abuse, sexual abuse, and child labour. The main perpetrators of child abuse are the primary caregivers including fathers, mothers, step-fathers, and step-mothers. A few cases of extended family members such as aunts, uncles, and grandmothers were noted as perpetrators of abuse of children.

The study revealed that 50.0% of children go to the streets due to a lack of basic needs at home, 18.6% after physical abuse, and 11.4% as a result of peer influence. While

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on the streets, most of the children (82.9%) aged 8-15 years old beg for money and food for their survival. In addition, the children collect and sell scraps such as metal, bottles, plastics, and tins to earn little coins for their survival. On the street, children engage in maladaptive behaviours such as stealing, sexual business, violence, and using and selling drugs such as *glue, bhangi, tobacco, msii, chavis, miraa, piere, mlela* and *mowaiti*.

Prevalence of Trauma Observed among Children Aged 8-15 Years Old in the Rehabilitation Centres

The study established that most children experience acute and chronic trauma which is brought on by highly stressful events such as daily beating, domestic violence, and neglect. Further, the study noted that at the selected rehabilitation centres, children manifest traumatic experiences such as fighting. The traumatic experiences exposed to children in the streets include frequent beatings by bigger boys and law enforcement agencies and fitness to survive.

The study results revealed that most street children go to selected rehabilitation centres to access education, basic needs, and receive care and protection. Some of the children take themselves to rehabilitation centres, while others are taken by police officers, rescue mission officers, and referrals from other organizations as well as individuals. The study also revealed that at first in the centres, most children are always unfriendly, have dirty appearances, carry drug substances, are phobic due to a new encounter, and other children provide fake names as well. To create a good rapport with the children, the PSS providers become friendly and have a general talk with the children. The PSS providers also use recreational activities, athletics, and indoor games to create a good rapport with the children.

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Types of PSS Offered to Children Aged 8-15 Years Old in the Rehabilitation Centres

This study revealed that children at the selected rehabilitation centres receive counselling, psychosocial support, and rehabilitation. Further, children engage in life skills programs, spiritual support, and co-curriculum activities such as brass band, theatre, acting, and sports while at the rehabilitation centre. While providing PSS, the providers consider the age of the child, physical appearance, communication skills, and behaviour of the child. Oof the careleavers, 37.5% said that children at rehabilitation centres are always ready to accept the PSS offered whereas 62.5% said that children at rehabilitation centres are not always ready to accept the PSS offered.

The PSS offered is helpful to the children as it transforms their lives by giving them a second opportunity in life. In addition, the PSS makes the children resilient to challenges, responsible persons, and wise decision-makers who are no longer easily influenced by society. The services also make the children have a good relationship with Christ as well as other people in the community.

Before the PSS provision, most children have poor anger management and a fearful demeanour, and were violent, as shown by 46.2%, 46.2%, and 38.5% respectively. Others are quiet, feel lonely, and use abusive language, as shown by 38.5%, 30.7%, and 23.1% respectively. Other children were noted to be judgmental, unfriendly, unhappy, and lacked respect, as shown by 7.7% in each. After the provision of PSS, a great change is always noted in most children's lives as most of them become social, jovial, and have self-control, as shown by 30.7%. They respond politely (15.3%) to people and are more friendly, talkative, and have respect. After receiving the PSS, children can manage their anger, have a positive attitude about life, and become responsible (7.7%).

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The study also established that PSS providers face the following challenges while offering the PSS: children lack interest in the program and do want to be engaged, hence follow-up becomes a challenge (61.5%); children were unwilling to disclose their information, making it difficult to offer the PSS (53.8%); lack of enough resources to offer PSS effectively to the children(15.4%); inadequate budget to keep the basic needs of the children (23.1%). The study also revealed that an uncooperative family setup, especially broken families where the father and mother are reluctant to reunite, poses a challenge as well.

Summary

This chapter has provided intensive data analysis and interpretation on social-demographic information, types of abuse experienced by children before being in the rehabilitation centre, the prevalence of trauma observed among children aged 8-15 years at rehabilitation centres, and PSS offered to children aged 8-15 years old at rehabilitation centres. The chapter has also analysed the impact and challenges of the different types of PSS. The following chapter presents the discussions, conclusions, and recommendations for the study.

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CHAPTER FIVE

DISCUSSIONS, CONCLUSIONS, AND RECOMMENDATIONS

Introduction

This chapter presents the discussions of key findings, conclusions, and recommendations proposed by the researcher. The conclusions are drawn and recommendations are focused to address the objectives of the study. The chapter also includes other study areas for further research.

Discussions of Key Findings

Socio-Demographic Information of Respondents in the Study

The study established that the majority (53.8%) of the PSS providers were males and in terms of education, 92.3% had a minimum Diploma education level. The finding was contrary to that of Shamne (2013), who noted that females were most PSS providers. Most (61.5%) of the PSS providers were between the age of 20 - 25 years, 15.4% of the PSS providers were aged between 32 to 37 years, and 15.4% of the PSS providers were above 44 years old. Children's data was collected from 70 files with all the children being between 8-15 years.

Most of the children (25.7%) whose files were extracted were 13 years old. Similarly, a 2019 Violence Against Children Survey Report established that most children experienced emotional violence from a parent or caregiver between the age of 13-17 years old. The statistics from the report indicated that 45.2% of females and 41.6% of males experienced any type of violence between the age of 13-17 years old (Ministry of Labour and Social Protection, 2020). Contrary to the 2019 violence against children survey report, this study revealed that most of the children (75.7%) in the

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centres were males. However, the high number of boys can be attributed to the fact that one of the institutions visited took care of boys only.

Types of Trauma-Exposure Experienced Before Being in the Rehabilitation Centres

The study revealed that the majority, 34.3% (n=70), of children who were at rehabilitation centres were emotionally abused before being in the rehabilitation centre. This was followed closely by physical abuse at 27.1% (n=70) and child neglect at 24.3%. There was also evidence of verbal abuse, sexual abuse, and child labour. Similarly, Finkelhor et al. (2013) in their survey established that 41.2% of children experienced physical assault, 12.7% experienced sexual abuse, and 13.7% experienced maltreatment by a caregiver. Emotional abuse, physical abuse, child neglect, verbal abuse, sexual abuse, and child labour are the main abuse the street children go through. These types of abuse on children have severe negative consequences on their development. The finding also concurs with that of Saunders and Adams (2014), who noted that a significant number of children have experienced physical abuse, sexual assault, bereavement, or serious violence from caregivers.

This study established that the main perpetrators of child abuse are the parents, including fathers, mothers, step-fathers, and step-mothers. A few cases of guardians such as aunts, uncles, and grandmothers being perpetrators were also noted. This finding concurs with the Kenya violence against children survey 2019 report, which established that the common perpetrators of childhood violence are parents, caregivers, and adult relatives (Ministry of Labour and Social Protection, 2020). Therefore, it is evident that most perpetrators of violence against children are parents and guardians. This calls for advocacy at a family level to enhance the protection of children. It seems parental empowerment is necessary to enhance positive parenting for positive outcomes for children.

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The study results showed that 50% of the children go to the streets due to a lack of basic needs at home, 18.6% after physical abuse, and 11.4% as a result of peer influence. This finding is in line with that of Cicchetti and Toth (2015), who established that children go to the street due to violence and a lack of basic needs at home. Others go to the street as a result of a hostile home environment, a threat at home, lack of parental care, and sexual abuse. While on the streets most of the children (82.9%) aged 8-15 years old beg for money and food for their survival. In addition, the children collect and sell scraps such as metal, bottles, plastics, and tins to earn little coins for their survival. On the street, children engage in maladaptive behaviours such as stealing, sexual business, violence, and using and selling drugs such as *glue, bhangi, tobacco, msii, chavis, miraa, piere, mlela,* and *mowaiti*.

Prevalence of Trauma Observed among Children Aged 8-15 Years Old in the Rehabilitation Centres

Children on the street experience acute or chronic trauma, which is brought about by highly stressful events such as daily beating, domestic violence, and neglect. At the rehabilitation centre, children manifest traumatic experiences such as fighting. This finding concurs with that of Mbwayo et al. (2020), who noted that street children were the most likely to be affected by trauma since they were going through difficult events in their lives. As a result of the difficult life on the street, some children take themselves to rehabilitation centres, while others are taken by police officers, rescue mission officers, and referrals from other organizations as well as individuals to access education, basic needs, care, and protection.

The study revealed that children who are taken to rehabilitation centres are always unfriendly, dirty, and use abusive language before receiving the PSS. This finding was in line with Burger et al. (2013), who noted that children who undergo traumatic

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experiences show interpersonal issues mostly manifesting deficits in emotion regulation and an inability to relate to other people. To create a good rapport with the children, the PSS providers accompany the children and talk to them through a variety of tools (physical, mental, and spiritual). The PSS providers also use recreational activities, athletics, and indoor games to create a good rapport with the children.

Types of PSS Offered to Children Aged 8-15 Years Old in the Rehabilitation Centres

Cook et al. (2017) noted that caregivers play a big role in meeting the psychological and social needs of a child. Similarly, this study revealed that PSS providers play a vital role in transforming the lives of children. Children at the rehabilitation centres receive counselling, psychosocial support, life skills programs, spiritual support, and co-curriculum activities such as brass band, theatre, acting, and sports. The PSS offered helps the children transform their lives by giving them a second opportunity in life. In addition, the PSS makes the children resilient to challenges, responsible persons, and wise decision-makers who are no longer easily influenced by society. The services also make the children have a good relationship with Christ as well as with other people in the community. In this study, 37.5% of the careleavers said that children at rehabilitation centres are always ready to accept the PSS offered whereas 62.5% said that children at rehabilitation centres are not always ready to accept the PSS offered.

Before the PSS provision, most street children at rehabilitation centres have poor anger management, fear, and violence. They are noted to be quiet, feel lonely, and use abusive language. Other children are noted to be judgmental, unfriendly, unhappy, and lacked respect. After the provision of PSS, children become social and jovial and have self-control. They respond politely (15.3%) to people and are more friendly, talkative, and have respect. After receiving the PSS, children can manage their anger,

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have a positive attitude about life, and become responsible (7.7%). These findings are in line with those of Kinniburgh et al. (2017), who established that children learn how to regulate their behaviour by the kind of care they are given. It is evident that PSS is critical in helping children regulate their behaviour, thus rehabilitation centres need to be keen on offering effective services to children in their institutions for positive outcomes.

As traumatic events continue to be reported among children, governments seem to be overwhelmed by this expanding issue as many governments increase security funding as a way of mitigating the effects of child abuse and violence (Mbwayo et al., 2020). Similarly, this study established inadequate resources as the main challenge facing rehabilitation centres. Some children have no interest in the program, hence follow-up becomes a challenge. Furthermore, some children do not speak the truth as they are unwilling to disclose their information, which makes it difficult to offer the PSS. The study also revealed that an uncooperative family setup, especially broken families where the father and mother are reluctant to reunite, poses a challenge as well.

Conclusion

1. The study concludes that the majority of PSS providers are men and have a high level of education. PSS providers are from all age categories with the majority being between 20 to 25 years old.
2. Children experience several forms of abuse ranging from emotional abuse, physical abuse, child neglect, verbal abuse, sexual abuse, and child labour. The main perpetrators of the abuse are parents, caregivers, and adult relatives.
3. The study concludes that children go to the streets due to a lack of basic needs, a hostile home environment, a threat at home, a lack of parental care, and

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sexual abuse. On the streets, most of the children beg for money and food for their survival. In addition, the children collect and sell scraps such as metal, bottles, plastics, and tins to earn little coins for their survival. Children also engage in maladaptive behaviours such as stealing, sexual business, violence, and using and selling drugs.

4. In conclusion, children on the street experience acute and chronic trauma, which is brought about by highly stressful events such as daily beating, domestic violence, and neglect. At the rehabilitation centres, children manifest traumatic experiences such as fighting. As a result of the difficult life on the street, some children take themselves to rehabilitation centres, while others are taken by police officers, rescue mission officers, and referrals from other organizations as well as individuals to access education, basic needs, care, and protection.
5. The study further concludes that the PSS offered at the rehabilitation centres is effective since it helps transform children's lives, making them resilient to challenges, responsible persons, and wise decision-makers. It was evident that children receive counselling, psychosocial support, life skills programs, spiritual support, and co-curriculum activities such as brass band and theatre.
6. The challenges to offering PSS services are inadequate resources, lack of interest in the program by children, and children's unwillingness to speak the truth and disclose their information. The study also revealed that an uncooperative family setup, especially broken families where the father and mother are reluctant to reunite, poses a challenge as well.

Recommendations

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1. Children experience several forms of abuse ranging from emotional abuse, physical abuse, child neglect, verbal abuse, sexual abuse, and child labour. Therefore, this study recommends that the National Directorate of Children's Services and the County Department of Children's Services should prioritize the sensitization of caregivers on the rights of the children and positive parenting. Further, law enforcers should be trained on how to handle street children and be sensitized to the need to protect the rights of children.
2. This study recommends that PSS should be offered to all children who have gone through a traumatic event. Also, the children's directorate and its partners should come up with a strategy that will ensure most street children, if not all, are taken to rehabilitation centres.
3. The study recommends that county governments should set aside more resources to ensure more children are directed toward rehabilitation centres to have improved development.

Recommendations for Further Research

1. This study was limited to selected rehabilitation centres in Nairobi County, therefore, the study proposes the same study to be done across all the rehabilitation centres in the 47 counties of Kenya.
2. More studies need to be done on the main causes of trauma for children living on the streets as well as the effects on the development of children living in the streets.
3. Further research should be done to establish the role and effectiveness of the Directorate of Children's Services in Kenya in ensuring better PSS for trauma-exposed children and enforcing the National PSS guideline.

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4. Further research should be conducted through the use of psychometric testing to establish the prevalence of trauma observed among children on the streets.

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APPENDICES

Appendix A: Personal Letter of Introduction

My name is Doreen Atieno Ochieng, I am carrying out a research study on an "Evaluation of Psychosocial Support Services Provided to Trauma-Exposed Children aged 8-17 years in selected rehabilitation centres in Nairobi Kenya." This study is for my partial fulfilment of the requirements for the degree of Master of Arts in Child Development at Daystar University. This questionnaire is given to achieve the objectives of this research as outlined in the three sections.

Today we will engage in an interview. The purpose of this interview is to collect information for an ongoing study. The study aims to evaluate the effectiveness of psychosocial support services provided to trauma-exposed children aged 8-17 years in selected rehabilitation centres in Nairobi, Kenya.

This interview will take 45 minutes and will proceed upon your consent.

Signature: Date:

April 23, 2022

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Appendix B: Key Informant Questionnaires

A. Counsellor Key Informant Questionnaire

The Counsellors in this study, are trained professionals working at the selected rehabilitation centres of the study; of which one is a resident counsellor and three are temporary. They provide psychological support for the children and help them in cultivating their inner resources and resilience.

a. Demographic Data

1. What is your gender?

- ☐ Male
- ☐ Female
- ☐ Other _____

2. How old are you?

- ☐ 20 - 25 years old
- ☐ 26 - 31 years old
- ☐ 32 – 37 years old
- ☐ 38 – 43 years old
- ☐ 44 + years old

3. What is your education level?

- ☐ Secondary education level
- ☐ Diploma education level
- ☐ Bachelors education level
- ☐ Masters education level
- ☐ PhD education level
- ☐ Other _____

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b. Types of abuse experienced by children before being in the Rehabilitation Centre

4. Regarding the children at the centre/home, what type(s) of abuse was experienced that led them to go to the streets?

- ☐ Neglect
- ☐ Physical
- ☐ Sexual
- ☐ Emotional/Psychological
- ☐ Other
- ☐ Not sure
- ☐ None of the above

5. Who is the perpetrator(s) of these types of abuse? (Indicate Y for yes and N for no)

	Neglect	Physical	Sexual	Emotional/ Psychological
Father				
Mother				
Both Parents				
Guardians				
Caregivers				

6. Tell me about the neglect they faced. How did it occur?

7. Tell me about the physical abuse they faced. How did it occur?

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8. Tell me about the sexual abuse they faced occur? How did it occur?
9. Tell me about the emotional/psychological abuse they faced. How did it occur?

c. *The type of trauma experienced by children before being in the Rehabilitation Centre*

10. How would you classify the type of trauma these children face at home?

- ☐ Acute
- ☐ Chronic
- ☐ Complex
- ☐ Secondary
- ☐ Other
- ☐ None of the above

11. What kind of traumatic experiences were they exposed to in the streets?
12. Based on interactions with the children, what drove them to go to the Rehabilitation Centre?

d. *The psychosocial support services offered to children at the Rehabilitation Centre*

13. How would you describe the first contact with a child at the Rehabilitation Centre's drop-in site?
14. How is rapport built with the children?
15. What PSS is provided to the children?
16. Are the children always ready to accept the PSS offered?

- ☐ Yes
- ☐ No

17. If 'YES', what is the reason for this?

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18. If 'NO', what is the reason for this?

e. Changes in the children when PSS is provided

19. To the best of your knowledge, kindly talk about the emotional changes that you observed in children before and after PSS was provided without mentioning any of the children's names.

Emotional state Before the provision of PSS	Emotional state After provisioning of PSS

20. To the best of your knowledge, talk about the behavioural changes that you observed in children before and after PSS provided without mentioning any of the children's names.

Behavioural change Before the provision of PSS	Behavioural change After provisioning of PSS

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B. Social Worker Key Informant Questionnaire

The Social workers in this study, are trained professionals working at the selected rehabilitation centres of the study. They are responsible for the rehabilitation and reintegration of the children into society. They provide further support by conducting home tracing and home visits as well as facilitating access to medical check-ups and attention when necessary.

a. Demographic Data

1. What is your gender?

- ☐ Male
- ☐ Female
- ☐ Other _____

2. How old are you?

- ☐ 20 - 25 years old
- ☐ 26 - 31 years old
- ☐ 32 – 37 years old
- ☐ 38 – 43 years old
- ☐ 44 + years old

3. What is your education level?

- ☐ Secondary education level
- ☐ Diploma education level
- ☐ Bachelors education level
- ☐ Masters education level
- ☐ PhD education level
- ☐ Other _____

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b. Types of abuse experienced by children before being in the *Rehabilitation Centre*

4. Regarding the children at the centre/home, what type(s) of abuse was experienced that led them to go to the streets?

- ☐ Neglect
- ☐ Physical
- ☐ Sexual
- ☐ Emotional/Psychological
- ☐ Other
- ☐ Not sure
- ☐ None of the above

5. Who is the perpetrator(s) of these types of abuse? (Indicate Y for yes and N for no)

	Neglect	Physical	Sexual	Emotional/ Psychological
Father				
Mother				
Both Parents				
Guardians				
Caregivers				

6. Tell me about the neglect they faced. How did it occur?

7. Tell me about the physical abuse they faced. How did it occur?

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8. Tell me about the sexual abuse they faced. How did it occur?
9. Tell me about the emotional/psychological abuse they faced. How did it occur?

c. The type of trauma experienced by children before being in the Rehabilitation Centre

10. How would you describe the first contact with a child at the Rehabilitation Centre's drop-in site?
11. How is rapport built with these children?
12. Before coming to the centre, what type(s) of abuse was experienced by the children?

- Neglect
- Physical abuse
- Sexual abuse
- Emotional/Psychological abuse
- Other
- Not sure
- None of the above

13. What maladaptive behaviours were engaged in by children when living in the streets?
14. How do the street children come to the Rehabilitation Centre drop-in site?

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C. Careleavers Key Informant Questionnaire

The careleavers in this study, are children who resided in the rehabilitation centres and consequently left to pursue their lives outside the centre. They continue to engage with the rehabilitation centres as adult persons by providing mentorship for the children at the rehabilitation centre.

a. Demographic Data

1. What is your gender?

   □ Male

   □ Female

   □ Other _____

2. How old are you?

   □ 20 - 25 years old

   □ 26 - 31 years old

   □ 32 – 37 years old

   □ 38 – 43 years old

   □ 44 + years old

3. What is your education level?

   □ Secondary

   □ College

   □ University

   □ Other _____

b. Your life before going to the Rehabilitation Centre

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4. Regarding the children at the centre/home, what type(s) of abuse experienced led them to go to the streets?

- ☐ Neglect
- ☐ Physical
- ☐ Sexual
- ☐ Emotional/Psychological
- ☐ Other
- ☐ Not sure
- ☐ None of the above

5. Who is the perpetrator(s) of these types of abuse? (Indicate Y for yes and N for no)

	Neglect	Physical	Sexual	Emotional/ Psychological
Father				
Mother				
Both Parents				
Guardians				
Caregivers				

6. Would you be comfortable sharing your experience with me?

i. Tell me more about the neglect faced. How did it occur?

ii. Tell me about the physical abuse faced they face How did it occur?

iii. Tell me about the sexual abuse faced. How did it occur?

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iv. Tell me about the emotional/psychological abuse faced. How did it occur?

7. What led you to the streets?

c. Your life at the Rehabilitation Centre

8. What types of psychosocial support services were offered to you?
9. How would you describe the impact of the psychosocial support services offered to you?

d. Your life after the Rehabilitation Centre

10. How was your life changed by the psychosocial support services offered at the Rehabilitation Centre?
11. In your opinion, how can street boys be supported with the provision of psychosocial support services?

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Appendix C: Key Informants Interview Schedule

Establish Rapport:

Hello, it is a pleasure to make your acquaintance. Thank you for making time to speak with me today. My name is *[name of research assistant]*, what is yours?

Before we begin, I want to take you through why we are meeting today.

Purpose of Interview:

Today we will engage in an interview. The purpose of this interview is to collect information for an ongoing study. The study aims to evaluate the effectiveness of psychosocial support services provided to trauma-exposed children aged 8 to 17 years in selected rehabilitation centres in Nairobi, Kenya.

Motivation for the Interview:

The information shared here will be necessary to provide a better understanding of the competence required by psychosocial support services providers and if these services are beneficial to the children or not.

Ethical Considerations:

The researcher will adhere to ethical considerations to protect all participants of the study and for the study's credibility. The researcher will not commence the interview without the provision of informed consent from the participant. Because the interview will be recorded, the participants also need to give consent to the use of audio recordings. The interview and audio recordings are strictly for the study. The contents of the interviews and audio recordings are confidential. The names of the participants will not be shared.

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Risks of participating in the study:

The questions asked during the interview may bring you discomfort and/or feelings of uneasiness.

Benefits of participating in the study:

It is hoped that with increased understanding and knowledge of the effectiveness of psychosocial support services provided to trauma-exposed children, more effort will be put to maximize the benefits to the children.

Duration:

This interview will take 45 minutes.

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Appendix D: Key Informants' Consent Form

I ---------- voluntarily accept to participate in this study to Evaluate the Effectiveness of Psychosocial Support Services Provided to Trauma-Exposed Children Aged 8 to 17 Years in Selected Rehabilitation Centres in Nairobi, Kenya.

I ---------- give my informed consent to participate in this study. I am fully aware that some questions asked may be unsettling and/or bring discomfort to me. This informed consent is not coerced, forced or given due to harassment and/or payment.

Signature ---------- Time ---------- Date ----------

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A. Counsellor Key Informant Interview Schedule

The Counsellors in this study, are trained professionals working at the selected rehabilitation centres of the study; of which one is a resident counsellor and three are temporary. They provide psychological support for the children and help them in cultivating their inner resources and resilience.

a. *Demographic Data*

2. Please share with me your age and level of education

b. *Types of abuse experienced by children before being in the Rehabilitation Centre*

3. Regarding the children at the centre/home, what type(s) of abuse experienced led them to go to the streets?
4. Who is the perpetrator(s) of these types of abuse?
5. Tell me more about the abuse they faced. How did it occur?

c. *The types of trauma experienced by children before being in the Rehabilitation Centre*

6. How would you classify the type of trauma these children faced at their homes?
7. What kind of traumatic experiences were they exposed to in the streets?
8. Based on interactions with the children, what drove them to go to the Rehabilitation Centre?

d. *The psychosocial support services offered to children at the Rehabilitation Centre*

9. How would you describe the first contact with a child at the Rehabilitation Centre's drop-in site?

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10. How is rapport built with the children?
11. What PSS is provided to the children?
12. How is the reception of the children regarding the PSS offered?

e. *Changes in the children when PSS is provided*

13. To the best of your knowledge, kindly talk about the emotional changes that you observed in children before and after PSS was provided without mentioning any of the children's names.
14. To the best of your knowledge, talk about the behavioural changes that you observed in children before and after PSS provided without mentioning any of the children's names.

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B. Social Worker Key Informant Interview Schedule

The Social workers in this study, are trained professionals working at the selected rehabilitation centres of the study. They are responsible for the rehabilitation and reintegration of the children into society. They provide further support by conducting home tracing and home visits as well as facilitating access to medical check-ups and attention when necessary.

a. Demographic Data

2. Please share with me your age and level of education

b. Types of abuse experienced by children at the *Rehabilitation Centre*

3. Regarding the children at the centre/home, what types of abuse experienced led them to go to the streets?
4. Who is the perpetrator(s) of these types of abuse?
5. Tell me more about the abuse they faced. How did it occur?

c. The types of traumas experienced by children at the Rehabilitation Centre

6. How would you describe the first contact with a child at the Rehabilitation Centre's drop-in site?
7. How is rapport built with these children?
8. Before coming to the centre, what were the types of abuse experienced by the children before being in the Rehabilitation Centre?
9. What maladaptive behaviours were engaged in by children when living in the streets?
10. How do the street children come to the Rehabilitation Centre drop-in site?

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C. Careleavers Key Informant Interview Schedule

The careleavers in this study, are children who resided in the rehabilitation centres and consequently left to pursue their lives outside the centre. They continue to engage with the rehabilitation centres as adult persons by providing mentorship for the children at the rehabilitation centre.

a. Demographic Data

1. Please share with me your age and level of education

b. Your life before going to the Rehabilitation Centre

2. Regarding the children at the centre/home, what types of abuse experienced led them to go to the streets?
3. Who is the perpetrator(s) of these types of abuse?
4. Regarding the abuse you may have faced, would you be comfortable sharing your experience with me?
5. What led you to the streets?

c. *Your life at the Rehabilitation Centre*

6. What types of psychosocial support services were offered to you?
7. How would you describe the impact of the psychosocial support services offered on you?

d. *Your life after the Rehabilitation Centre*

8. How was your life changed by the psychosocial support services offered to you at the home/centre?
9. In your opinion, how can street boys be supported with the provision of psychosocial support services?

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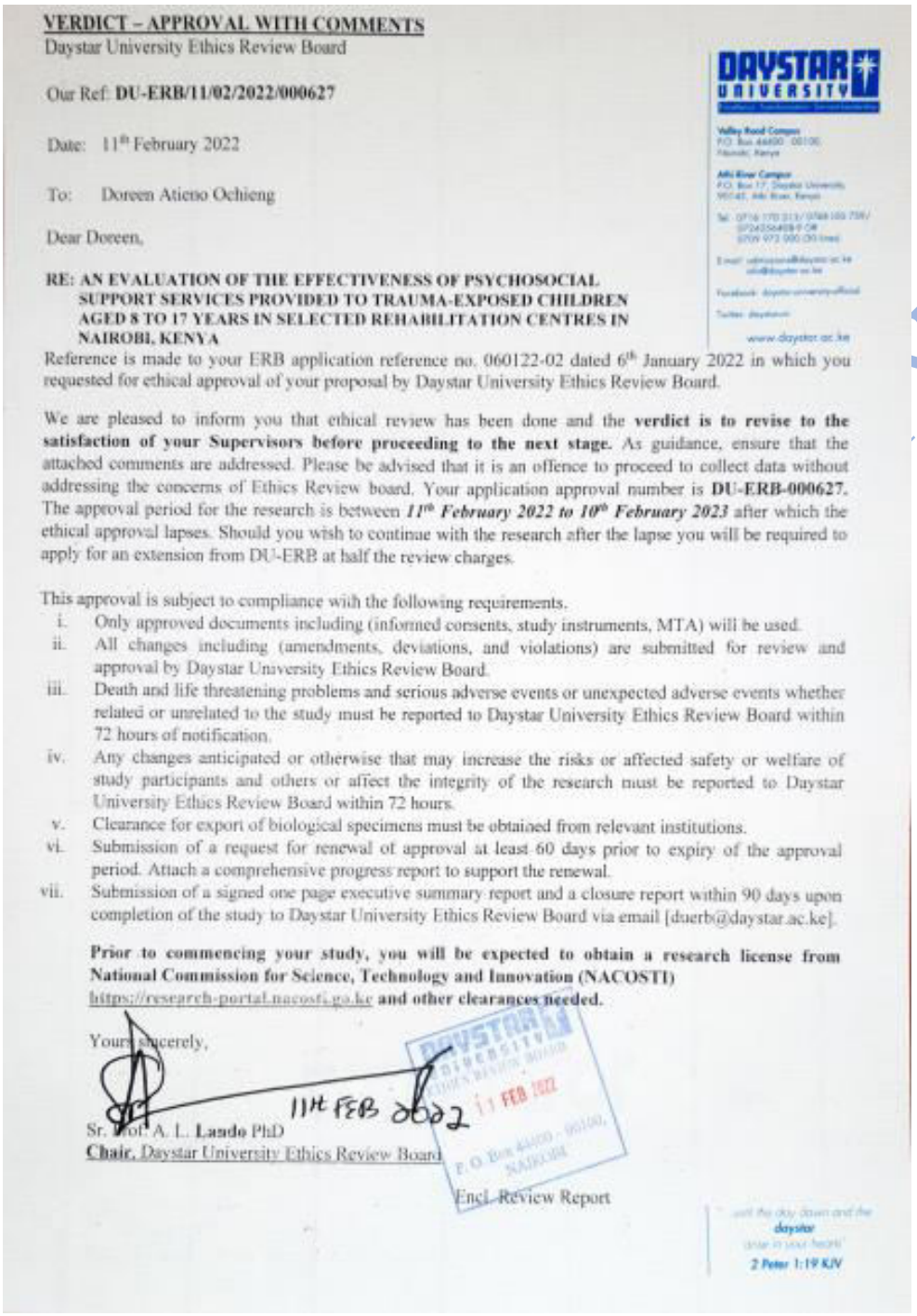
Appendix E: Ethical Clearance



VERDICT – APPROVAL WITH COMMENTS
Daystar University Ethics Review Board

Our Ref: **DU-ERB/11/02/2022/000627**

Date: 11th February 2022

To: Doreen Atieno Ochieng

Dear Doreen,

RE: AN EVALUATION OF THE EFFECTIVENESS OF PSYCHOSOCIAL SUPPORT SERVICES PROVIDED TO TRAUMA-EXPOSED CHILDREN AGED 8 TO 17 YEARS IN SELECTED REHABILITATION CENTRES IN NAIROBI, KENYA

Reference is made to your ERB application reference no. 060122-02 dated 6th January 2022 in which you requested for ethical approval of your proposal by Daystar University Ethics Review Board.

We are pleased to inform you that ethical review has been done and the **verdict is to revise to the satisfaction of your Supervisors before proceeding to the next stage.** As guidance, ensure that the attached comments are addressed. Please be advised that it is an offence to proceed to collect data without addressing the concerns of Ethics Review board. Your application approval number is **DU-ERB-000627.** The approval period for the research is between ***11th February 2022 to 10th February 2023*** after which the ethical approval lapses. Should you wish to continue with the research after the lapse you will be required to apply for an extension from DU-ERB at half the review charges.

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 affected 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 a signed one page executive summary report and a closure report within 90 days upon completion of the study to Daystar University Ethics Review Board via email [duerb@daystar.ac.ke].

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

Yours sincerely,

11th FEB 2022

Sr. Prof. A. L. **Lando** PhD
Chair, Daystar University Ethics Review Board

11 FEB 2022

Encl. Review Report

2 Peter 1:19 KJV

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Appendix F: Daystar Research Authorization Letter

DAYSTAR UNIVERSITY
Excellence - Transformation - Servant Leadership

Athi River Campus
P.O. Box 17, Daystar University,
90143, Athi River, Kenya

Valley Road Campus
P.O. Box 44400 - 00100,
Nairobi, Kenya

Tel: 0709 972 000 (Pilot Line)
0716 170 313 (Marketing)
0748 100 759 (PR Line)

Email: admissions@daystar.ac.ke OR
info@daystar.ac.ke

Website: www.daystar.ac.ke

15th February 2022

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

Dear Sir/Madam,

RE: DOREEN OCHIENG

The above named is a student in the Master of Arts, Child Development 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.

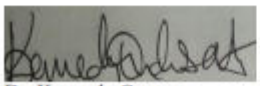
The topic of study is *'An Evaluation of The Effectiveness of Psychosocial Support Services Provided to Trauma-Exposed Children Aged 8 to 17 Years in Selected Rehabilitation Centers in Nairobi, Kenya.* Her proposal has been passed and approved by the Institute of Child Development and Daystar University 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,



Dr. Kennedy Ongaro
DEAN, SCHOOL OF HUMAN AND SOCIAL SCIENCES

Ref/hd/ministry letter

DA

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Appendix G: Research Permit

REPUBLIC OF KENYA

NATIONAL COMMISSION FOR SCIENCE,TECHNOLOGY & INNOVATION

Ref No: 551547

Date of Issue: 25/February/2022

RESEARCH LICENSE

This is to Certify that Miss.. Doreen Atieno Ochieng of Daystar University, has been licensed to conduct research in Nairobi on the topic: AN EVALUATION OF THE EFFECTIVENESS OF PSYCHOSOCIAL SUPPORT SERVICES PROVIDED TO TRAUMA-EXPOSED CHILDREN AGED 8 TO 17 YEARS IN SELECTED REHABILITATION CENTRES IN NAIROBI, KENYA. for the period ending : 25/February/2023.

License No: NACOSTI/P/22/15909

551547

Applicant Identification Number

Director General
NATIONAL COMMISSION FOR SCIENCE,TECHNOLOGY & INNOVATION

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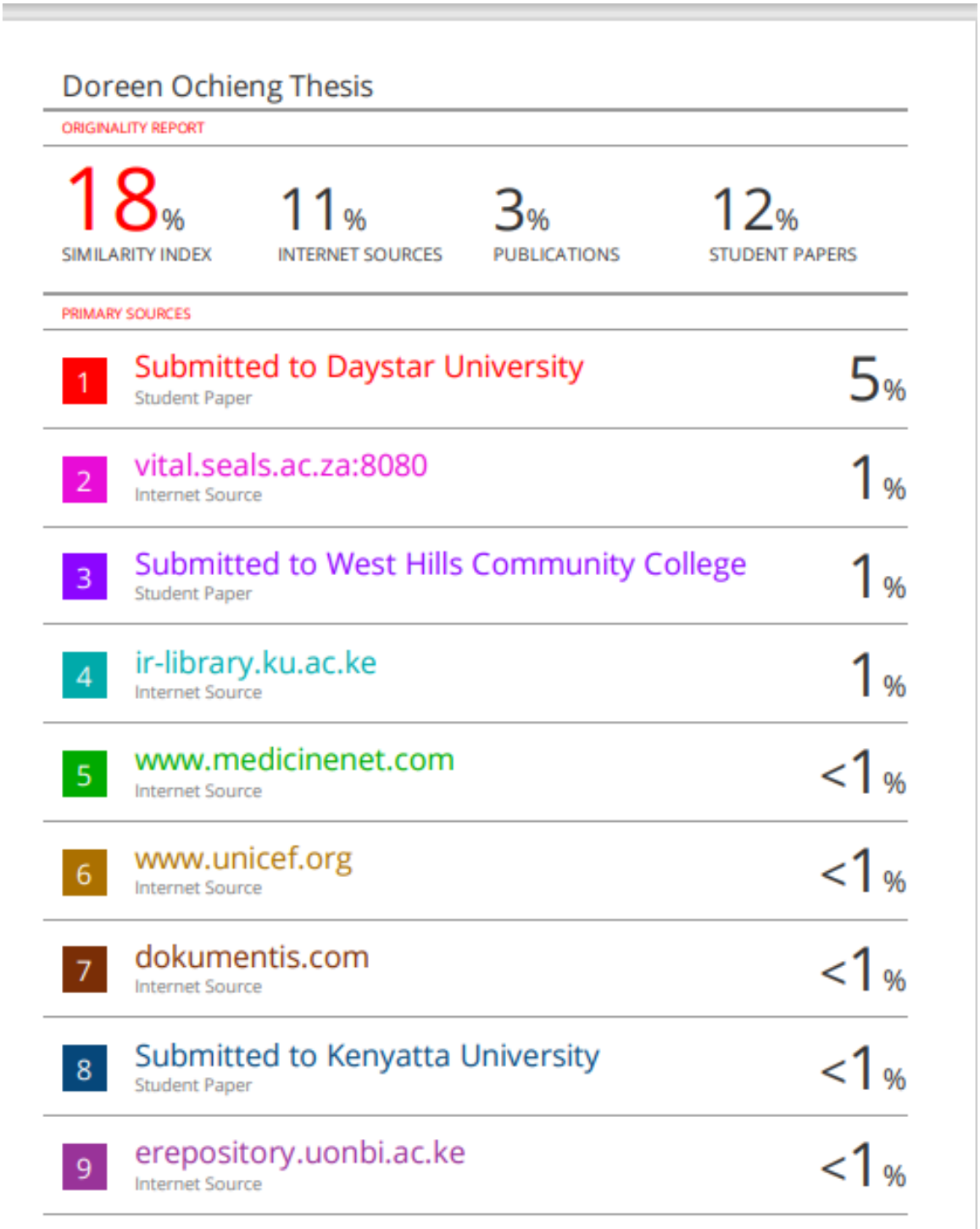
Appendix H: Similarity Index Report



Doreen Ochieng Thesis

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