

**FEASIBILITY OF PSYCHOSOCIAL INTERVENTION FOR CHILDREN  
EXPOSED TO ETHNIC VIOLENCE IN KENYA**

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## Abstract

**Background:** There is limited evidence on the cultural acceptability and feasibility of psychosocial interventions for children in post-conflict settings in low-income countries.

**Aim:** To establish the feasibility of a psychosocial intervention for children exposed to ethnic violence and who experience mental health problems.

**Methods:** A mixed methods two-phase design was adopted. In phase I, four focus groups were conducted with community stakeholders (children, parents, teachers and other professionals) in Nakuru, Kenya. In phase II, children were screened on trauma exposure (SLES), post-traumatic stress (CRIES-13), anxiety (RMCAS), and depressive symptoms (DSRS). Fifty-four children subsequently randomly allocated to a psychoeducational and trauma-focused intervention (Writing for Recovery) or wait-list control group. The same measures, as well as free text and attendance data were collected to evaluate five feasibility criteria.

**Results:** Emerging themes from phase I indicated that socioeconomic constraints, limited mental health knowledge, stigma, impaired parenting and engagement, and lack of culturally appropriate interventions and inter-agency collaborations as key challenges. In phase II, 85% participants completed the study, of whom 95.8% suggested that Writing for Recovery was acceptable and suitable, with a similar proportion (95%) finding it useful in controlling emotional symptoms. Effect size for outcome measures ranged from small to high with time/group analysis, showing reduction in PTSD symptoms ( $d=0.691$ ).

**Conclusions:** Community stakeholders' views are important in informing the planning, delivery and evaluation of psychosocial interventions in post-conflict settings. Brief psychoeducational approaches such as Writing for Recovery are feasible, culturally acceptable and resource-effective in being delivered by non-specialist facilitators. These are indicated as first-line intervention in a stepped model.

**Implications:** Findings contribute to the literature of evidence-based psychosocial interventions for children in post-conflict settings. These are useful for policy makers and other stakeholders involved in child care, by providing an additional low-cost resource to help traumatized children in similar communities and socio-cultural contexts.

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## List of Abbreviations

AIDS .....	Acquired Immunodeficiency Syndrome
APA.....	American Psychological Association
AHRQ .....	Agency for Healthcare Research and Quality
BACP.....	British Association for Counselling and Psychotherapy
BPS.....	British Psychological Society
CAMH.....	Child and Adolescent Mental Health
CBT.....	Cognitive-Behavioral Therapy
CBPR.....	Community-Based Participatory Research
CAQDAS.....	Computer Assisted Qualitative Data Analysis Software
CRIES.....	Revised Child Impact of Event Scale
CRPD.....	Convention on the Rights of Persons with Disabilities
DMT.....	Dance and Movement Therapy
DRC.....	Democratic Republic of Congo
DSRC.....	Depression Self-Rating Scale
EMDR.....	Eye Movement Desensitization and Reprocessing
HSML.....	Health System Management Institute
HQoL.....	Health Related Quality of Life
HIV.....	Human immunodeficiency virus
HFP.....	Happy Families Program
IASC.....	Inter-Agency Standing Committee
IFRCRCS.....	International Federation of Red Cross and Red Crescent Societies
IPT.....	Interpersonal Psychotherapy
KIDSCREEN-10.....	Health-Related Quality of Life Questionnaire for Children
LICs.....	Low Income Countries
MRC.....	Medical Research Council
MHPSS.....	Mental Health and Psychosocial Support
MDGs.....	Millennium Development Goals
MMs.....	Mixed Methods
NCTSN.....	National Child Traumatic Stress Network
NICE.....	National Institute for Health and Care Excellence
NGOs.....	Non Governmental Organizations
PTSD.....	Post-Traumatic Stress Disorders
PSST.....	Problem Solving Skills Training
PFA.....	Psychological First Aid
PSSA.....	Psychosocial Structured Activities
RCMAS.....	Revised Children's Manifest Anxiety Scale
RCT.....	Randomised Controlled Trial
SDGs.....	Sustainable Development Goals
SMI.....	School Mediation Intervention
SIT.....	Stress Inoculation Training
SLEs.....	Stressful Life Events scale
T-FCB.....	Trauma-Focused Cognitive Behavioural Therapy
TRC.....	Truth and Reconciliation Commission
UN.....	United Nations
UNESCO.....	United Nations Educational, Scientific and Cultural Organization
UNHC.....	United Nations High Commissioner for Refugees
UNICEF.....	United Nations Children's Fund
WfR.....	Writing for Recovery

WHO..... World Health Organization

## **CHAPTER ONE**

### **MENTAL HEALTH PROBLEMS AMONG CHILDREN WHO EXPERIENCE ETHNIC CONFLICT**

## **1.1 Introduction**

This chapter critically reviews the research literature with regard to the main topic of the study. The evidence will explore various aspects of the impact of ethnic conflict on children's mental health such as the nature and prevalence of child mental health problems, and the factors which mediate exposure to ethnic conflict and related trauma. The literature sources predominantly consist of research articles, but also texts, policy reports and official statistics. Current definitions, the context of ethnic conflict, and critical evaluation of previous research will be presented to demonstrate the key findings and their implications, as well as identify research gaps for further study. The term 'children' is used to refer to both children and young people throughout this thesis.

This review will focus on internally displaced children who have been affected by ethnic conflict in the low income countries (LICs). Literature on war affected children will be included, because at times war this often leads to displacement, and these boundaries are often not clear in the available literature. Also, most of research on internally displaced children (i.e. risk and protective factors, mental health problems and interventions) in LICs is difficult to differentiate from studies with other groups of refugee children (Turnip & Hauff, 2007), despite differences in relation to legal status and needs (Aburas et al., 2018). For this reason, literature on internally displaced and refugee children in LICs, but not in high income countries, will be considered.

## **1.2 Ethnic conflict**

### **1.2.1 Definitions**

The term 'ethnic', which has its roots in the Greek word *ethnos*, refers to a community or group of common descent. The terms 'community' or 'group' can be interchangeably used as communal group, ethnic group, ethnic community or ethnic minority (Kempin, 2015). Social sciences scholars view the content and symbols of an ethnic group in different ways. Some researchers consider ethnic identity as an objective entity that is fixed and has its own distinct social boundaries, whilst others view it as a subjective phenomenon that is a socially constructed and fluid entity that continuously changes through inter-ethnic interaction (Jemma, 2006). Kipgen (2013) described an ethnic group as a section of people who are a collective or corporate formed along shared values. Their attributes serve as a common ground for their ethnic ties or ethnicity. Singh (2001) highlighted some of these values to

include, but not limited to, common origin, myths, cultural practices, history, ideology, religion, kinship, language and shared territory (Jemma, 2006).

‘Conflict’ is defined as a total breakdown of law, security and community structures. It is characterised by gross violations of human rights committed against the general population, state failure, refugee flows, economic decline and environmental damage (UNICEF, 2005; Kempin, 2015). According to Patton (2014), conflict occurs at various levels such as intrapersonal, interpersonal, intragroup, or intergroup. Whether they are individuals or groups, the actors pursue incompatible goals. They misunderstand each other, disagree, struggle or contest when actions of one group are either resisted by or become unacceptable to the other because of differences in their values, goals, beliefs, needs or ideas.

The term ‘ethnic conflict’ lacks a universal definition or consensual meaning because social science scholars construe the concept in various ways (Jemma, 2006). Kempin (2015) states that, for a conflict to be regarded as ethnic, the emerging problems and their possible solutions must be perceived along ethnic lines. Basedau (2011) proposes that the construct denotes any conflict in which at least two ethnic groups are incompatible in terms of access to either power and/or resources. These ethnic groups are always opposed to each other. Blagojevic (2009) defines ethnic conflict as a group phenomenon that develops due to social collectivities expressing their fundamental differences. Similarly, Kane (2008) describes ethnic conflict as a form of violence perpetrated against individuals or groups, simply because of belonging to a particular minority ethnic group. He argues that such conflict takes place wherever different ethnic groups live or come into contact with one another. Furthermore, for Cooper et al. (2011) the use of armed force between organised groups is central to the definition, through clashes between ethnic, religious or other social groups.

### **1.2.2 Types of ethnic conflict**

Ethnic conflict can take different forms that vary from peaceful expression of grievances to outright use of physical force/violence (Jemma, 2006). Blagojevic (2009) argues that each form of violence, due to different contexts, has distinct characteristics. He observes that most ethnic conflicts are complex and involve more than one single ethnic group. Different parties are linked together in complex networks, i.e. political institutions which normally disagree on various issues, especially on resource distributions. In some situations, ethnic conflicts are



long-term phenomena, where some of the parties are not willing to reach a peace agreement (Bergmann & Crutchfield, 2009). Typically, the minority are normally discriminated by the majority, who have long-standing negative attitudes towards them (Kane, 2008).

Bergmann and Crutchfield (2009) classify racial and ethnic violence into civil wars, genocides, pogroms, ethnic cleansing, and violent separatist movements. Oyeniyi (2011) categorises ethnic conflicts into three types. First, elite conflicts exist within the political leadership, and can significantly impact on policies. Such conflicts have occurred in almost every African country after their independence from colonial rule. Second, factional conflict involves ethno-regional inequalities, and intensifies competition among various interested groups. It has especially been experienced in countries such as Nigeria, Cameroon or Sudan. The main purpose of factional politics is to influence the composition of the official power apparatus, and to determine who rules in a given political centre. Finally, communal and mass conflict calls into question not only the legitimacy of specific regimes but also the essentials of state power. They challenge the state's territorial integrity and protest the existing distribution of power. Inter-ethnic animosity grows where religion and customs are clearly distinguished among groups.

### **1.3 Theories of ethnic conflict**

The causes of ethnic conflict are highly contested across academic disciplines (Jemma, 2006). Several scholars have put forward some based on assumptions regarding the origin of ethnic identities and conflicts. Such theories try to explain the nature of ethnicity, whether inherited or constructed, and what determines its affiliations or identification. These theories include, but are not limited to primordialism, instrumentalism and constructivism (Williams, 2015).

#### **1.3.1 Primordialism**

According to this theory, ethnicity is an ascribed identity or assigned status, which is inherited from one's ancestry. It is consequently argued that membership, which is assigned at birth, is difficult to change (Williams, 2015), because it is fixed and passed on intact across generations, with distinct social boundaries (Poata-Smith, 2013). Differences between ethnic groups are perceived to be ancestral and are irreconcilable, because they are deeply rooted (Esteban et al., 2012) in the natural divisions with others (Weir, 2012; Chia-Chou, 2018). Identity is the main root cause of the rivalry history over land and vengeance killings (Tong, 2009). According to Bergmann and Crutchfield (2009), cultural differences can be the origin

of clashes between parties, while Kabiru et al. (2013) argue that many ethnic groups have ancient hatred among themselves that runs through their human ancestors. They point out that the colonial system accounts for the source of some of the ethnic enmity and discrimination against others. Colonialists used the system of ethnicity to divide and rule people for the purpose of strengthening their power. Several studies indicated that the same approach has been adopted by some leaders to achieve their political ends (Kipgen, 2013; Wegenast & Basedau, 2014). Such situations have in many cases led to genocide, an extreme kind of violence on a horrific scale (Pedersen, 2002; Caselli & Coleman, 2013). Oyeniyi (2011) identifies the military coup in Uganda led by Idi Amin in 1971, while Bezemer and Jong-A-Pin (2013) point out the 2007 disputed Kenyan presidential election violence between Raila Odinga and the incumbent President Mwai Kibaki as examples where ethnically divided groups clashed.

This theory has been credited for explaining the passion-driven behaviour of ethnic groups and gives some insight into the emotive dimension of ethnic conflicts. It also explains what leads people from different ethnic communities to develop and establish rivalry (William, 2015). However, it has also been criticised for assuming that identities are fixed. For instance, some societies like Botswana, which is an ethnically heterogeneous country, has a ‘constitutionally grounded ethnic differentiation’ that has discouraged disintegrative ethnicity (Mulinge, 2008). Another criticism is that the theory fails to adequately address issues such as the timing of an outbreak of violence. It does not account for and when the conflicts happen, or why fresh ethnic conflicts and new identities emerge (Tong, 2009).

### **1.3.2 Constructivism**

Ethnicity is a socially constructed identification. It is a fluid entity that can be formed by social, economic and political means; with language, history, symbols and culture playing a significant role in instigating and sustaining ethnic rivalry (William, 2015). Violence rises out of a combination of factors, from economic pressure to loss of political rights. Social systems can lead to conflicts along ethnic lines. These can be mitigated by institutions such as free press, elections, and opposition parties. These institutions can be used to prevent instances of political manipulation once they have created social trust (Tong, 2009). The theory of constructivism explains that ethnicity is flexible, subjective, and changes with interethnic interaction (Jemma, 2006). However, this theory has also been criticised, because it does not account for the timing of the outbreak of conflict (William, 2015).

### **1.3.3 Instrumentalism**

Groups or collectives strongly identify with a certain part of their identity, for economic or political gain. In such situations, ethnic violence or conflict may take place in the interests of the ruling majority. This was the strategy that was applied by the Europeans who colonized Africa. They used ethnic groups to avoid any uprising against their interests. Europeans used the minority to rule, which led to hatred. In Rwanda the Hutu dominated and thus locked out the Tutsi for their own gains. Ethnicity can, therefore, adversely be used as a tool to restrict resources to a few individuals. It may lead to forming the basis of coming together for a common interest, which is to gain a larger share of scarce economic or political power. This implies that it is a deliberate manipulation to incite or encourage ethnic violence. Paradoxically, in this case some individuals may follow the majority, even when they are not personally convinced by the reasons for participating in the violence. For instance, the conflict in the Democratic Republic of Congo has mainly been caused by the elite on the pretence of concerning claims of state failure to control the illegal exploitation of mineral resources. Likewise, the rape of Muslim women in Bosnia (Weitsman, 2008) and genocide in Rwanda were used as instruments to humiliate, intimidate and degrade the 'enemies' (William, 2015). Unfortunately, this theory fails to provide explanations on how and give reasons why mobilizing mass participation takes place along ethnic lines.

Generally, these theories of ethnic conflict try to explain the nature of ethnic identity and interethnic relations based on assumptions. In as much as they tend to understand the origin and role of ethnic conflict, these explanations are neither comprehensive nor convincing enough to inform peace building and intervention strategies. They only base ethnic identity as the main cause of conflicts, thus making it difficult to plan and design comprehensive responses. More complex grievances that address unequal distribution of economic resources, security breakdown and socio-political issues need to be considered too for the purpose of informing inclusive and effective policies.

## **1.4 Causes of ethnic conflict**

Understanding the causes and dynamics of the complexities of political and social environments which surround ethnic conflict can provide the basis of informing effective strategies or policies for prevention, intervention and peace resolution. Human diversity and ethnicity carry various degrees of potential conflict (Blagojevic, 2009) that can develop either within the same group of people or between different ethnic groups (Kipgen, 2013). For

instance, violence against Roma minorities in some Eastern European countries (Kane, 2008), the Rwanda genocide of the Tutsi by the Hutus (Richters et al., 2005, Hain, 2011), the genocide in Darfur, the ethnic cleansing in Bosnia, sectarian violence in Iraq (Blagojevic, 2009), and the 2007 violence in Kenya (Obonyo et al., 2008; Cooper et al., 2011) are examples of such conflicts.

The catastrophic consequences of ethnic conflicts have underpinned the efforts of politics, economics and social sciences to establish causes and mechanisms, before informing solutions (Montalvo & Reynal-Querol, 2005). For instance, according to Patton (2014), conflict is a complex behaviour where perceptions also play an important role. He argues that the causes of conflict may be genuine or illusory, since one party perceives that its interests are being opposed or negatively affected by another party. He thus suggests that understanding the cause of conflict can make it easier for the concerned parties to anticipate as well as intervene at an appropriate time.

In as much as it is argued that the immediate causes of ethnic conflict vary (Ishiyama, 2009; Debelo, 2012; Kipgen, 2013), it has been noted that, when a particular set of factors and conditions converge in ethnically diverse societies, conflict is an inevitable outcome (Sambanis & Shayo, 2013). Part of the reasons for such risk is that each party pursues incompatible and inevitable opposing goals (Oyeniyi, 2011) without considering and respecting the position of others (Murer, 2012). According to Bergmann and Crutchfield (2009), no single factor can comprehensively explain the causes. The diversity, dynamics and fluid qualities of ethnic conflicts illustrate the variety of underlying causes. Therefore, according to Oyeniyi (2011), some of the causes of ethnic conflict that emerge from these theories include, but are not limited to political, institutional factors, competition over resources and globalization. These causes are discussed in detail in the next section.

#### **1.4.1 Institutional factors**

Ethnic conflicts can be influenced to a large extent by the functioning of state institutions. Bergmann and Crutchfield (2009) note that, when institutions are democratic, inter-ethnic co-operation and mitigation of any potential conflict of ethnic nature can easily be resolved by bringing people together. They can thus boost incentives for co-operation accountability, representation, participation and allocation of resources in the community. On the contrary, countries are vulnerable to ethnic or cultural conflict if their political institutions politicize

ethnicity or cultural identity. Nevertheless, according to Bezemer and Jong-A-Pin (2013), democracy can also have a negative impact. They argue that the advent of political multi-party democracy in some states which are formed on ethnic lines has played a big role in sporadic eruption of ethnic violence. Africa, with its diversity of ethnic groups, has been the region mostly hit by political multi-party democracy.

#### **1.4.2 Political factors**

The course of ethnic politics can be affected by the electoral system and structure of the executive government. This often determines and defines political representation, which in turn influences resource allocation. Fairness and proportional representation in the electoral system can prevent the escalation of any crisis, as it promotes multiple ethnic interests (Ishiyama, 2009). In contrast, lack of fairness and transparency can lead to inflammatory rhetoric likely to cause violence. Politicians can resort to hate speech to gain or strengthen their power, by manipulating ethnic emotions or exploiting prevailing ethnic differences, historical memories or grievances. Similarly, Benesch (2011) identifies speech as a catalyst of ethnic mass violence, as indeed was the case in Kenya during the catastrophic 2007 and 2008 disputed presidential elections.

#### **1.4.3 Competition over resources**

It has been argued that unresolved ethnic intolerance and competition over economic grievances and rights can lead to violence, especially when resources are scarce (Ishiyama, 2009). Ethnicity in this case acts as a source of protection and security for any minority group. Thus, one reason why groups identify themselves in silo within ethnically diverse societies is resource mobilization. Such groups respond to dispute over territory, unequal distribution of resources and government treatment (Pedersen, 2002; Kipgen, 2013; Wegenast & Basedau, 2014). This is accentuated, particularly in developing countries, by minority ethnic groups having an economic advantage over the majority (Bezemer & Jong-A-Pin, 2013). Indians in East Africa and Lebanese in West Africa constituted such examples, who consequently experienced violence by the general population.

#### **1.4.4 Globalization**

Globalization shapes local circumstances through the intensification of social relations due to international economic integration. Materialistic and superficially universalistic sets of western values are after forced on the rest of the world, and this factor is likely to cause violent reactions (Song, 2013). Economic integration has social and political consequences potentially triggering ethnic and cultural conflict. The global spread of market capitalism enables people to easily move from one country to another, thus leading to competition for jobs and other economic benefits.

However, in as much as ethnic diversity has been exploited for negative purposes, it does not necessarily pose risks of violence (Kipgen, 2013). Some ethnic groups co-exist peacefully, even after periods of slight conflict or misunderstanding (Caselli & Coleman, 2013). Aapengnuo (2010) observes that there are high degrees of mixing, to an extent of having economic partnerships and shared values leading to marriages in some communities. Countries that have managed to avoid ethnic conflicts include Zambia, Niger and Eritrea (Sambanis & Shayo, 2013). Considering Zambia, for instance, ethnicity is used to shape identification through the formation of political blocs to gain power, but not to cause conflict (Easterly, 2001). Similarly, Ishiyama (2009) note that ethnic identity serves as the development of democracy by assisting the stabilization of party formation. He argues that ethnic parties only emerge as a result of ethnic identity, since they simply reflect existing differences. They promote inter-ethnic relationships and facilitate the integration of other subcultures into the political system, hence make institutions more accessible and, therefore, allow conflicts to be resolved politically rather than through violence. These ethnic parties thus help sustain democracy, once institutionally encouraged to compete on multiple dimensions.

#### **1.5 Trends of ethnic conflict in the developing world**

Ethnic conflict is a phenomenon which is experienced worldwide in varying degrees of intensity (Easterly, 2001; Jemma, 2006; Caselli & Coleman, 2013; Tepfenhart, 2013 - Figure 1.1). Historically, Africa and Asia have experienced extensive ethnic conflicts, some of which are still capable of flaring into violence today, even as new ones arise (Bergmann & Crutchfield, 2009). The African continent in particular, has been at the heart of many conflicts, with several persisting for long periods. For instance, ethnic conflicts continue to fuel violence in Congo, Nigeria, Somalia, Kenya, and Darfur among others. It can be argued

that many of these conflicts were made more intractable and violent by the way European colonialists carved Africa up, drawing borders according to European national conflicts and interests, disregarding the historic territories of African ethnic and national groupings, and forcing traditionally hostile groups under a single flag.

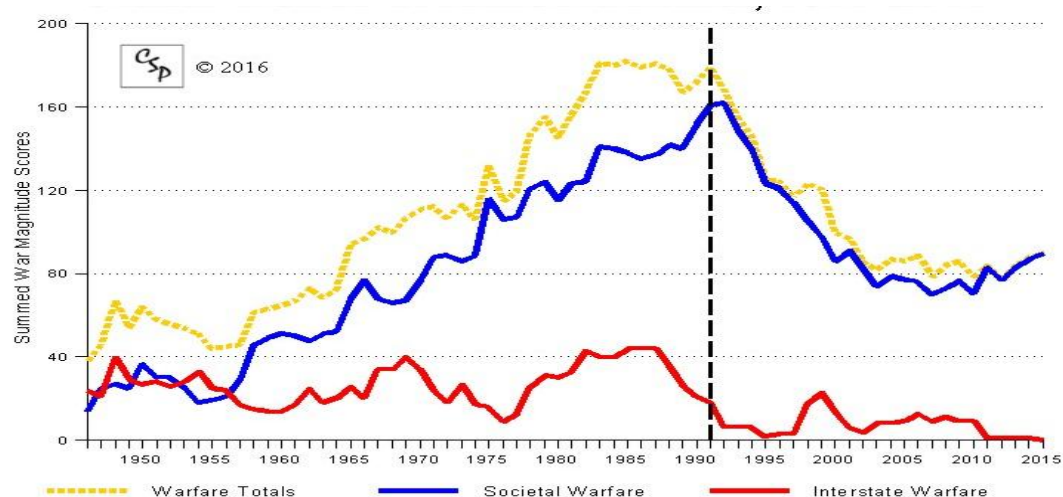
Following independence, these ethnic groups faced the question of who the new states should belong to. Since Nigeria's independence in 1960, the ethno religious groups Yoruba, Ibo, and Hausa/Fulani have repeatedly clashed over the division of political power, in conflicts ranging from civil war (Biafra) to communal riots, during which thousands died. Scholars point out that the Belgian government's policies in Rwanda gave the Tutsi minority power over the Hutu majority, which was much resented and led to genocide in 1990. The UK government followed a similar strategy in Kenya with the Kikuyu and other ethnic groups, including the Luhya, Luo, Kalenjin, and Kamba. These are considerable minorities. For example, the Kikuyu are the largest group, but they still constitute less than one quarter of the population. These historical contexts contributed to the genocide in Rwanda and to Kenya's post-election violence in 2007–8.

During 2011 alone, 37 armed conflicts were recorded globally, with Africa ( $n = 15$ , 41%) leading, followed by Asia ( $n = 13$ , 35%) and the Middle East ( $n = 6$ , 16%) (Tol et al., 2014). Similarly, more than half of the countries in the Sub-Saharan Africa region have experienced some form of conflict (Bodea & Elbadawi, 2008; Oyeniya, 2011), with the Horn of Africa, central Africa and the Great Lakes among the worst affected zones (Kabiru et al., 2013).

**Figure1.1**

**Global trends of ethnic conflict between 1945 and 2015**

*(Adapted from Centre for Systemic Peace, 2016)*



In an assessment of the trends of conflicts between 2002 and 2008, carried out by Cooper et al. (2011), out of the 28 countries studied, 50% of the identified records originated from only four sub-Saharan African countries; Somalia, Ethiopia, Sudan and Nigeria (Table 1.1). During 2008, the authors noted that the number of conflicts were slightly higher than the rest of this period. The reasons for such increase were partly due to several ethnic conflicts recorded in Kenya (eight conflicts) and Pakistan (six conflicts). The study found that the violence in Kenya was associated with the contested re-election of President Mwai Kibaki in December 2007, while in Pakistan it was linked to the security situation in the country.

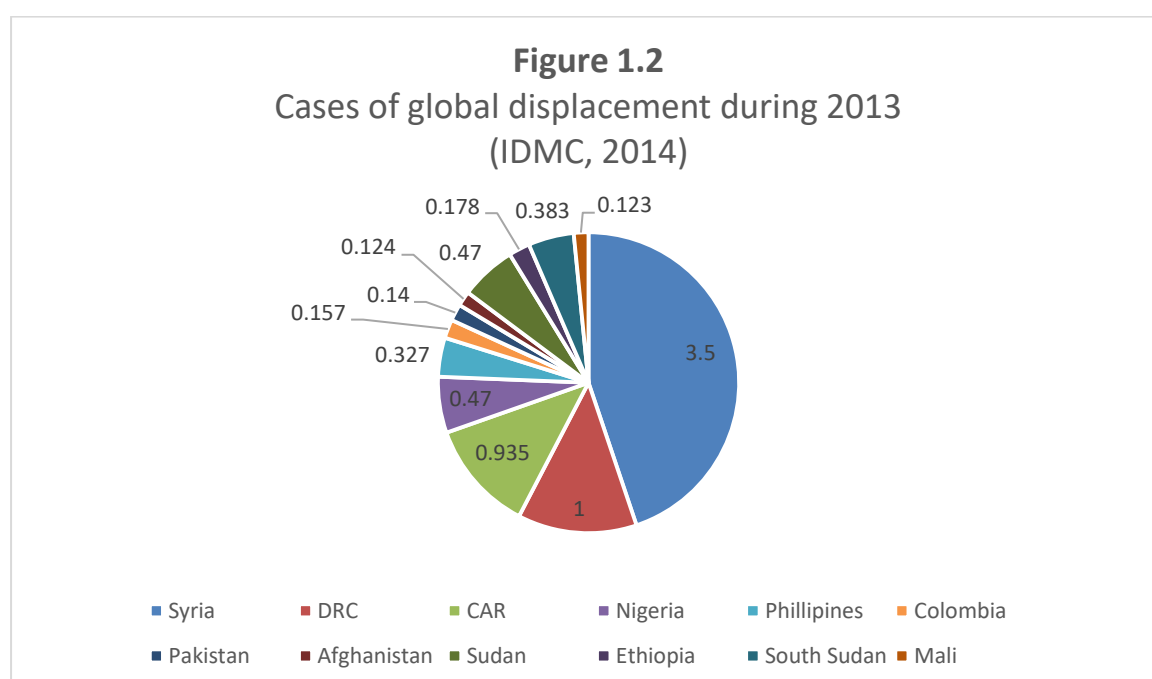
**Table 1.1**

**World trends of ethnic conflicts and the resulting number of deaths (2002-2008)**  
(IDMC, 2014)

Year	2002	2003	2004	2005	2006	2007	2008
Approximate number of conflicts	33	34	26	23	22	16	35
Approximate number of deaths	6,000	500	3,700	2,000	2,000	1,700	3,000



Similarly, according to the Internal Displacement Monitoring Centre (IDMC) (2014), population displacement in the aftermath of conflict, also shows varying trends. The report states that in 1998 there were 19.3 million internally displaced persons worldwide. The number increased by approximately 5 million in 2001. By the end of 2013, the number had escalated to 33.3 million. Sub-Saharan Africa had the largest number, with a total of 12.5 million, followed by the Middle East and North Africa with 9.1 million each. The new highest recorded cases during this year are illustrated in Figure 1.2.



The causes of most of these displacements were related to armed conflict, generalised violence and human rights violations. These were particularly prominent in countries such as Syria (6.5 million), Colombia (5.7 million), Nigeria (3.3 million), Democratic Republic of Congo (DRC) (2.9 million), Sudan (2.4 million), Iraq (2.1 million) and Somalia (1.1 million).

## 1.6 Impact of ethnic conflict on children

Millions of children are caught up in conflicts either as bystanders or targets (King'ori et al., 2014). These can result in severe material destruction, denial of basic human rights, and significant loss of carers and loved ones, because of general onslaught against civilians and/or in more extreme cases of genocide. For instance, during the armed conflicts between 1986

and 1996, two million children died; six million were seriously injured or permanently disabled; and millions more were separated from their families, physically abused, abducted into military groups and sexually abused (UNICEF, 2005). The same report noted that over 15,000 children were killed in Bosnia and Herzegovina, 40 per cent of civilian casualties were children in Chechnya, while in Rwanda 300,000 children were killed and a vast number were physically maimed, and forced to flee their homes.

### **1.6.1 Statistics of impact of ethnic conflict on children**

Ethnic conflicts have accounted for an average of 65% of civil wars since the end of the Second World War (Sambanis & Shayo, 2013), with most Asian and African countries being drastically affected, thus creating one of the largest humanitarian crises in history (Bodea & Elbadawi, 2008; Oyeniyi, 2011; Kabiru et al., 2013; Quinn et al., 2014). Children and young people are the majority of the victims affected by armed conflicts globally (Friedrich, 2008; Attanayake et al., 2009). According to Betancourt and Khan (2008), during the last decade such conflicts have left 20 million children homeless, six million disabled, two million killed and over one million separated from their parents. UNICEF (2009a) reported that over one billion children and adolescents lived in countries or regions affected by conflict. Alarming, an estimated 300 million of these children are under the age of five years. In 2006, there were about 18.1 million children affected by displacement, of whom 8.8 million were internally displaced and 5.8 million sought refugee status. UNICEF (2014) estimated that 10,000 children were killed during conflict, while 1.5 million children were forced to flee their homes during 2014. Some conflicts have accounted for a substantial proportion of the grim statistics. For instance, during 2012 5,000 cases of child rapes were reported, more than 2.7 million children died, and 30,000 children were recruited as combatants in DRC (Bayer et al., 2007).

### **1.6.2 Impact of ethnic conflict and violence on children's communities and systems**

Ethnic conflict and violence have multiple and profound impacts on children. They can affect children in various ways, either directly or indirectly. Communities and systems are destroyed throughout, well beyond the loss of health services infrastructure, to compound disruption in food, water supplies and sanitation. Crucially, children's attachments are severely disrupted. Children experience and witness many horrific traumatic events during conflict and war (Thabet et al., 2007). They may lose parents, siblings, relatives and friends. Communities can no longer provide a secure environment for children, because they are

ripped apart (UNICEF, 2005). Many structures, networks and protective social institutions such as schools collapse, thus both exposing children to danger and depriving them of opportunities to build their resilience. Families may become separated, as they escape. Children may become internally displaced or refugees, depending whether they take shelter within or without the country. If they are internally displaced local communities may find it hard to assist them because there are no international child protection laws (Wangeci et al., 2014). Affected children may end up in substitute care such as with relatives or an orphanage, with additional risks involved. When forcefully displaced, children are subjected to crowded camps and settlements, which are insecure, poor and unhealthy, with unclean and unsafe drinking water, thus making them susceptible to disease infections (Pedersen, 2002; Cooper et al., 2011).

The disruption of family and community structures and supports in turn affect children and young people (Obonyo et al., 2008). Carers, families and communities on which children depend on are undermined and weakened (Grayson, 2012; UNICEF, 2014). Thabet et al. (2007) highlight that conflict can compromise basic health care infrastructure, informal social networks and parental responses. At the time of conflict, hospitals and health centres are often destroyed or closed down. Health professionals are killed or flee from the affected zones, leaving many gravely ill children to suffer or die. Likewise, schools and playgrounds can either be destroyed, thus compromising children's educational attainment and resilience (UNICEF, 2005; Obonyo et al.). Many children in conflict-affected areas spend limited time in school or drop-out (UNESCO, 2017), which significantly diminishes their future life prospects; in particular, their access to the labour market, earnings and health outcomes (Justino, 2014). This cycle of deprivation and social exclusion can trigger fresh outbreaks of violent conflicts. In addition, children's moral development can be affected, particularly when children are either forced to kill as part of a military force or to enter into sexual acts for their own survival (UNICEF, 2009b). The impact of conflict is worse in regions where these infrastructures and services are already fragile.

Crucially, conflict leads to violation of children and young people's rights. The systems and structures that should be in place, as set by Convention on the Rights of the Child, are lost. Consequentially, they lose their rights to be nurtured and protected, lead a normal and healthy life, be with their family and community, live in dignity, and ultimately maximise their full potential. Conflict-affected children, especially unaccompanied minors, lose all adult

protection, as well as supports from both their community and government. A substantial number are forcibly recruited as combatants. They are seized from the streets, schools or orphanages by either governments or rebel armies. Other children may join armed groups to receive attention and protection because of poverty and fear respectively. Girls may be forced to provide sexual services, while inexperienced boys and girls are pushed onto the battlefield (UNICEF, 2005; Justino, 2014). Bayer et al. (2007) cite some of the conflict-affected countries such as Sierra Leone, Uganda, Mozambique, Rwanda and Angola, where children have experienced significant impact i.e. forced recruitment of child soldiers has taken place.

In these regions, children suffer serious injuries during and after the conflict. UNICEF (2014) reported that children constitute one third of casualties from landmines and other explosive remnants of war. In Syria, for example, explosive weapons have caused over 70 per cent of child casualties. They further note that, during 2013, more than half of the people killed in Afghanistan by explosives were children. On the other hand, girls and young women frequently experience sexual violence wherever they seek refuge (Thabet et al., 2007; Tamashiro, 2010). Even after the conflict and violence are over, children are at high risk, for example by landmines which failed to detonate. Children in particular are exposed to these dangers because of their lack of information and curiosity to investigate any strange objects (UNICEF, 2005). Carrying any normal activity in the countryside such as going to school, herding animals and fetching water can be dangerous or even fatal (Wangeci et al., 2014). In addition, violence can feed further violence (Dubow et al., 2010). This can take various forms such as corporal punishment and other forms of cruel, inhuman or degrading treatment or torture; sexual violence that involves any sexual activities imposed on a child by an adult; and mental violence that includes psychological maltreatment, emotional abuse or neglect. The cycle of violence continues through the generations once it has taken root (UNICEF, 2014). About 40 percent of countries experience a new conflict or war each decade. Children are at risk of repeated attack or becoming violent themselves if they live in a community that is impoverished and isolated (IDMC, 2014).

Finally, violence erodes economies and societies that children's future depends on (King'ori et al., 2014). Globally, it is estimated that the cost of violence against children is approximately £2 trillion, which is equivalent to 4% loss of the global GDP. In Brazil alone, annual violence against youth is estimated to cost nearly £12 billion. The costs involve government's expenditure in efforts to respond and prevent violence against children

(UNICEF, 2014). The destruction of infrastructure leads to unemployment and further disadvantage (Kabiru et al., 2013). Consequently, parents often fail or struggle to provide and look after their children (UNICEF, 2005). Unemployed youth are likely to be involved in criminal behaviour such as theft, drugs and alcohol abuse; as well as prostitution, particularly girls and young women, in order to earn a living, thus subjecting them to severe health consequences like pregnancy, sexually transmitted infections (HIV/AIDS) and psychological trauma. Conflicts and displacement place children at a higher risk of food deprivation and malnutrition, which make them even more vulnerable to diseases (Cooper et al., 2011). Such humanitarian disasters are compounded by the disruption or collapse of health services (Tamashiro, 2010).

#### **1.6.2.1 Extent of children's exposure to trauma**

The expansion of child-focused research through the use of self-report questionnaires and, particularly, interviews, has captured children's direct recollection of experiences, rather than solely relying on adult views. Murthy and Lakshiminarayana (2006), for example, found that the most common types of traumatic events that Palestinian children were exposed to included witnessing arrests or beatings (11%), watching violence on TV (34%), seeing an injured or killed family member (62%) or other adult (67%), shooting (83%), and attending funerals (95%). Similarly, in another study with Palestinian children by Thabet et al. (2007), children reported experiences of tanks firing on their homes (51%), killing of a close relative (60%), bombing by jetfighters (89%), shelling on the ground (91%), and witnessing mutilated bodies and wounded people on TV (97%). Bayer et al. (2007) highlighted experiences by former Ugandan and Congolese child soldiers that included, witnessing shooting (boys=94.3%, girls=85.7%), witnessing someone being wounded or killed (boys=90.1%, girls=89.3%), being seriously beaten (boys=83%, girls=89.3%), personal property looted (boys=69.5%, girls=89.3%), and having killed someone themselves (boys=61%, girls=21.4%). Similarly, analysis of traumatic experience among children who were primary survivors, those who were directly affected by 2007/2008 post-election violence in the Nakuru County in Kenya, King'ori et al. (2014) found out that hearing people crying for help (97%), forceful displacement (94%), not going to school for a prolonged period (94%), looting of property (91%), sleeping in the cold (89%), witnessing people being injured (86%), seeing people killed (75%), and being deprived of food (64%) were the main traumatic events experienced. In the case of secondary survivors, i.e. those who were indirectly affected by the conflict, witnessing people crying for help (93%), sleeping in the

cold (87%), deprived of food (82%) and their property being destroyed (83%) were frequently reported.

Such serious and often lengthy exposure to trauma can variably affect children across different domains (Grayson, 2012). Their nature of response depends on several factors such as previous trauma exposure, developmental capacity, ethnic and cultural context, pre-existing individual and family problems, and available supports (American Psychological Association, 2008). These factors can be grouped and viewed within the child's social ecology (family, school, peer group and community), intensity of exposure (type, duration, frequency and proximity), involvement (passive victim or perpetrator), attributions about the violence, and emotional and cognitive processing of the experience (Murthy & Lakshiminarayana, 2006; Patel et al., 2008; Dubow et al., 2010). Such factors can thus play both a mediating and moderating a role in the development of mental health problems in childhood and young life.

### **1.6.3 Ethnic conflict and trauma as risk factors for children's wellbeing**

The term *trauma*, originates from the ancient Greek reference to 'injury' or 'wound' (Schauer et al., 2011 p.7). King'ori et al. (2014) define trauma as an overwhelming event that makes an individual unable to cope, thus leading to helplessness. Grayson (2012) defines trauma as an emotional shock that is related to particular incidents or events. According to the American Psychological Association (2008), these incidents, normally referred to as traumatic events, are described as those that cause injury or death, or that threaten one's physical integrity.

Children are exposed to a variety of complex and inter-related traumas during and after conflict (Thabet et al., 2007). These include sexual or physical abuse, loss or separation from loved ones, neglect, forced displacement, and witnessing political or war violence (Agency for Healthcare Research and Quality (AHRQ), 2013; Neugebauer et al., 2009; Briggs et al., 2013; Mwanja & Muola, 2013). The National Child Traumatic Stress Network (NCTSN) (2008) argued that traumatic events can be distinguished on the basis of their nature, individuals involved, and their legal interpretation.

## **1.7 Ethnic conflicts as a risk factor for child mental health problems**

According to the World Health Organisation (2014), mental health is defined as a “state of well-being, rather than the mere absence of disorder, in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community”. Positive mental well-being is fundamental to good quality of life, and equipping children with problem-solving skills, social competence and a sense of purpose. Conversely, mental health problem affects the individuals thinking, feeling or mood and the ability to relate to others.

As already discussed, ethnic conflict leads to a range of negative outcomes that act as risk factors for child mental health problems. These include political (Pedersen, 2002; Huibregtse, 2010), social or economic instability (Morgos et al., 2007; Reed et al., 2011; Matanov et al., 2013); loss of values and poor quality of life (Oyeniyi, 2011). The wellbeing and quality of life of children and young people is particularly affected through these mechanisms (Thabet et al., 2007; Utzinger & Weiss, 2007; Werner, 2012; Matanov et al., 2013; UNICEF, 2014). Exposure to violence is a strong predictor of the development of mental health problems (Dubow et al., 2010). Poor mental health is likely to continue throughout young life into adulthood, in the presence of vulnerabilities and lack of supports (Murphy & Fonagy, 2012).

### **1.7.1 Prevalence of child mental health problems**

It is estimated that between 10 and 20 per cent, or over one billion, of children and adolescents, experience a mental health condition that impacts on their life each year worldwide (Belfer, 2008; Cortina et al., 2012; United Nations, 2014). According to a review by Ellis et al. (2008) and the World Health Organisation (2006), there are comparable findings on the prevalence of child mental health problems from countries such as Switzerland (22.5 %), Spain (21.7 %), USA (21.0 %), Germany (20.7 %), Canada (18.1 %), Ethiopia (17.7 %), Japan (15.0 %), India (12.8 %) and Brazil (12.7 %). Accounting for methodological differences between these studies, primarily in sampling and measures, it appears that the range of prevalence rates is broadly similar in most parts of the world, although their nature and extent can vary depending on each socio-cultural context. Overall, where diagnostic interviews, rather than questionnaires, are used, prevalence rates range between 10-20% and these rates increase with disadvantage and other risk factors.

Mental health problems have been studied in many samples of displaced children and adolescents from various conflict settings. These have predominantly, but not exclusively, focused on post-traumatic stress disorders (PTSD). Again depending on sample characteristics and instruments used (especially if solely relying on questionnaires rather than interviews), established PTSD rates range widely (AHRQ, 2012). For instance, Fasfous et al. (2013) report that about 70% of Kuwaiti children who had lived through the Gulf war showed PTSD symptoms that were classified as between moderate to severe. A similarly high proportion of 75% of Iranian children who had witnessed a public hanging next to their school in Isfahan, reported moderate-to-severe symptoms of PTSD (Attari et al., 2006).

A large body of evidence originates from research in the Palestinian territories and the longstanding regional conflict. These originally estimated prevalence rates, whilst more recent studies have examined the role of specific traumatic events. For example, 41% of children in the Gaza Strip revealed moderate-to-severe PTSD symptoms, which rose to 87% for those exposed to bombings (Qouta et al., 2003; Verdelli et al., 2008; Fasfous et al., 2013). Some researchers differentiated PTSD psychopathology in terms of impairment, thus identifying which children would most benefit from a psychological intervention, considering the limited specialist resources that were available.

Various studies have been conducted to evaluate the impact of conflict and war on mental health of children. A study on Kosovar Albanians aged 15 years or older reported that about 17.1% had significant symptoms of PTSD. The type of conflict, length of exposure and related factors, predominantly resulting from displacement, possibly explains the variation in PTSD rates (Cardozo et al., 2000). In Gaza a study with children and adolescents aged 10-19 years estimated that 32.7% suffered from PTSD symptoms that required treatment, 49.2% from moderate PTSD symptoms, 15.6% from mild PTSD symptoms, and only 2.5% had no symptoms (Sarraj & Qouta, 2005). In Uganda, Ssenyonga et al. (2012) examined PTSD amongst a sample of 89 adolescent Congolese refugees in the camps. Results showed that 49.4% of refugee children met diagnostic criteria for PTSD, particularly among females (75%). Other studies focused on the high comorbidity between PTSD and other mental health problems, particularly depression and anxiety. For example, in a longitudinal study with 40 Cambodian refugees, there was 50% prevalence of PTSD and 56% prevalence of depression, with a high overlap between the two conditions, four years after leaving refugee camps in Cambodia (Hinton et al., 2009). Similarly, in a study with Nepalese former child soldiers, the



majority were found to be affected by mental health problems, i.e. 55.3% reported PTSD, 53.2% depression and 46.1% an anxiety disorder, with a high degree of comorbidity (Kohrt et al., 2008).

As already mentioned, a number of methodological reasons account for differences in the established rates of child mental health problems, mainly in sampling and instruments used (Kieling, 2011; Betancourt et al., 2013; Kohrt, 2013). Fasfous et al. (2013) argue that cultural differences and the type of conflict are important factors too. Reed et al. (2012) note that securing representative samples is particularly difficult, because of the constant movement of displaced people and operating in dangerous conflict zones. Recent studies indicated a different pathway to depression and often anxiety, which were associated with post-displacement factors such as poverty, living in refugee camps or impaired parenting (Eruiyar et al., 2017). Nevertheless, the overall consistent finding from the literature is the strong association between exposure to war traumatic events and PTSD (Attari et al., 2006; Fasfous et al., 2013), often with a cumulative and dose-effect relationship (AHRQ, 2012).

### **1.7.2 Mechanisms that underpin the impact of ethnic conflict on child mental health**

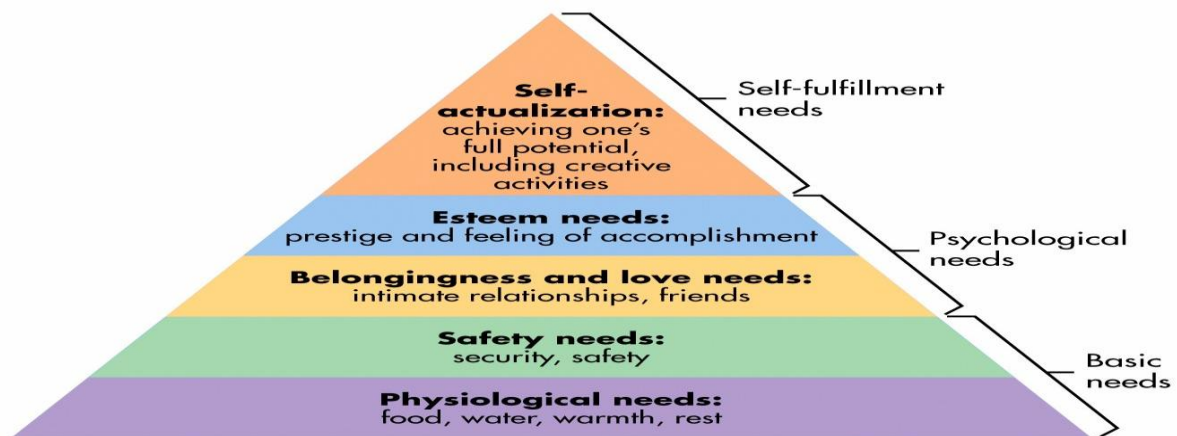
The association between ethnic conflict and CAMH problems is complex (Sambanis & Shayo, 2013). Various factors contribute to this complexity. These include, but are not limited to: differences in the individual's emotional and cognitive ability to process their experiences, response, degree of involvement (passive victim, soldier), and exposure (type, duration, frequency, proximity) to the conflict (Barber, 2008; Dubow et al., 2010).

As with other vulnerable groups, it is also important to consider the dynamic interaction between risk and protective factors (Table 1.2 - Reed et al., 2012; Werner, 2012). The identification of these factors will guide the establishment of preventive and responsive strategies (O'Connell et al., 2009). Such strategies aim at the enhancement of positive factors and the minimisation of those that place children at risk (Lieberman & De Martino, 2006; Betancourt & Khan, 2008). A risk factor increases the probability that a child will develop an adverse outcome (AHRQ, 2013), including mental health problems (Lieberman & De Martino, 2006). In contrast, a protective factor decreases the potential harmful effect of a risk factor, thus mitigating the possibility of developing mental health problems, but also strengthens the child's resilience in dealing with similar stressors in the future (Betancourt et al., 2010; Kids Matter, 2013).

Risk factors often cluster together and interact with each other. They may be found in the individual, the environment, or the individual's capacity to respond to the demands or requirements of the environment; whilst others involve the family, neighbourhood, school, or peer group (Essex et al., 2006; Wille et al., 2008). The frequency and stability of risk factors may vary, depending on children's constitution such as gender, temperament, and developmental age (Galambos et al., 2004; Costello et al., 2008). Their effects on children can also be hierarchically different. Different theories have tried to encompass such multiplicity of risk factors. A particularly influential theory for practice and services has been Maslow's hierarchy of needs (Maslow, 1943).

**Figure 1.3**

**Maslow's hierarchy of needs (Maslow, 1943)**



Risk factors can affect a child's self-development by influencing all these levels (Ellerby, 2016). Individuals are thus perceived to be motivated by needs (physiological, love or belonging, esteem and self-actualization) that are hierarchical. In this process, they initially thrive to achieve lower needs before seeking those available at the next level of the pyramid (Gorman, 2010). According to this theory, a child will not achieve positive mental health or self-actualization without progression through these stages (Shives, 2008). Instead they may fail to enjoy life, develop self-concepts or relate well to other people and their environment. Therefore, failure to have these needs met at the respective stages of the hierarchy may result in mental problems. In contrast, interventions and services should target children's needs in a stepped (or tiered) order in order to help them achieve their potential (Huitt, 2007).

### 1.7.3 Key risk and protective factors for mental health problems in childhood

The main risk and protective factors that influence child mental health are highlighted in Table 1.2 (Mattejat & Remschmidt, 2008; O’Connell et al., 2009; Herrenkohl et al., 2012; WHO, 2012). These will be discussed in more detail, starting with a brief overview on knowledge related to the general population, followed by specific findings, where available, from studies with internally displaced or refugee children in LICs.

**Table 1.2**

#### **Risk and protective factors for child mental health problems**

<b>Category of factors</b>	<b>Risk factors</b>	<b>Protective factors</b>
<b>Individual factors</b>	<ul style="list-style-type: none"> <li>- Genetic</li> <li>- Physical and mental illness/impairment</li> <li>- Communication difficulties</li> <li>- Difficult temperament</li> <li>- Low self-esteem</li> <li>- Lack of problem-solving skills</li> <li>- Low intelligence</li> </ul>	<ul style="list-style-type: none"> <li>- Biological resilience,</li> <li>- Good problem-solving skills</li> <li>- Secure attachment</li> <li>- Good communication skills</li> <li>- Humour / religious faith</li> <li>- Positive physical development</li> <li>- Academic achievement/intellectual development</li> <li>- High self-esteem</li> <li>- Good coping skills and problem-solving skills</li> <li>- Optimistic outlook on life</li> <li>- Good attachment to parents or carers</li> <li>- Engagement in meaningful activities</li> <li>- Life skills and social competence</li> <li>- Cultural identity and connection</li> <li>- Positive self-concept and personal qualities</li> </ul>
<b>Family factors</b>	<ul style="list-style-type: none"> <li>- Family history of the problem behaviour</li> <li>- Family conflict</li> <li>- Death and loss</li> <li>- Physical, sexual and emotional abuse</li> <li>- Parental unemployment</li> <li>- Impaired parenting</li> <li>- Disrupted attachment with parents</li> <li>- Parent/s with mental illness or drug substance abuse</li> </ul>	<ul style="list-style-type: none"> <li>- Secure attachment</li> <li>- Family involvement in activities</li> <li>- Family harmony and stability</li> <li>- Strong family values</li> <li>- Family connectedness</li> <li>- Positive parenting style</li> </ul>
<b>School factors</b>	<ul style="list-style-type: none"> <li>- Poor academic attainment</li> <li>- Bullying in school</li> <li>- Racial tension/harassment</li> <li>- Peer rejection</li> <li>- School-level stressful or traumatic events</li> <li>- Loss of close relationship or friends</li> <li>- Lack of personal commitment to</li> </ul>	<ul style="list-style-type: none"> <li>- Schools with high rates of achievement, emotional literacy and whole school ethos</li> <li>- Lack of bullying</li> <li>- Range of positive sport/leisure activities</li> <li>- Presence of mentors and support</li> <li>- Opportunities for engagement within school</li> </ul>

Category of factors	Risk factors	Protective factors
	school	<ul style="list-style-type: none"> <li>- Physical and psychological safety</li> <li>- Connected to school</li> <li>- Caring school climate</li> <li>- Student participation in extracurricular activities</li> </ul>
<b>Community and cultural factors</b>	<ul style="list-style-type: none"> <li>- Social or cultural discrimination</li> <li>- Socioeconomic disadvantage</li> <li>- Neighbourhood violence and crime,</li> <li>- Lack of recreational opportunities</li> <li>- Availability of alcohol/drugs</li> <li>- Lack of community supports</li> <li>- Transitions and mobility</li> <li>- Low neighbourhood attachment and community disorganisation</li> </ul>	<ul style="list-style-type: none"> <li>- Attachment to and participation in community networks</li> <li>- Sense of connectedness to community</li> <li>- Economic security</li> <li>- Strong cultural identity and ethnic pride</li> <li>- Community cultural norms against violence</li> <li>- Safe, supportive, connected neighbourhood</li> <li>- Strong community infrastructure</li> <li>- Faith, religion or spirituality</li> </ul>
<b>Service and societal factors</b>	<ul style="list-style-type: none"> <li>- Economic recession</li> <li>- Housing shortage</li> <li>- Social exclusion</li> <li>- Limited access to services</li> </ul>	<ul style="list-style-type: none"> <li>- 'Inclusive' policies</li> <li>- Local, state policies and practices that support healthy norms and child-youth programmes</li> <li>- Availability of and access to appropriate services</li> </ul>

### 1.7.3.1 Risk factors

#### 1.7.3.1.1 Individual factors

##### 1.7.3.1.1.1 Age

Previous studies have found out that 8% of primary (5-10 years) 12% of secondary school (11-16 years) age children and young people respectively have at least one clinically diagnosable mental health problem or a more severe disorder (Green et al., 2004). Consistent with other studies, there are up to 25% of children showing signs of such mental health problems, with more than half of these children continuing through into their adulthood (Kieling, 2011). In as much as it has been noted that 50% of these problems emerge before the age of 14 years, with 75% by the age of 25 years (Kessler et al., 2005; Kleintjes et al., 2010; Kelly et al., 2012), the overall findings from the literature on age as a risk factor to children's mental health problems remains inconclusive. Some evidence suggests that younger children are more vulnerable to developing certain mental health problems during stressful situations (Mels et al., 2009), while other mental health problems increase with age (Betancourt & Kahn, 2008).

A meta-analysis of risk factors for PTSD in children reported that these increased with age, though this pattern only applied to females (Trickey et al., 2012). This finding has been associated with various reasons such as exposure and discrimination (Mels et al., 2009). For example, a study with Palestinian children indicated that older youth were exposed to the highest levels of ethnic political conflict or violence than younger children (Dubow et al., 2012). Some older children become directly involved in the conflict, especially by being recruited as child soldiers (Bayer et al., 2007). Older children are likely to be exposed to and witness more traumatic events (Moussa et al., 2015). They are also likely to be more vulnerable to perceive discrimination and victimization against them than younger children (Qouta et al., 2008a). Consistent with the literature, these observations have been associated with higher rates of PTSD symptoms (Mels et al., 2010) and increased psychological distress (Oxman-Martinez et al., 2012).

It is argued that older children, particularly during their transition to adolescence, struggle with their autonomy, mobility, identity formation and social rank position, all of which can place them at greater risk (Halevi et al., 2016). Additionally, in many cultures older children are likely to assume adults' responsibilities, some which expose them to further risks, especially after family disruption (Reed et al., 2012). In cases of political violence or conflict, for instance in the Gaza region, youths are more likely to be involved in activism and conflict by distributing leaflets, demonstrating or throwing stones (Barber, 2008).

However on the contrary, some studies report that younger children, i.e. less than 12 years old (Reed et al., 2012), are more vulnerable to fearfulness and apprehension than old ones. Younger children have more limited cognitive, social and emotional abilities to mitigate any traumatic experiences they encounter (Mels et al., 2010), compared to older children, who have better cognitive skills to process these experiences (Halevi et al., 2016). They have difficulties in comprehension and lack verbal maturity to communicate and express their emotions regarding the traumatic events that they have faced (Slone & Mann, 2016). It is also argued that younger children are easier targets for abuse, exploitation and manipulation (Bartels et al., 2010).

These findings have implications for developing mental health interventions for children affected by conflict and war. Factors such as developmental stage, emotional maturity and

cognitive levels have to be taken into consideration (Kar, 2009; Sheikh et al., 2016), as children develop different coping styles as a function of age (Moreland & Dumas, 2008).

#### **1.7.3.1.1.2 Gender**

The effects of gender and exposure to traumatic experiences on children's mental health after displacement are inconsistent (Drury & Williams, 2012). Although both girls and boys are exposed to war-related conflicts and their severe consequences leading to displacement, they are likely to be vulnerable to the main types of mental health problems, i.e. PTSD, depression and anxiety, in different ways (Araya et al., 2007). Some studies report that boys have higher PTSD rates than girls (Qouta et al., 2008a), while others report higher rates among girls (Dawes & Flisher, 2009) or no gender effect (Lustig et al., 2004; Morgos et al., 2007). For instance, a study of school children in Afghanistan detected higher vulnerability for PTSD among males (Catan et al., 2009), in contrast with the reverse trend in a study with adolescents who had experienced war in the Democratic Republic of Congo (Mel et al., 2009).

These contradictory findings could be attributed to geographical and cultural variations of displacement, consequently the nature, mechanisms and extent that these children are exposed to traumatic experiences (Drury & Williams, 2012). For instance, where girls report more severe levels of traumatic reactions than boys, it can be associated with gender differences in levels of disclosure of personal information to a third party. Girls are more ready to express their feelings and admit to any symptomatic effects. In some cultures such as in Africa boys do not need to speak out the difficulties they go through (Morgos et al., 2007). Girls are more likely to experience sexual or physical violence at home (Araya et al., 2007), or to witness atrocities befalling their family members or close friends such as seeing others being raped, abducted or killed (Qouta et al., 2008b; Chen, 2010; Ssenyonga et al., 2012; Moussa et al., 2015). Unaccompanied female children have also been reported to experience more frequent harsh events than their male counterparts (Drury & Williams, 2012). In cases where boys report more PTSD symptoms than girls, it has been argued that they are prone to more violent exposure and victimization (Copeland-Linder et al., 2010). Among Arab youth in the Middle East, males are more likely to be exposed to witnessing assaults with weapons or beatings than females (Butcher, et al., 2015). They have a greater opportunity for exposure to activism and involvement in conflicts (Dubow et al., 2012), for example, Palestinian boys were more likely to be exposed to higher levels of ethnic-political violence (Thabet &

Vostanis, 2009). In Uganda and other African countries, boys are at high risk of being recruited as combatant soldiers (Klasen et al., 2010) as opposed to girls, who are likely to be kept indoors during the time of conflict (Catan et al., 2009). The place of stay during and after the conflict also influences gender differences in PTSD (Mel et al., 2009). Males have been found to be more vulnerable in refugee or IDP camps compared to females (Ssenyonga et al., 2012). Another potential explanation related to gender differences in coping skills, with females using more affective and social strategies (Moreland & Dumas, 2008; Quiroga et al., 2017) as buffers to stressors, in contrast with males are less likely to seek and access social supports (Betancourt & Khan, 2008; Ellis et al., 2008; Mels et al., 2010).

#### **1.7.3.1.1.3 Physical illness**

Poor physical health has been linked to an increased risk of developing mental health problems in various populations (Koopman & Lamers, 2005; Turnip & Hauff, 2007; Fazel et al., 2012; Naylor et al., 2012). During conflict and war, children experience different atrocities such as torture, physical injuries (being beaten up, or being wounded by gunshots and landmines), sexually assault and rape (Drury & Williams, 2012). For instance, children who are recruited to armed groups are more vulnerable, because they are forced to becoming domestic servants or combatants, or being subjected to sexual violence (IDMC, 2009). Resulting injuries may lead to arrange of physical and psychosocial impairments (Tamarisho, 2007; Betancourt et al., 2008; Kherallah et al., 2012). Similarly, displaced children with chronic diseases such as diabetes, cancer, HIV or tuberculosis have limited or no access to medical care, thus increasing the risk of acute health conditions, psychosocial maladjustment and mortality (Aburas et al., 2018).

Children with physical illness or disability are exposed to additional risks during and after displacement. They are especially vulnerable to protection risks such as being physically and sexually abused, exploited, harassed, discriminated and neglected (Reilly, 2010); as suffering malnutrition and starvation (Aburas et al., 2018). For instance, Somali children with disabilities living in refugee camps in Kenya, were found to be exposed to physical abuse and neglect. This included being tied up, stoned, sexually abused, excluded from accessing education, abandoned or neglected by family members (Reilly, 2010).

Lack of infrastructure such as appropriate physical layout of camps restricts even further the mobility of disabled children in accessing latrines, bathing facilities and social amenities, thus compounding their psychological distress (Reilly, 2010). For example, a study with Afghani young people aged 15 years and above aimed to understand exposure to trauma in relation to having a physical disability. The most common traumatic events experienced by the respondents were: lack of food, water and shelter (56.1% for non-disabled vs 69.7% for disabled), depressive (67.7% vs 71.7%), and anxiety symptoms (72.2% vs 84.6%). Disabled youth also had significantly lower social functioning than their non-disabled peers, although there was no difference in the prevalence of PTSD symptoms (42% in both groups), (Cardozo et al., 2004). These findings are consistent with the larger body of literature on the association between chronic physical illness or disability and mental health. Underlying reasons include stigma, social isolation, poor social adjustment, and low self-worth (Turnip & Hauff, 2007; Reed et al., 2012).

#### **1.7.3.1.1.4 Temperament**

Temperament refers to a range of biologically or constitutionally based individual differences in functions such as reactivity and self-regulation that are influenced over time by heredity, maturation and experience (Crawford et al., 2011; Shigeto et al., 2014). Children have different ways through which they understand emotions. When they are faced with stressful events, their vulnerability may increase, depending on their temperamental traits such as in self-regulation (effortful control) and reactivity (negative affect) (Crawford et al., 2011). The effect of temperament can be influenced further through interactions between intrinsic traits and environmental factors such as family, peer or community violence (Saudino et al., 2005; Schermerhorn et al., 2013). For example, low effort control has been linked to poor social functioning and inter-parental conflict (David & Murphy, 2007), while poor self-regulation has been associated with affiliation to deviant peers and externalizing problems (Gardner et al., 2008). Although there is limited literature on the effect of temperament on displaced children, it is well documented that associated traumatic events like family disruption, socioeconomic challenges or peer rejection that children often experience during conflict and war, adversely affect their capacity to self-regulate and respond adaptively in the face of adversities (Araya et al., 2007; Mel et al., 2010; Reed et al., 2012).

Difficult temperament in children is associated with negative emotionality, anger proneness or poor effortful control (Schermerhorn et al., 2013). These significantly constrain children from taking advantage of any social support opportunities that are available, because they



become detached and lose their sense of belonging (Mathiesen & Prior, 2006). This can further increase their vulnerability through emotional dysregulation expressed through aggression, and misinterpreted as conduct-related by adults and peers (Kochanska & Kim, 2013).

#### **1.7.3.1.1.5 Maladaptive coping strategies**

Coping refers to an individual's response to stressful or negative events. Their response can be internal or external, and processed through cognitions or behaviours to help them tolerate or manage the situation (Araya et al., 2007). There are several theories and classifications of coping styles and strategies. A commonly used system includes four types of coping strategies in children: the way they react to a stressor (e.g. emotional expression, problem-solving, and emotion regulation); adapt (positive thinking, acceptance, cognitive restructuring and distraction); disengage (avoidance, wishful thinking and denial); and involuntary stress responses (intrusive thoughts, arousal and impulsive actions) (Drury & Williams, 2012). In the event of being faced with a stressful situation, these coping categories fall into the domains which enable one to seek social support, seeing a positive light in it, solving the problem logically, falling back on their emotions to reflect, or detaching physically and mentally from it (Moreland & Dumas, 2008; Dubow et al., 2012; Seguin & Roberts, 2017).

Many children affected by conflict and war employ maladaptive strategies to curb trauma, due to the lack of psychosocial supports and the presence of other confounding risk factors (Cherewick et al., 2015). These complex relationships were shown in a study with displaced children and families in Afghanistan. Poor coping skills which could not allow them to express feelings such as fear or sadness were inter-linked with interpersonal difficulties and lack of friendships (Kamal & Danish, 2013). In Kenya, children with emotional dysregulation in a post-conflict setting were more likely to have reduced pro-social behaviour and increased aggression (Kithakye et al., 2010). Both studies thus showed how inherent and learnt coping strategies interacted with other environmental vulnerabilities.

The consequences of maladaptive strategies further compound this chain of adverse outcomes. For example, young people aged 10–15 years who had been exposed to violence in eastern DRC, were more likely to use risk-taking behaviours. These included seeking revenge, violence, drinking, stealing, fighting, and prostitution, all which were posing

additional risks to both their physical and mental health (Cherewick et al., 2015). Similarly, in Sierra Leone a study of children aged between 10–17 years investigated the impact of coping strategies on their mental health and found that many children used avoidance, i.e. escape or denial, and this was linked to less adaptive behaviours. About 98% of the children used alcohol or drugs as a coping strategy, which resulted in a disproportionate rise in psychiatric hospital admissions, with up to 90% being related to drug use (Cummings et al., 2017). In contrast, other studies have shown that coping strategies can be enhanced through the appropriate levels of supports and interventions (Moreland & Dumas, 2008). These will be discussed in more detail in the next chapter.

### **1.7.3.1.2 Family factors**

#### **1.7.3.1.2.1 Parental mental illness**

Numerous studies have established the strong association between parental and child ill mental health (Lustig et al., 2004; Bayer et al., 2011). This association can be bi-directional or be underpinned by confounding factors such as domestic violence (Halevi et al., 2016). In the context of conflict and war, parents are traumatised themselves, and this can compromise their parenting capacity, thus exacerbate children's distress (Dubow et al., 2012).

Parental mental health problems have been shown to be related to children's both internalizing (emotional) and externalizing (behavioural) problems, although through different pathways (Slone & Mann, 2016). For instance, a study on refugee adolescents in Ethiopia examined the influence of caregiver mental health on children's mental health while living in the camps. The results indicated that caregiver distress was significantly associated with children's both internalizing and externalizing symptoms (Betancourt et al., 2012). These findings are consistent with other studies that have assessed the link between parental or caregiver and child psychological distress in conflict and war-affected settings such as Palestine (Thabet et al., 2008) and Indonesia (Catani et al., 2008).

Recent years have seen an increase in studies on how parenting skills, thus their protective function, are diminished in these situations (Halevi et al., 2016), and how this is related to parents' response to trauma (Van Ee et al., 2012). The findings have begun to inform the development of suitable interventions for parents and families (Catani et al., 2008; Betancourt

et al., 2012). The specific parental factors and mechanisms involved are discussed below in more detail.

#### **1.7.3.1.2.2 Impaired parenting capacity**

Parenting style is a construct that describes the different types of attitudes and ways in which parents approach their relationship with their child. Different frameworks and classifications have been put forward over the years, with variable cultural influences. One commonly used system includes three types of parental styles, i.e. permissive, authoritarian and authoritative (Bolghan-Abadi et al., 2011). A permissive style promotes children's autonomy and empowers them to develop self-control. Parents avoid confrontation by tending to be warm and supportive (Bayrami, 2009). An authoritative style adopts good nurturing skills, with moderate parental control. Parents set reasonable, re-enforceable and achievable limits, with positive restriction to their children. These allow children to attain self-esteem and increasingly become self-reliant (Dwairy & Menshar, 2006).

In contrast, the authoritarian rearing style is characterised by a high degree of restriction, severe control, harsh and punitive discipline. Evidence shows that this style can negatively influence a range of child outcomes such as self-esteem, aggression and emotional functioning (Mousavi et al., 2016). Punitive practices such as hitting (spanking and slapping), threatening, and scolding (Roche et al., 2011) are linked to children exhibiting aggression, antisocial behaviour and other mental health problems (Bender et al., 2007; Catani et al., 2008; Bayer et al., 2011). Both these variables can themselves be influenced by family factors such as domestic violence, mental illness and drug or alcohol abuse, all of which are inter-linked (Bender et al., 2007; Roche et al., 2011).

Parenting style is itself adversely affected by trauma and associated factors such as lack of social support, which in turn increases further children's vulnerability (Thabet et al., 2009). A number of studies have shown a correlation between parents' perceived need for help and their children's level of distress (Huh et al., 2006). For instance, in a study on families exposed to violence during the Israeli–Palestinian political conflict, where children experienced repeated rocket attacks, low maternal support was associated with high levels of child mental health problems such as PTSD, in particular avoidance symptoms (Slone & Mann, 2016). Parenting has many universal features, but is also subject to sociocultural influences.

#### **1.7.3.1.2.3 Cultural factors in child rearing**

Cultural beliefs and behaviours can also shape the way parents care for their children. Consequently, children's experiences with their parents, within a given cultural context, enhance their roles and competence within that society (Bornstein, 2012). For example, in Africa and Asia, parents, especially mothers, tend to maintain close physical proximity to their children. In western countries, (America and Europe) parents discourage dependence in children, instead they are more prone to encourage them to act autonomously and gain control over their environment (Bornstein et al., 2012).

Parenting styles such as discipline, can also be interpreted and experienced by the parent according to the cultural context (Le et al., 2010). For example, in a study using longitudinal data to explore reciprocity and contextual variations in the associations between punitive discipline and youth adjustment from early to late adolescence in US low-income families, a significant cultural variation was established. Results indicated that in the European American community, punitive discipline was linked to more externalizing behaviours in adolescents, unlike in African American families (Roche et al., 2011). Despite the evidence on the association between negative parenting and child outcomes, some communities still hold beliefs that mild to moderate punitive discipline such as spanking and slapping are not harmful for children, while other cultures increasingly reject these approaches (Lansford et al., 2004; Bender et al., 2007). Culturally constructed beliefs can thus be powerful determinants for parents on how they look after their children (Bornstein, 2012).

#### **1.7.3.1.2.4 Domestic violence and conflict**

Domestic violence is characterized by a range of abusive behaviours (i.e. emotional abuse, physical aggression, economic deprivation, sexual abuse and controlling behaviour) by one or both partners in a relationship, although predominantly by the male partner (Médecins Sans Frontière, 2009). It commonly increases with disadvantage, and with high levels of community violence and conflict, especially in developing countries (Archer, 2006). For instance a study in India reported that 42% of all female respondents indicated experiencing some kind of violence (of whom 69% reported emotional abuse and 29% reported physical violence) at some point (Chandrasekaran et al., 2007).

In many societies, domestic violence is still regarded as a private matter, because of perceived socio-cultural norms and structures which the perpetrators selectively fall upon to

normalise it (Fawole et al., 2005). In parts of some cultures, it can still be viewed as acceptable for men to beat their wives (Jewkes et al., 2002; Koenig et al., 2003; WHO, 2010a). In addition, women often find it shameful and stigmatising to report the abuse and to seeking medical attention or other help, which increases their distress and sense of rejection (Chandrasekaran et al., 2007). In turn, mothers' vulnerability and ill mental health, impact on their ability to protect their children and to execute their usual parenting functions. These mechanisms have been well established in explaining the consequent impact on their children's mental health, and the increased rates of child mental health problems in domestic violence situations (Catani et al., 2008; Betancourt et al., 2012; Slone & Mann, 2016).

#### **1.7.3.1.2.4 Separation from caregivers**

In the aftermath of ethnic/political violence that results in displacement, children are often separated from their parents or caregivers, whether temporarily or permanently. These children may be referred to as 'unaccompanied minors', 'homeless', 'abandoned', 'separated', 'orphans' or 'left-behind' children (Derluyn et al., 2009; Reed et al., 2012; Vostanis, 2014; Wang et al., 2017). All these terms were considered in this literature review. Children may be separated or left on their own when parents or caregivers join the war, where they may end up killed or arrested. In the process of running away or being resettled, children may travel as unaccompanied without adult supervision or any identifiable guardians (Kirmayer et al., 2011; Drury & Williams, 2012; Badri et al., 2013).

Separation of children from their parents or caregivers, either when left behind or travelling unaccompanied without adult guidance or supervision, in itself is an important risk for physical and sexual exploitation, illegal labour, or forced to fight as child soldiers (Bayer et al., 2007; Derluyn et al., 2009). Many end up living on the streets or taken into care (Reed et al., 2012). All these reasons explain why all studies with unaccompanied displaced or refugee children reported even higher rates of mental health problems than similar groups of children living with their displaced or refugee parents. This even applies in non-conflict settings. For instance, a recent study in China compared the psychosocial adjustment of left-behind children and those who migrated with their parents or caregivers from rural areas to cities. The findings showed that unaccompanied children significantly reported higher levels of mental health symptoms, particularly of emotional nature, and lower levels of pro-social behaviours than migrant children (Wang et al., 2017). Also evidence from Syria shows that,

within the last six-years of war in the country, children who were separated from their families suffered significant psychiatric impact (UNICEF, 2017).

The reasons why these children are so vulnerable are obvious, nevertheless these are also complex and difficult to address in order to protect them. Children lack the crucial buffers against stressors (Morgos et al., 2007); their ability to self-regulate because they lack emotional, social, physical and financial support provided by their parents or caregivers; and the protection offered by social networks and education (Derluyn et al., 2009; Kirmayer et al., 2011). These multiple factors mediate exposure to traumatic events, can thus lead to the development of mental health problems such as PTSD, depression and anxiety (Thabet et al., 2004; Badri et al., 2013; Seguin & Roberts, 2017).

### **1.7.3.1.3 Community risk factors**

#### **1.7.3.1.3.1 Socio-economic factors**

Socioeconomic disadvantage is a well-established risk factor for children's physical and mental health (Lorant et al., 2007; Benova et al., 2015). Poverty is linked with several other risk factors such as disrupted social networks, inadequate education, shortage of food, malnutrition, poor housing, and violent communities all of which increase the likelihood of mental health problems (Patel et al., 2007a; Saxena et al., 2007). Poverty also often leads to social isolation and further loss of protective factors for children (Funk et al., 2012). Familial economic pressures and concerns adversely impact of parents' capacity to care for them (Le et al., 2010; Nasıroğlu & Çeri, 2016), or to access basic needs (Oxman-Martinez et al., 2012). Discrimination at school and in the community add to their burden (Gureje & Jenkins, 2007). Vice versa, children and families with mental health problems are more likely to end up in poverty because of difficulties in functioning independently, remaining in education, or holding on to housing and employment (Lund et al., 2011; Ehiemua, 2014).

Many studies have investigated how socioeconomic factors influences children's mental health, including in conflict settings (Drury & Williams, 2012; Amuyunzu-Nyamongo, 2013; Reiss, 2013; Reed et al., 2014). A study in Egypt investigated the presence of child mental health symptoms after the political revolution in relation to perceptions of the political impact and socio-economic status. The interaction between these two factors, i.e. perceived political impact of the conflict and lower socioeconomic status were associated with higher prevalence of PTSD, depressive and anxiety symptoms (Moussa et al., 2015). Similarly, Bosnian

adolescent refugees showed more depressive symptoms and lower self-esteem associated to lower socioeconomic status, after adjusting for trauma exposure (Sujoldžić et al., 2006). Internally displaced Congolese children reported experiencing insufficient food and medical care because of poverty compared to their peers who were not displaced, which added to the cumulative effect on their well-being (Mels et al., 2010).

#### **1.7.3.1.3.2 Social, ethnic and cultural discrimination**

Discrimination is the unfair treatment of individuals on the basis of recognition of characteristics such as ethnicity, race, culture, socio economic class, age or gender (Çelebi et al., 2017). Children go through major changes in many aspects of their lives after being displaced by ethnic conflict and war. These changes include language barriers, school moves, religious and cultural traditions (Jensen et al., 2014). Such changes and conflicts that they undergo, many of which are discriminatory, additionally affect their adjustment in their new environment (Lustig et al., 2004; Montgomery & Foldspang, 2008). They may consequently struggle in renegotiating their cultural identity, learning new ways of life, communicating and help-seeking.

Research has shown that social exclusion is common among displaced and refugee children (Cortes & Buchanan, 2007; Mels et al., 2010), and that this acts as an important predictor of ill mental health (Kirmayer et al., 2011; Oxman-Martinez et al., 2012). Betancourt et al. (2010) conducted a study in Sierra Leone where they examined the role that discrimination played in the association between war trauma exposure and mental health problems such as aggression, depressive and anxiety symptoms. They found out that discrimination was inversely associated with family and community acceptance, for example following rape, and increased the risk of depression. Another study with North Korean refugees who had been resettled in South Korea examined the relationship between perceived discrimination and depressive symptoms. Results showed that perception of being discriminated against was linked to higher rates of depressive symptoms (Um et al., 2015). Similar findings have been established by other studies in refugee populations (Cortes & Buchanan, 2007; Montgomery & Foldspang, 2008; Mels et al., 2010; Betancourt et al., 2010; Çelebi et al., 2017). There has been less research on the mechanisms that underpin this association. Perceived discrimination such as lack of acceptance and integration affects children's self-esteem. When children lose their sense of belonging and security, they may find it increasingly difficult to self-regulate their emotions, a factor that leads to elevated levels of mental health problems. In addition,

social exclusion and marginalization compounded by discrimination detach children from social relations and institutions, thus prevent those at risks of mental health problems from seeking early support and treatment (Oxman-Martinez et al., 2012; Jensen et al., 2014; Um et al., 2015).

#### **1.7.3.1.3.3 Community disorganization**

Community disorganization implies a state of inadequacy and disunity. The state provides a platform for free play to the forces of deterioration in community life. Disorganization in the community exposes children to other traumatic experiences even after being displaced (Chen, 2010). Resettlement can be affected by structural barriers and inequalities aggravated by new policies and practices, existing ethno-cultural community organizations and different religious institutions opportunities (Kirmayer et al., 2011). Displaced children encounter difficulties in having their identity and credentials recognised, thus creating uncertainty on their future. Lack of identity further denies them the opportunity to register and join a new school, or to seek health care.

Life in refugee camps, where temporal settlement takes place, is often unbearable. These settings have poor resources such as shortage of shelter, lack of clean drinking water, poor sanitation and hygiene. The poorly constructed shelters are overcrowded and do not guarantee security for children. Lack of latrines, filthy environment without soap and other detergents pose health threats (Norwegian Refugee Council, 2014; Getanda et al., 2015). In a survey of stressful experiences and reactions among young Sudanese refugees in a Kenyan refugee camp, lack of basic needs such as adequate water, food, and medical care were the key concerns raised (Lustig et al., 2004). Among Afghan refugee children living in different camps in Pakistan the prevalence of mental health problems was higher for those living in poor camp establishments (Reed et al., 2012).

Disorganization in the community exposes children to violent threats too. They are exposed to witnessing violent acts and personal victimization, hence learn to be violent themselves (Chen, 2010). For instance, in a study investigating the impact of neighbourhood disorganization on exposure to violence among youth, higher levels of exposure to community violence were linked to higher levels of re-traumatization, and to loss of social relationships and supports (Butcher et al., 2015). Therefore, although resettlement instils optimism, it also carries additional risks and barriers for children. These can be exacerbated



when their initial hopes and expectations are not realized by the host community or country, this can lead to disillusionment and demoralization, followed by mental health problems such as depression (Noh et al., 2007). New events such as victimization can evoke memories loss and past trauma, thus a relapse of PTSD and anxiety (Kirmayer et al., 2011).

#### **1.7.3.1.3.4 Peer rejection**

Relationships are important in children's lives, because they form the context for their social learning (Dodge et al., 2003; Nesdale & Duffy, 2011). Peer relationship difficulties are associated with a range of child mental health problems (Diab et al., 2014). Social rejection in children can be viewed as a continuum of adverse experiences that children go through, ranging from difficulties in forming and maintaining friendships to complete rejection. Social rejection may include coercion, physical harm, social banning and bullying (Beeri & Lev-Wiesel, 2012). War trauma significantly disrupts children's social relationships (Hodes et al., 2008). This is exacerbated when children are rejected by their own peers following violence such as for ethnic reasons (Diab, 2011). In a study among 227 Palestinian children, aged between 10–14 years, there were increased sibling rivalry and deteriorating friendships, particularly among females, following exposure to severe military trauma (Peltonen et al., 2010).

These findings can be attributed to various reasons. Problematic relationships in children can impact on their social life for a long time. Peer rejection may cause negative information processing. If children have been withdrawn from social contacts and have developed emotional regulatory problems, they can develop hostile cue interpretation of information, resulting in increased aggressive behaviour, social avoidance, impaired social skills, depression and suicidal thoughts (Beeri & Lev-Wiesel, 2012). When children are rejected they lose sense of belonging in the community (Cortes & Buchanan, 2007). They feel insecure and lack confidence in themselves and others, all factors compounding their psychological distress. The situation becomes worse when isolated as they develop negative expectations about future relationships, thus engage in antisocial behaviour (Dodge et al., 2003; Nesdale & Duffy, 2011).

#### **1.7.3.1.3.5 School-related factors**

Schools can be a source of several risk factors such as bullying, violence, language barriers and poor academic performance for children who have been displaced due to ethnic conflict and war. If these risks are not addressed, these can result in discrimination and exclusion, with a circular and detrimental impact on school adjustment (Chen et al., 2010; Side & Johnson, 2014). For instance, bullying in some cultures may not be perceived as a problem. Palestinian refugee children, for example, perceived bullying as an acceptable behaviour, because they were continuously exposed to violent acts like beatings, and use of knives and guns in the refugee camps (Beydoun et al., 2017). However, when properly assessed, the incidence of bullying in such environments, as well as in the community, is very high. In South Africa, refugee and migrant children reported frequent incidents of bullying through physical and verbal abuse. These attitudes and behaviours are not confined to peers, but have been reported to be shared and exhibited by adults, even teachers (Crush & Tawodzera, 2014).

Although there is limited literature on school-based risk factors for displaced children, these findings are consistent with other studies which have been conducted with different populations. Findings from these studies were thus considered relevant to this study. For example, in a study that examined relationships between perceived ethnic discrimination, psychosocial functioning and academic performance among Asian immigrant children, perceived discrimination by peers was reported by 22.9% of the participants in relation to unfair treatment they regularly experienced at school. The levels of psychological distress were significantly higher among the discriminated children (Oxman-Martinez et al., 2012). Similarly, in a study of Chinese immigrant children aged 8–13 and living in Canada, participants reported experiencing discrimination in the classroom mainly on the basis of their racial and linguistic differences, and these perceptions were associated with increased rates of mental health problems (Dyson, 2005).

Rejected or discriminated children in school, develop negative attitudes towards school activities (Bal, 2014). They socially detach themselves from the others because they experience poor peer relationships, increased violence, low motivation, and loss of sense of belonging and hope (Moussa et al., 2015). They develop lower self-esteem, perform poorly in class (Mpango et al., 2017) and are more likely to suffer from a range of mental health problems, thus perpetuating this vicious cycle (Schwartz et al., 2010).

### **1.7.3.2 Protective factors**

#### **1.7.3.2.1 Individual protective factors**

##### **1.7.3.2.1.1 Self-esteem**

Self-esteem refers to an attitude, either favourable or unfavourable, towards the self (Trzesniewski et al., 2006). It entails an evaluation of oneself, which may be positive, encompassing feelings of being socially and culturally accepted (Kheswa et al., 2017). Self-esteem is often construed as a proxy measure of mental health and wellbeing, and as an indicator of a child's resilience capacity (Copeland-Linder et al., 2010). This is based on a substantive body of evidence on its association with children's mental health, and as a protective factor that buffers exposure to stressors (War et al., 2016).

This process involves other individual psychological factors. For example, self-esteem has been shown to be highly correlated with self-efficacy in adolescents (Stark et al., 2018). Children with higher levels of self-esteem react to stressors differently. They are able to appraise stressors and moderate their negative impact (Dubow et al., 2012). In contrast, children with low self-esteem are less likely to respond adaptively to trauma exposure, are thus vulnerable to developing PTSD and other mental health problems (Qouta et al., 2008). High levels of self-esteem make children to have a more positive outlook towards self and life (McAdams-Crisp, 2006). High self-esteem serves as a resilient or protective factor by promoting behaviours, goals and adaptive coping strategies. In particular, it has been found to enable the utilization of acceptance and disengagement coping strategies, instead the child seeking social support (Dubow et al., 2012).

In addition to individual factors, self-esteem can be influenced by societal, cultural, and peer factors. A study in Ethiopia was conducted to understand the effect of gender- and violence-related norms on self-esteem among refugee girls. The results showed that peer collective attitudes (often referred to as collective peer norms) toward the same items were significantly associated with girls' self-esteem. In turn, low self-esteem has been found to predict a range of negative outcomes such as antisocial behaviour and ill mental health (Trzesniewski et al., 2006).

#### **1.7.3.2.1.2 Coping strategies**

Despite the evidence of extensive psychological distress and mental health problems in the aftermath of conflict and war, children can also demonstrate remarkable resilience to the impact of the trauma experienced (Drury & Williams, 2012; Seguin & Roberts, 2017). Resilience can be defined as the ability to cope or return to normality following exposure to armed conflict (Cherewick et al., 2015). However, the process of resilience is also dynamic, because it varies from one traumatic event or situation to the other (McAdam-Crisp, 2006), and this may explain why some individuals cope well or are better adapted in one situation than others (Masten, 2013).

A number of studies have shown that internally displaced persons (IDPS) display different coping strategies towards adversities that they face (Qouta, 2007; Carlson et al., 2012). For instance, in Indonesia many IDPS were found to function well in their daily life, while fulfilling their normal expected roles (Turnip & Hauff, 2007). A post-conflict survey in Kenya reported that the children who used emotion regulation controlled their aggression and increased pro-social behaviours (Kithakye et al., 2010). In another post-conflict study in Uganda, a substantial proportion of children were relatively well psychosocially adjusted, despite experiencing and witnessing many horrific atrocities (McMullen et al., 2012). These findings prompted research on which factors could explain why those children and young people were better adapted than the others.

In Sudan, students aged between 17 and 22 years were able to identify resources, responses and strategies that enabled them to enhance their psychosocial adjustment during the time of conflict in Darfur. They highlighted interpersonal relationships, social support networks, hope, praying and religious beliefs as the main strategies that they applied as buffer against traumatic challenges (Badri et al., 2013). In line with these findings, Cortes and Buchanan (2007) proposed that children are better equipped to overcome the effects of war when they have good social skills (communication skills and seeking trusting relationships), as well as cognitive and self-regulation skills (able to stop, think, and handle emotions when making decisions). Using these attributes to gain life skills can further enable them to adapt positive behaviours in the face of trauma exposure (Srikala & Kumar, 2010). As already discussed, the development of such protective layers is influenced by family and community factors, for which reason multi-modal approaches are more likely to be effective, as will be discussed in Chapter 2 (Cherewick et al., 2015).

#### **1.7.3.2.1.3 Religious and spiritual beliefs**

People's faith, religious beliefs and practices (Tol et al., 2013) have been assessed in various studies and have been shown to have a protective role (Betancourt et al., 2010; Caribe et al., 2012; Werner, 2012). Faith and beliefs determine who people are, how they develop and what they can achieve (Henry, 2015), by providing them with internal drives that steer and nurture their life stance. For example, the Islamic religion has largely shaped the way Muslims lead their life, as well as their approach to health and wellbeing. They believe that God (Allah) is supreme and everything in the world belongs to him. Prayers to Allah thus produce spiritual energy that mobilize, transform and improve their positive intrapersonal well-being (War et al., 2016).

Some studies have explored the role of religion in the context of post-conflict displacement (Tol et al., 2013). In a research examining the posttraumatic growth of former child soldiers in Uganda, results indicated that such growth was associated with perceived spiritual support. Spirituality and Christian religion formed central sources of healing and reconciliation within their community (Klasen et al., 2010). Similarly, in Sri Lanka a study examined how historical traditions of faith fostered resilience among children of war. Religious practices, mainly in Buddhism and Christianity, were reported as useful tools in coping with trauma or with developed mental health problems (Fernando & Ferrari, 2011). In trying to identify and understand some of the mechanisms and resources that Colombian child soldiers used to overcome trauma and to become resilient, Cortes and Buchanan (2007) found out that about 70% appealed to God's compassion when they felt their life was in danger. In Sierra Leone, more than 95% of children who took part in a study that examined ways of coping with war-related traumatic events, endorsed using religious strategies (Cummings et al., 2017).

Religion may thus act as a protective factor in different ways for conflict and war affected children and their communities (Betancourt et al., 2010; Werner, 2012). It can play a crucial role in how they manage and make sense of displacement and the risks associated with it (Lauterbach, 2014). It promotes integration into the community, serves as a source of cultural identity, and provides children with a sense of new meaning and hope (Eggerman & Panter-Brick, 2010). Religion and spirituality can also act therapeutically, by providing the foundation on which children can interpret both trauma and healing (Cortes & Buchanan, 2007; Betancourt & Khan, 2008). This process thus enables children to exercise better control

over their past traumatic experiences, and to enhance self-regulation leading to mental stability (Pajevic et al., 2007; Good & Willoughby, 2014).

### **1.7.3.2.2 Family protective factors**

#### **1.7.3.2.2.1 Secure attachment relationships**

The protective role of a secure attachment to the primary as well as other caregivers for optimal child development is well documented (Slone & Mann, 2016). Following the increasing influence of attachment theory, a large body of research has investigated how this essential care quality operates in different vulnerable groups of children (Bolghan-Abadi et al., 2011; Halevi et al., 2016). The caregiver's comfort helps the child to make meaning of frightening events and adjustment by regulating their negative emotions (Slone & Mann, 2016). When caregiver and child mutually interact sensitively and responsively to the child's needs, this promotes children's emotional regulation strategies when distressed in the future (Betancourt & Khan, 2008).

Some studies have also been conducted among families who are victims of political and ethnic violence, and have also found secure attachment relationships to act as moderators to children's reactions to recurrent trauma (Betancourt & Khan, 2008). However, this research has approached attachment from a wider perspective, i.e. in relation to also building new family relationships and accessing community supports. For example, in a survey of war affected youths in northern Uganda, a secure attachment base in the family was a strong predictor of successful reintegration of former child soldiers. Children who had more secure relationships and social supports exhibited better social functioning and lower levels of emotional distress (Annan et al., 2006). Eloranta et al. (2016) recruited 482 war affected Palestinian school children through an RCT design to examine how attachment styles predicts changes in mental health in the context of the psychosocial intervention Teaching Recovery Techniques. Having a secure attachment interacted with the intervention to predict better mental health outcomes.

#### **1.7.3.2.2.2 Positive parenting**

Positive parenting includes several qualities such as warmth and caring, communication, consistent discipline, parental self-efficacy, monitoring and supervision, psychological and behavioural control (Le et al., 2010), all of which have been found to protect children exposed to adversities (Qouta et al., 2008a). Parental warmth demonstrates affection,

nurturance and compassion towards children. It enables the child to feel valued, and to experience care and attention from their parents. Parental monitoring and knowledge regarding the child's whereabouts, tracking the child's behaviour activities and friends becomes increasingly important as the child thrives to develop autonomy. These components have also been shown to lead to optimal growth (Tol et al., 2013).

Studies on children growing up in war zones show that positive parenting influences children's mental well-being (Cortes & Buchanan, 2007). For instance, higher levels of perceived parental support have been associated with positive adjustment, and lower levels of aggression and mental health problems during periods of violence (Dubow et al., 2012). A systematic review on the resilience and mental health of children living in areas of armed conflict also showed that parental monitoring was associated with school attainment, less mental health problems, positive life outlook and life satisfaction (Tol et al., 2013).

Positive parenting offers containment and stability through the close interpersonal relationship when a child is faced with external stressors (Bolghan-Abadi et al., 2011). Even in the context of war trauma, it can instil a sense of physical and emotional safety, comfort and nurturing (Slone & Mann, 2016). These feelings form the secure base for the child to develop positive views of their self, self-worth and motivation, and such attributes can help them cope effectively during future distressing situations (Thabet et al., 2009; Copeland-Linder et al., 2010). These findings have been crucial in informing parent training programmes, which will be discussed in the next chapter (Orpinas et al., 2014).

#### **1.7.3.2.2.3 Caregiver mental well-being**

The healthy socialization and nurturing provided by their primary but also other caregivers is essential in promoting the child's wellbeing (Quinn et al., 2014). Caregivers' (i.e. parents, family members and other important adults) own mental health is thus vital in this process. This can act as a protective shield for the child during conflict and war, by enabling the parent or other caregivers to maximize their care functions, both physically and emotionally (Panter-Brick et al., 2014).

A study with displaced children in Ethiopia found that mothers who had access to health care and who were of higher socioeconomic status, were more likely to have good mental health, and this in turn promoted the mental health of their children (Betancourt et al., 2012). In

conflict situations in LICs, women are under particular strain in maintaining their parenting duties (Panter-Brick et al., 2009). In such contexts, there are various overarching factors that can help stabilize parents' mental health. These are related to material and social supports, as well as to access to help or treatment, when required. Regular links and communication between children's and adult agencies, especially mental health services, are thus very important.

#### **1.7.3.2.2.4 Family connectedness and cohesion**

The extended family (aunts, uncles, cousins and grandparents) adopts an essential role in child rearing in LICs (Abebe & Aase, 2007), and often steps in to compensate for parental deficits or loss such as providing a safety net in the care of orphans (Lund & Agyei-Mensah, 2008). More than 90% of orphaned children in most of sub-Saharan Africa are looked after through family networks, who serve as a natural haven in the absence of statutory social welfare systems (Oleke et al., 2005; Karimli et al., 2012). Children's connection to their extended or new caregivers during and after traumatic events is, therefore, an important predictor of psychosocial adjustment (Tol et al., 2013). For example, a cluster randomized design study including 283 orphaned children in Uganda showed the central role of the extended family, mainly of grandparents, in responding to the needs of AID-orphaned children (Karimli et al., 2012).

Healthy family adaptation and higher levels of family social support have been found to be associated with lower levels of perceived war-induced stress (Betancourt et al., 2010). A number of studies in different populations has shown that higher levels of family cohesion are linked to lower rates of externalizing and internalizing problems among children (Henderson et al., 2003; Kheswa et al., 2017). Positive family environments (cohesion, coherence and adaptability) thus enhance children's emotional and behavioural wellbeing (Crea et al., 2014). This is inter-linked with access to other social supports for these family types (Ohaeri, 1998; Kim et al., 2016). As in the case of secure attachment relationships and positive parenting, factors which are often strongly correlated with family cohesion, these qualities make a child feel secure and accepted, have a sense of belonging, self-regulate their emotions, even when subjected to major external stressors (Lucia & Breslau, 2006). This has also implications for displaced children, especially those who have lost their immediate family, by applying to their extended or new family unit (Oleke et al., 2005; Ahmadi et al., 2015).



### **1.7.3.2.3 Community protective factors**

#### **1.7.3.2.3.1 The role of school**

School plays a very important part in children's lives, because this is where they spend a lot of their time with peers and teachers (Diab et al., 2014). School thus serves as a community setting that provides a forum for jointly promoting children's mental health and academic learning (Barry et al., 2013). A caring and nurturing relationship between staff and children has been associated with positive mental health outcomes such as significantly lowering their levels of distress (Betancourt & Khan, 2008). Schools often represent the primary setting where displaced and refugee children are first confronted by a new culture. At the same time, they provide a unique opportunity for acculturation through academic development, language acquisition and cultural learning (Trickett et al., 2005). Also, considering the vacuum of supports and service access for these children, school provide an entry and non-stigmatizing point for service provision and integration. For example, in time of displacement, schools constitute an important platform for programmes and activities that can be tailored to restore predictability and social supports (Barry et al., 2013). This was highlighted in Afghanistan, where most of the places in the country are considered high risk environments, therefore, families anchor their children in school as an expression of hope and resilience, and as the gateway to socioeconomic advancement (Panter-Brick et al., 2011).

Schools are regarded as safe havens and affirming places, particularly in the aftermath of conflict and war, for children to develop a sense of belonging, and to feel able to trust and talk openly about their worries or problems (Department of Education, 2016). They provide and restore opportunities, which were lost in the event of conflict and war, for children to study or acquire vocational skills, thus enhance their sense of security and predictability. The return of children back to their studies enriches their social networks and supports, thus add protective shields to their life. All these factors can help break the cycle of adversity in the short- and long-term (Tennant et al., 2007).

Academic attainment is another well-established protective factor for mental well-being (Dubow et al., 2012). According to Barry et al. (2013), educational opportunities, particularly those that involve life skills, social and emotional learning, are the key factors involved. For instance, refugee children first experience stability and protection when they have access to education. Academic achievement subsequently equips them with skills to resettle in the host country (Bal, 2014). Determined children place value on education, because they

understand that high academic achievement will enable them to achieve mobility and economic pay-offs in later life (Kim, 2002).

#### **1.7.3.2.3.2 Peer relationships**

Peer relations refer to multi-faceted social interactions at home, school and in the wider community (Peltonen et al., 2010). The ability to form and sustain peer and other social relationships has been found to protect children through in life-endangering conditions such as war and military violence (Betancourt & Khan, 2008). This has repeatedly been associated with positive mental health outcomes (Ehnholt & Yule, 2006). A study with child soldiers in Nepal found that reintegration, particularly through peer support, was a major contributor to mental health adjustment. It was reported that, while there was increased hope, functional impairment and PTSD symptoms decreased (Morley & Kohrt, 2013). In such a situation, children can seize the opportunity to share their experiences with peers, where they can vent their emotions and disclose their traumatic experiences in a safe and trusting space. This makes them feel accepted, a factor that normalizes their experience, can thus enable them to overcome the trauma of war (Cortes & Buchanan, 2007; Mueller et al., 2009). Several psychological mechanisms already discussed are also involved such as by enhancing self-expression, sense of security, assurance and self-esteem, competence, worthiness, and regulation of emotions (Peltonen et al., 2010; Diab et al., 2014).

#### **1.7.3.2.3.3 Acculturation**

The term acculturation refers to the cultural and psychological adjustments or changes that take place when groups and individuals from two different cultures meet (Phillimore, 2011). Cultural adjustments involves reshaping one's customs, political and economic life; whereas psychological alterations surround modifications in one's feelings toward the adaption process, through cultural identities and social behaviours, in regards to the groups which one gets in touch with (Berry et al., 2006). Acculturation takes place through different strategies, including integration, assimilation, marginalization and separation. In integration, individuals maintain their original culture when they adopt the receiving culture, while in assimilation they adopt the receiving culture as they do away with their own. In contrast, in marginalization, individuals neither have interest in cultural maintenance nor in adopting the receiving culture; and in separation, they reject the receiving culture but keep their original heritage because they value it (Berry et al., 2006; Sam & Berry, 2010; Bartlett et al., 2017).

The process of acculturation depends on ethnicity, culture and language, among other factors. Ethnicity defines the heritage and set of shared values, beliefs and customs of the groups in contact. Culture describes what a group perceives to be shared meanings and understandings of the similarities of the cultures that come in contact with each other. Finally, language is a system of communication that determines the individual group's acculturation process (Persky & Birman, 2005; Schwartz et al., 2010). Taking these factors into consideration, it is argued that individuals acculturate well through an integration strategy. This is facilitated when there is a degree of similarity between the birth and host heritage such as in language or religion (Schwartz et al., 2010).

Research evidence highlights that acculturation is associated with the psychological adjustment of displaced and refugee individuals (Giang & Wittig, 2006; Sam & Berry, 2010; Nwosu & Barnes, 2014; Bartlett et al., 2017). However, there is limited literature on the acculturation of displaced children in LICs. The available studies were mostly conducted among immigrants, refugees and asylum seekers settled in foreign (usually high-income) countries. These studies have shown how cultural integration is linked to better mental health outcomes (such as lower depression, higher self-esteem, and prosocial behaviours), with friendships with own and other ethnic groups playing a mediating role (Bhui et al., 2012). For instance, a study in America aimed to find out the places that were important to children at school; the people who helped them to succeed, adjust and/or transition to school; and the challenges they faced. Twenty-three refugee students (16 female and seven male) who hailed from different LICs were interviewed. The findings indicated that school-based acculturation practices fostered their development. Important factors reported by the young people were a sense of safety, building trust among peers and teachers, and embracing optimism (Bartlett et al., 2017).

#### **1.7.3.2.3.4 Community connectedness and safety**

Feeling connected to one's community is associated with positive individual and social outcomes. Connectedness in the community forms a critical element in establishing a collective identity that can promote mutual, influential and satisfying relationships (Ashmore et al., 2004). Communities thus form fundamental arenas for children's development and wellbeing (Whitlock, 2007). How many close friends one has, frequency of interactions with these friends and their families, trust in neighbours, and participation in community events all play a significant role in enhancing health and well-being (Bhandari & Yasunobu, 2009). A

connected community is composed of families, schools, and groups that work together in facilitating children's healthy development (Betancourt et al., 2010; Werner, 2012), even when resources are limited (Bhandari & Yasunobu, 2009).

Available research demonstrates the association between community connectedness and mental well-being. When individuals bond and bridge relationships in the community they create healthy social norms, increase health literacy and connect with local services that provide emotional support (Kim et al., 2014). For instance, school connectedness acts as a protective factor for children, because it creates a conducive environment. This can decrease school absenteeism, early sexual initiation and forced marriage, alcohol and substance use. It can also protect children from emotional distress when faced with external stressors (Centre for Disease Control and Prevention, 2009). Children function even better when school connectedness is extended from school to their neighbourhood (Reed et al., 2012). A well connected community supports and protects children by making them feel safe and develop a sense of belonging (Whitlock, 2007). In such a space, children learn that adults are concerned and care for them, in contrast with violent neighbourhoods (Costello et al., 2008). This is a sound foundation for them to achieve their goals in life (Vostanis, 2014).

#### **1.7.3.2.3.5 Social support**

The main dimensions of social support that can be provided to children are material, emotional and informational (Semmer et al., 2008). Material support consists of tangible resources and services provided to carry out necessary tasks. Emotional support provides reassurance, empathy, trust and caring (Cohen, 2004), while informational supports offers guidance and advice on daily activities (Betancourt & Khan, 2008).

It has been widely demonstrated that social support is an important protective factor in buffering the adverse effects of life stresses (Cortes & Buchanan, 2007). For instance, a study by Kliever et al. (2001) with Colombian children exposed to severe violence, showed that higher levels of social support were linked to lower rates of emotional problems. As already discussed, social support can also affect children's mental health indirectly through their parents. Greater perceived and real social support for the parents is thus significantly associated with a lower risk of their offspring developing physical or mental health problems (Slone & Mann, 2016).

## **1.8 Outcome and prognosis**

Several studies have shown that war conflict is associated with a wide range of negative child mental health outcomes, both in their psychosocial functioning, and in the development and continuation of mental health problems such as PTSD, depression and anxiety (Thabet et al., 2007; Betancourt et al., 2010; Thapa & Hauff, 2012; O'Callaghan et al., 2013; Patton et al., 2014; Moussa et al., 2015). The prognosis of these conditions is likely to be worse when children face ongoing or recurrent risks to their physical, emotional and social growth (UN, 2014; Calam, 2017). Such adverse outcomes are compounded by stigma of mental illness, prejudice, discrimination and social exclusion (Cortes & Buchanan, 2007; Skre et al., 2013; Diab et al., 2014). Notable examples are child soldiers who wounded or killed others and girls who were victims of sexual violence during or after the conflict. These children are further victimized and discriminated in the community, which increases their psychological distress and weakens their capacity to recover (Betancourt et al. 2008; Tamashiro, 2010). Such a cycle of re-traumatization has been established in other vulnerable groups such as children who suffer abuse, homeless or living on care (Oshodi et al., 2016). A number of consequences of such re-traumatization are drug and alcohol abuse, unemployment and criminality (Murthy, 2008; Moussa et al., 2015). These problems hinder children from making a healthy transition to adulthood, reaching their full potential in life, and fully participating in their communities socio-economically (United Nations, 2014; UNICEF, 2014).

Several studies have investigated the relationship between mental health problems in childhood and long-term outcomes (Patton et al., 2014; Downer & Trestman, 2016; Oshodi et al., 2016). Although these did not include children of focus in this review, there are similarities and lessons from studies in the general population and vulnerable groups. For instance, a study in South Africa assessed the long-term mental health outcomes (PTSD, depression and anxiety) in young women who had been subjected to rape, and found high rates of suicidal ideation in 50% of the participants (Van Niekerk et al., 2012). As in previous literature with sexually assaulted victims, high suicidal ideation was the sequel of ongoing and unresolved stress, fears and depression (Downer & Trestman, 2016). Another longitudinal study assessed common mental problems at five points during childhood and three points in young adulthood. Lengthy episodes of ill mental health, compounded by parental separation and loss, increased the probability of continuities of mental disorders into

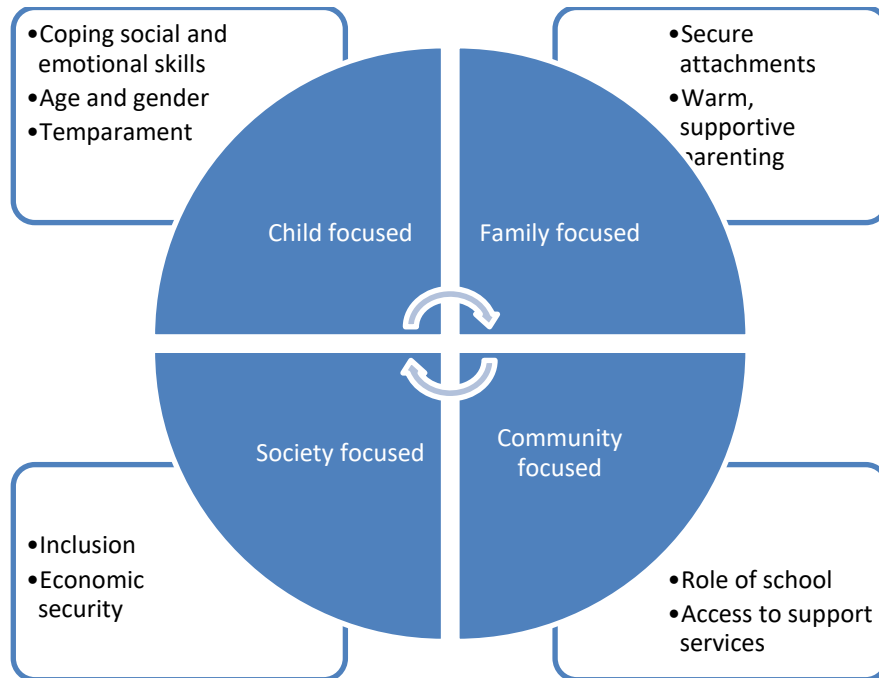
adulthood (Patton et al., 2014). These findings have influenced the increasing attention to early intervention and preventive programmes (Bhui et al., 2012; Barry et al., 2013).

### **1.9 Chapter summary**

This chapter critically discussed definitions, theories and causes of ethnic conflict, and illustrated the trends of ethnic conflict in the developing world. This was followed by evidence on the mechanisms that underpin the impact of ethnic conflict on child mental health, and on the role of both risk and protective factors based on the socio ecological framework (i.e. individual, family and community levels). The chapter was concluded with consideration of predictors of mental health and related outcomes, which have informed the development of psychosocial interventions for children exposed to ethnic violence (Figure 1.4). The next Chapter 2 will further discuss the theoretical literature and evidence-base of such interventions.

**Figure 1.4**

**Inter-linked protective factors for future mental health outcomes**



## **CHAPTER TWO**

### **MENTAL HEALTH INTERVENTIONS FOR CHILDREN EXPOSED TO ETHNIC CONFLICT**



## **2.1 Introduction**

This chapter builds on the previous evidence on risk and resilience factors, by critically highlighting the literature with regard to mental health interventions for children exposed to ethnic and other types of war conflict. These include child mental health policy, a range of psychosocial interventions, levels of implementation and emerging service models and gaps. The achievements of the Millennium Development Goals (MDGs) and the focus of Sustainable Development Goals (SDGs) in relation to CAMH interventions are also discussed too (WHO, 2015; WHO, 2016). The review leads to the justification and rationale for the study.

The literature review in this chapter concentrates on displaced and war children from low income countries. Unfortunately, only a small number of studies of mental health interventions for children exposed to ethnic conflict in these countries were identified in the literature. Taking this factor into consideration, some interesting and generalizable models from LICs but not from conflict settings were included, while emerging models from high income countries that could be of relevance in the future, for example service models for refugee children, will only be mentioned in passing without going into detail, because they were not included in this review.

Mental health interventions can be categorised in various ways. Though neither exhaustive nor exclusive, the ecological systems framework (at individual, family and community level) was adopted in this review, as this allowed conceptual consistency with the consideration of risk and resilience factors in the previous chapter. It is also acknowledged that there is a degree of overlap, as some interventions can fall under more than one category (for example, a school-based trauma reprocessing approach that does not involve active teacher involvement), whereas others combine or integrated different frameworks (for example, psychoeducational interventions increasingly use cognitive-behavioural techniques).

## **2.2 Child and adolescent mental health policy**

Mental health policy is the official expression or documentation that provides for a framework on mental health interventions for affected populations at international, national or local level. It communicates and presents a structured and organized set of values, principles, objectives and sections or activities for either improving or reducing the burden of mental health disorders in a population (WHO, 2011; Juengsiragulwit, 2015). Child and

adolescent mental health (CAMH) policy translates the knowledge base on the actual way of supporting mentally affected children and their families. A policy framework is usually influenced by and formed through the combination of evidence, advocacy, public awareness and mobilization initiatives (Harper & Çetin, 2008).

### **2.2.1 Child and adolescent mental health policy in low income countries**

Despite the substantial evidence available on the burden and impact of child and adolescent mental health disorders (Sharan & Sagar 2007; Braddick et al., 2009), mental health policy and service development is not a priority for many countries (Kleintjes et al., 2010). Juengsiragulwit (2015) observes the paradox that most countries that lack specific CAMH policies are those with the largest number of children and adolescents. These countries, which are predominantly found in low income regions such as in Africa (WHO, 2011), do not have a clearly defined CAMH policy (Shatkin & Belfer 2004; Al-Obaidi et al., 2010). For instance, an international survey focusing on CAMH policies showed that, out of the 191 WHO member states, only 35 countries had CAMH policies, of which only seven from Africa (Shatkin & Belfer, 2004; Kleintjes et al., 2010). Similarly, in a survey of key informants working in child mental health settings in 15 out of the 46 African WHO member states (i.e. those which responded to the survey), only a third confirmed that they had a national CAMH policy (Patel et al., 2007a). In a general review of mental health policies and legislative frameworks that was conducted in 2010 in four African countries - Uganda, Zambia, Ghana and South Africa – it emerged that only South Africa and Uganda had drafted CAMH policies (Kleintjes et al., 2010; Juengsiragulwit, 2015).

The dearth of CAMH policy in low income countries has been highlighted by several studies and is attributed to several reasons. Research has identified that lack of strong advocacy (Sharan & Sagar 2007), financial and professional resources (Patel et al., 2007b; Kleintjes et al., 2010), lack of epidemiological data (Al-Obaidi et al., 2010), limited knowledge on child development and mental health disorders (Juengsiragulwit, 2015), unreliable networking infrastructure, and tensions between traditional and modern approaches to healing (Harper, 2012) are some of the barriers to CAMH policy development and implementation. Similarly, the focus of these countries on children's physical health initiatives has been noted to contribute to negligence of CAMH policy (Betancourt et al., 2013; Siriwardhana et al., 2013; Atilola, 2017).

CAMH policies in countries such as South Africa and Uganda aim at improving the mental well-being of children and adolescents, thus allowing them to maximize their growth and potential, and to function independently as adults. They aim to increase knowledge, understanding and involvement of policy makers and stakeholders; continuously develop and review CAMH policies and legislation; build capacity, improve access and availability of CAMH services; strengthen multi-sectoral collaboration and participation in providing quality CAMH services and strengthen research, monitoring and evaluation of services (Ministry of Health, Uganda, 2017). These policies strive to achieve their aims through various strategies, which include the following; counselling to help children gain self-knowledge, develop new capacities and acquire new skills; access to appropriate services at all levels of health care (national, provincial and local) within the primary health care system; skills-building such as life skills to enable self-determination; awareness of child development and socialization, and the role of risks and protective factors; knowledge of sources of help; promoting a culturally sensitive, safe and supportive child-centred environment; and supporting caregivers in providing, nurturing emotional support and material resources, while remaining sensitive to cultural practices and upholding children's fundamental rights (Kleintjes et al., 2010).

Some studies however, argue that even though set principles are mentioned in such policies in LICs, they often lack a national mental health plan to support their implementation (Braddick et al., 2009; Kleintjes et al., 2009; Juengsiragulwit, 2015), adequate financing (Kigozi et al., 2010), sufficient quality and quantity of services; integration between health and non-health sectors and skilled workforce (Akol et al., 2015). Despite these gaps, CAMH policy is the essential first step in developing quality services (Sharan & Sagar, 2007; Al-Obaidi et al., 2010; Harper, 2012). This can serve as the platform and fundamental tool for service development (Harper & Çetin, 2008; Braddick et al., 2009). Policy helps a government to articulate a commitment to treating, reducing and preventing CAMH (Kleintjes et al., 2010; Atilola, 2017). It is worth noting that CAMH policy is often 'hidden' in other policy frameworks in LICs, namely child protection, welfare, humanitarian, education, and physical child health (UNICEF, 2006; UNICEF, 2009a; UNICEF, 2010; Save the Children Sweden, 2011; Save the Children, 2013 and 2017). These policy frameworks are usually driven by children's rights and safeguarding, are thus guided and supported under several legislative instruments which stipulate and supply the needs of children and protect their rights (Kigozi et al., 2010; Akol et al., 2015).

Many LICs address CAMH issues through the ratification of international conventions and charters for children and adolescents, predominantly the United Nations Convention on the Rights of the Child (Convention on the Rights of the Child, 2015), an agreement or treat that particularly protects the rights of vulnerable children. These countries have thus acknowledged that children have the right to good quality health care, for both their physical and mental well-being (Juengsiragulwit, 2015). Other countries have adopted the Convention on the Rights of the Child and have incurred provisions for the protection of children in their constitutions. Any convention or treat they adopt is automatically, under their constitution, incorporated into law (Save the Children Sweden, 2011). Consequently, in countries such as the Republic of Uganda, the constitution provides various rights and forms of protection which include, but are not limited to; cared for by their parents/guardians; basic education; medical treatment; socio-economic benefits; not to be detained (offenders) with adults; and protection from all exploitation (employment and work) (Kigozi et al., 2010; Akol et al., 2015; Ministry of Health, Uganda, 2017). However, these new policies are often in contradiction with existing practice, for example Uganda is still waiting for legislature to criminalize, thus abolish, child sacrifice for fear of certain politicians not challenging traditional beliefs.

Policy frameworks such as child protection thus ‘hide’ CAMH policies within them in several LICs. The role and functioning of these policies are facilitated by both government structures (e.g. Children and Social Services; Children’s Courts and Police Force) and Non Governmental Organizations (NGOs) (e.g. United Nations Children’s Emergency Fund - UNICEF, Save the Children and the World Health Organization) concerned with the welfare of children (Save the Children Sweden, 2011). Governments, through various mechanisms such as identified ministries and other organizations or departments, play a central legislative and co-ordinated role in child protection. They adopt the responsibility for implementation of children’s care and safeguarding, prevention and response, to all forms of exploitation, abuse and violence. They rehabilitate and reintegrate child offenders; and exercise general supervision and control over planning, financing and co-ordination of child rights and welfare activities. For instance, courts resolve issues related to parental responsibility, children’s institutions, custody and maintenance, foster care placements and child offenders; while the child protection units within the police force offer temporary cells, thereby separating adults

from child offenders, and bring charges on perpetrators of child abuse (Save the Children Sweden, 2011).

Similarly, NGOs such as Save the Children, Red Cross, UNICEF, or World Vision often also play crucial roles in child protection by supplementing government efforts in priority areas regarding to protecting vulnerable children. Organizations may be instructed to develop policy frameworks, provide advocacy, capacity-building and awareness on children's rights; care and support (education, family re-union and shelter) and access to justice for trafficked and abused children (UNICEF, 2009b). Among the prominent organizations which champion leading roles in protecting children, as considered in this review, are UNICEF and Save the Children. These organizations employ different approaches to achieve their aims.

#### **2.2.1.1 UNICEF and child protection**

The United Nations Children's Emergency Fund (UNICEF) is a United Nations (UN) programme that provides humanitarian and developmental assistance to children and mothers in developing countries. UNICEF refers to child protection as the prevention and response to children's exploitation, violence or harmful traditional practices. Forms of maltreatment are child labour, trafficking, female genital mutilation/cutting, commercial sex, and marriage. The organization acknowledges that children are at risk of receiving poor parenting, lack of education, poor physical and mental health and even mortality when their rights are violated (UNICEF, 2006).

UNICEF aims to help prevent and respond to any violence, abuse exploitation and discrimination that children experience. It collaborates with other global development partners to ensure that both local and national policies that promote children's rights are strengthened and fulfilled. It works with the governments and communities to develop children's life skills, or reintegrate displaced ones back to the society. When children are protected from violation of human rights, their mental health can improve through to better social adjustment and educational achievements, even if this has not been as yet a primary objective of such global initiatives (UNICEF, 2009a).

### **2.2.1.2 Save the Children's approach**

Save the Children is a dual mandate organization that operates in both emergency development contexts, and addresses the immediate and long-term child protection consequences of nature and human-induced emergencies (Save the Children, 2013). Save the Children interprets child protection as measures and structures that address the violation of children's rights (abuse, violence neglect and exploitation) (Save the Children Sweden, 2011). Their vision is to ensure that every child's rights are protected through participation in legislation, policies, services, and societal activities. To achieve their objective, the organization works with governments to reinforce legal and policy changes that condemn physical and humiliating punishment in all settings (home, schools and community) (Save the Children, 2013). Like UNICEF, protecting children from violations of their rights is viewed as conditional in enhancing their broad quality of life, and their capacity to contribute and participate productively in the society. Recently the organization has begun to address more specific child mental health needs in this model (Save the Children, 2017), and these have led to the established of their first psychosocial support and mental health teams in the Middle East (Save the Children's Resource Centre, 2017).

### **2.2.1.3 Child protection and Millennium Development Goals**

Despite the fact that CAMH policies are often not defined in LICs, indirect albeit significant progress has been realised because of the Millennium Development Goals (MDGs). MDGs are the eight international development goals that were established by United Nations member countries during the 2000 Millennium Summit, and were universally adopted by the United Nations Millennium Declaration (WHO, 2015). With practical commitments from all the partner nations, these MDGs were to be achieved by 2015 following the set targets and indicators in place to monitor the progress of each of the goals (WHO, 2016) Although child mental health was not specifically defined, several indicators are well established risk factors for child protection, but also for child mental health problems and their continuation, as discussed in the previous chapter. In the following Table 2.1, the MDGs and their health targets are linked to the child protection issues as defined by UNICEF.

**Table 2.1**  
**Millennium Development Goals, child protection and health targets**

<b>Millennium Goals (WHO, 2015)</b>		<b>Child protection issues (UNICEF, 2010)</b>	<b>Health targets by 2015 (WHO, 2016)</b>
1	Eradicate extreme poverty and hunger	Discrimination, violence, abuse, exploitation, abandonment and separation from caregivers	Halve, between 1990 and 2015, the proportion of people who suffer from hunger
2	Achieve universal primary education	Child labour, sexual harassment, early marriage, violence and discrimination in schools	Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling
3	Promote gender equality and empower women	Sexual violence, female genital mutilation/cutting, child marriage, trafficking and domestic work	Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education, no later than 2015
4	Reduce child mortality	Abandonment, disability, child marriage and separation from caregivers	Reduce by two-thirds, between 1990 and 2015, the under-fives mortality rate
5	Improve maternal health	Female genital mutilation/cutting, forced early marriage and sexual violence	Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio. Achieve, by 2015, universal access to reproductive health
6	Combat HIV/AIDS, malaria and other diseases	Child labour (prostitution, soldiering and trafficking), children's conflict with the law, children without parental care, health consequences of sexual abuse and exploitation	Halt by 2015 and begin to reverse the spread of HIV/AIDS; achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it; halt by 2015 and begin to reverse the incidence of malaria and other major diseases
7	Ensure environmental sustainability	Child abuse and exploitation due to environmental disasters	Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation
8	Develop a global partnership for development	Encourages inter-sectoral (government, NGOs, civil society) co-operation at national and international level, in order to protect children	In co-operation with pharmaceutical companies, provide access to affordable essential drugs in developing countries

Child protection cuts across all eight MDGs. Some of the issues focusing on child welfare that are linked with the MDGs include, but are not limited to; protection from exploitation acts, violence neglect and abuse (UNICEF, 2010). Notably, no single goal can be achieved without taking into considerations these inter-linked issues. Taking into account fundamental human rights, MDGs provide a framework for UN systems working coherently towards achieving human development objectives (UNICEF, 2006). Article 25 of the UN Universal Declaration on Human Rights (UDHR) proclaims that every child has a right to “a standard of living adequate for health and well-being (right to food, clothing, housing and medical care)” (Convention on the Rights of the Child, 2015).

Of the eight MDGs, three goals (MDGs 1, 4 and 5) are specifically focused on health (Miranda & Patel, 2005), although several other MDGs (in relation to nutrition, water and sanitation) contain some health components (Jones et al., 2008). When considering the relationship between child mental health and MDGs, three goals are more closely linked to established risk factors for child mental health problems. These are MDG 1 (eradicating poverty), MDG 4 (reducing child mortality) and MDG 5 (improving maternal health) (Miranda & Patel, 2005). Children living in disadvantage are likely to experience stressful life events like family and community violence, poor physical health, accidents and delayed development, all notable vulnerabilities for common mental health problems such as depression, anxiety and conduct problems. Vice versa, children and young people with mental health problems are more likely to live in poverty because of social exclusion, lack of education, and stigma (Knifton, 2012; Benova et al., 2015).

However, there is increasing evidence that such cycles can be broken with early intervention, particularly through multi-modal programmes that concurrently tackle several inter-linked risk factors in a child's life (Miranda & Patel, 2005). One example is the association between postnatal maternal depression and later child mental health problems through a range of underlying risk factors for both mother and infant/child. Mothers with mental health issues, particularly depression, during the pre- and post-natal period increase the chances of infants being underweight and stunted in their early development. Depressed mothers are more likely to stop breastfeeding or looking after their children such as complying with their immunizations, thus increasing risk factors for childhood mortality and a range of later health problems. Recent evidence from LICs such as Pakistan and Bangladesh indicate that both mothers and children can be protected through preventive and responsive programmes, some delivered by trained community volunteers (Rahman et al., 2008; Aboud et al., 2013). Other socioeconomic and health MDGs also have relevance to child mental health. For example developmental disorders such as learning disabilities can affect children's ability to enrol in schools or complete their primary education (MDG 2). These children are often excluded from education in LICs. Similarly, mental health problems are highly prevalent in children and young people with HIV/AIDS (MDG 6), and these in turn can impede their adherence to antiretroviral therapy (McGovern, 2014).



Despite the achievements of MDGs in terms of reduction of the overall health gap between rich and poor countries (Sachs, 2012; United Nations, 2015), as well as on specific improvements such as infectious diseases (malaria or HIV/AIDS) (Omigbodun & Belfer, 2016), it is unfortunate that none of the eight goals included any reference to mental health or illness. This despite the strong evidence that mental health cross-cuts all MDGs to a variable degree (Votruba et al., 2016), and that it has an enormous impact globally (13% of the global burden of disease). Not surprisingly, LICs with lower resource also seem to be lagging behind in terms of mental health gains (McGovern, 2014).

This lack of focus on mental health reflects low prioritization, limited knowledge, negative attitudes and stigma, even within large global organizations such as the UN and the WHO, although recent years have seen slow but ongoing progress. This is reflected in the new health agenda and the formulation of the Sustainable Development Goals (SDGs), to follow from the 15-year MDG period (Sachs, 2012).

#### **2.2.1.4 Sustainable Development Goals, child protection and mental health**

The Sustainable Development Goals (SDGs) are a new universal set of 17 goals, including targets and indicators, which act as a framework for member states to achieve their agendas and political policies (Ford, 2015). These goals, targets and indicators are an extension and adjustment of the MDGs that expired in 2015 (Table 2.2). The SDGs strive to build on the MDGs successes, and to reflect on the lessons learnt to ensure that all countries, move in co-ordination towards a more prosperous, equitable and sustainable world (United Nations, 2015).

**Table 2.2**  
**Sustainable Development Goals (Izutsu et al., 2015)**

SDG	TARGET
SDG: 1	End poverty in all its forms everywhere
SDG: 2	End hunger, achieve food security and improved nutrition, and promote sustainable agriculture
SDG: 3	Ensure healthy lives and promote well-being for all at all ages
SDG: 4	Ensure inclusive and equitable quality education, and promote lifelong learning opportunities for all
SDG: 5	Achieve gender equality, and empower all women and girls
SDG: 6	Ensure availability and sustainable management of water and sanitation for all
SDG: 7	Ensure access to affordable, reliable, sustainable and modern energy for all
SDG: 8	Promote sustained, inclusive and sustainable economic growth, full and productive employment, and decent work for all
SDG: 9	Build resilient infrastructure, promote inclusive and sustainable industrialization, and foster innovation
SDG: 10	Reduce inequality within and among countries
SDG: 11	Make cities and human settlements inclusive, safe, resilient and sustainable
SDG: 12	Ensure sustainable consumption and production patterns
SDG: 13	Take urgent action to combat climate change and its impacts
SDG: 14	Conserve and sustainably use the oceans, seas and marine resources for sustainable development
SDG: 15	Protect, restore and promote sustainable use of terrestrial ecosystems, sustainably manage forests, combat desertification, and halt and reverse land degradation and biodiversity loss
SDG: 16	Promote peaceful and inclusive societies for sustainable development, provide access to justice for all, and build effective, accountable and inclusive institutions at all levels
SDG: 17	Strengthen the means of implementation and revitalize the global partnership for sustainable development

Unlike during the early phase that surrounded the formulation of MDGS in 2000, the UN declaration on SDGs acknowledged the importance of mental health, and included it in the global development plan towards Vision 2030 (Votruba et al., 2016). The Vision for 2030 is to have a world with equitable and universal access to quality services for all people. These services should include, but not limited to: health care and social protection, as well as education at all levels, while making sure that physical, mental and social wellbeing of all individuals are guaranteed (WHO, 2015). This time, member states realised that related SDGs cannot be attained comprehensively without the inclusion of mental health as a key global developmental priority. Therefore, several SDG targets and indicators make reference to mental health and disability (Izutsu et al., 2015). For instance, under SDG 3, which concerns ensuring healthy lives and promoting wellbeing for all ages, there are clear targets and strategies on implementation, as outlined in the framework (Table 2.3).

**Table 2.3**

**Sustainable Development Goal 3 and its targets (WHO, 2015; WHO, 2016)**

<b>SDG 3: Ensure healthy lives and promote well-being for all at all ages</b>		
<b>TARGET 3.8: Achieve universal health coverage, including financial risk protection, access to quality essential health care services, medicines and vaccines for all</b>		
<b>MDG unfinished and expanded agenda</b>	<b>New SDG3 targets</b>	<b>SDG 3 Means of implementation targets</b>
<ul style="list-style-type: none"> <li>- Reduce maternal mortality</li> <li>- End preventable newborn and child deaths</li> <li>- End the epidemics of AIDS, TB, malaria and NTDs and combat hepatitis, waterborne and other communicable diseases</li> <li>- Ensure universal access to sexual and reproductive healthcare services</li> </ul>	<ul style="list-style-type: none"> <li>- Reduce mortality from NCDs and promote mental health</li> <li>- Strengthen prevention and treatment of substance abuse</li> <li>- Halve global deaths and injuries from road traffic accidents</li> <li>- Reduce deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination</li> </ul>	<ul style="list-style-type: none"> <li>- Strengthen implementation of framework convention on tobacco control</li> <li>- Provide access to medicines and vaccines for all, support Research and Development of vaccines and medicines for all</li> <li>- Increase health financing and health workforce in developing countries</li> <li>- Strengthen capacity for early warning, risk reduction and management of health risks</li> </ul>
Interactions with economic, other social and environmental SDGs and SDGs 17 on means of implementation		

Similarly, other goals (SDGs 4, 8, 10, and 11) make direct references to mental health, for example through the protection and promotion of the rights of people with mental problems and disabilities. The overarching SDQ17 provides the means of implementation of these defined targets. This goal covers the overriding aspects of financing, partnership, technology, monitoring and accountability, which are crucial in the implementation of health targets in the context of LICs (WHO, 2016). SDGs thus built on the success and shortcomings lessons learnt from the MDGs (Sachs, 2012), as well identified newly emerging development challenges such as that no one should be left behind without having access to mental health services (WHO, 2015). This framework will hopefully act as the driving force in designing, delivering and implementing mental health interventions to children affected by conflict, especially in LICs.

### **2.3 CAMH intervention in LICs**

The literature review in Chapter 1 explicitly illustrated how children and young people are affected by traumatic experiences during and after ethnic conflicts and war (Betancourt & Williams, 2008). Although there is limited knowledge on the longer-term mental health and psychosocial sequelae plaguing this group (Betancourt & Khan, 2008), there are strong indicators from a small number of studies that mental health problems are likely to continue throughout young life into adulthood without timely and appropriate interventions (Stavropoulou & Samuels, 2015). This key finding has influenced the development and increasing evaluation of such programmes, with translation of knowledge informing practice and service development, both in terms of response to ill mental health (Harper & Çetin, 2008; Kleintjes et al., 2010) and broader outcomes (Braddick et al., 2009; Harper, 2012). Psychosocial interventions have evolved and adopted a broader approach rather than only targeting established disorders, i.e. in promoting positive child mental health. Their general objective is to equip children with the required life skills and support resources that enable them to overcome challenges in the face of similar adversities (Weare & Nind, 2011; Barry et al., 2013). However, their definitions, therapeutic frameworks and specific goals still widely vary.

### **2.4 Psychosocial approaches**

The term ‘psychosocial’ refers to the dynamic inter-connection between psychological (internal, emotional and thought processes, feelings and reactions) and social (relationships, family and community networks, social values and cultural practices) aspects of a person’s life (Inter-Agency Standing Committee (IASC), 2010; International Federation of Red Cross and Red Crescent Societies (IFRCRCS), 2014). Similarly, Fernando (2008), defines ‘psychosocial’ as the relationship between psychological (experiences which affect emotions, behaviours, thoughts, memory and learning ability, and how a situation may be perceived and understood) and social effects (how the diverse experiences of war alter people’s relationships to each other). The United Nations High Commissioner for Refugees (UNHCR) (2013) ‘psychosocial’ definition refers to internal processes (including physical and mental health) that are intimately related to interpersonal functioning and functioning in social domains (which include religious and cultural beliefs and practices, social roles, and social identity). According to these definitions from different authors, the term ‘psychosocial’

combines both social and psychological dimensional aspects related to mental health. Since these dimensions are closely linked, they continually interact and influence each other.

In conflict settings, addressing children's mental health and psychosocial well-being is increasingly viewed as central to humanitarian and post-conflict responses (UNHCR, 2013; Jordans et al., 2016). According to Betancourt and Williams (2008), psychosocial interventions in a humanitarian response context focus on the principle of restoring the physical and social environment as key factors in promoting mental health during or after the emergency. They highlight that some of the programmes which promote these principles include building or rebuilding infrastructure; restoring shelter and physical health services; and improving security, child tracing and family reunification; thus leading to the subsequent provision of skills training, spiritual support, community reintegration, increased economic opportunities, justice and accountability. The IFRCRCS (2014) elaborates that psychosocial programmes promote children and young people's mental health in a variety of ways. These include, promotion of resilience by giving them the ability to bounce back in a positive way after the traumatic event(s); help them develop coping mechanisms to deal with future similar challenges and difficult situations; and, finally, restore social cohesion through reinforcement and strengthening of affected social networks and structures.

Psychosocial interventions can be defined and positioned differently within healthcare and welfare systems. First, they can be implemented as stand-alone treatments (Mueser et al., 2013), or be integrated with other health, social and economic programmes under the same purpose of restoring the physical and social environment (Betancourt & Williams, 2008). Second, they can be implemented individually or in more resource-effective groups (Jhanjee, 2014). Third, several psychosocial programmes can be delivered by a range of health workers or paraprofessionals, which is a crucial factor for LICs with limited specialist services (Lecomte et al., 2014). Finally, considering all these characteristics in conjunction, and despite the limited evidence, psychosocial interventions are increasingly viewed as contextualized, flexible, accessible and cost-effective in promoting the mental health problems of children and young people affected by conflict in LICs. Although many still lack conceptual specificity, they tend to adhere to the therapeutic and resilience-building principles in promoting a sense of safety, containment, self-and-community efficacy, connectedness and hope (Betancourt et al., 2013; IFRCRCS, 2014).

Consequently, both for needs-related and pragmatic reasons, psychosocial programmes are particularly appropriate in war conflict settings. They are regarded to be the most appropriate type of intervention, since specialist professionals are rarely available, but also because most children require a stepped approach. Their additional indication and appeal is because they acknowledge that children suffer subject to contextual factors, thus jointly address the two ‘psychological’ and ‘social’ pathways to distress (Betancourt et al., 2013). This joined-up approach can thus concurrently target inner psychological difficulties and adjustment to disrupted family and community environments (Lith et al, 2007).

#### **2.4.1 Classification and frameworks of psychosocial interventions for children and adolescents**

There are different theoretical frameworks according to which psychosocial interventions can be categorised. Such frameworks include the pyramid of needs (IASC, 2007), ecological (individual/family/community) systems (Bonferbrenner, 1979), and the universal/targeted model (Fazel et al., 2014). These have informed classifications of psychosocial interventions, for which reasons their principles are discussed in more detail below.

##### **2.4.1.1 Pyramid model**

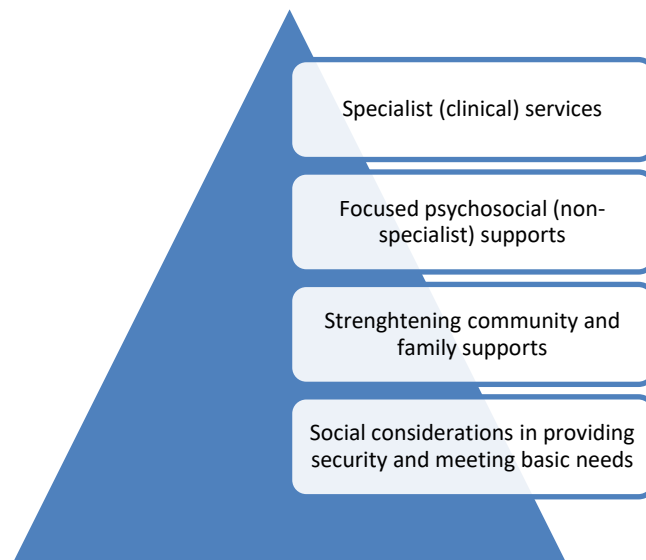
The pyramid model is a tiered evidence-based intervention framework. The framework provides a three-tiered response, depending on the level of children’s needs (Figure 2.1), and originates from Maslow theory of the hierarchy of human needs (Maslow, 1943). These tiers (or levels) include universal promotion (for all children); secondary prevention (children at risk) and tertiary interventions (children with persistent challenges and/or who have developed mental health problems) (Fox et al., 2009). When emergencies take place, children are affected in diverse ways, therefore they require different kinds of support in order to cope (IASC, 2007). The guidelines for mental health and psychosocial support (MHPSS) as outlined by the IASC, propose that the need for mental health interventions should be categorized depending on the perceived level of risk faced by the target population. A multi-layered system of support thus needs to be delivered at different levels (IASC, 2010). This framework emphasizes the integration of different forms of support, non-specialized activities that strengthen children’s and families’ resilience, and programmes that address psychological distress. Jordans et al. (2016) note that all these intervention levels need to be available in order to promote positive aspects of mental health and well-being, prevent

mental health problems from developing, and treating existing mental health problems to reduce symptoms and improve functioning.

As the intervention pyramid illustrates (Figure 2.1), psychosocial responses to the affected children and young people can be classified under related levels (IASC, 2007). The first level concerns security and basic services, and reflects the principle of ensuring that children's fundamental rights are met. Their basic needs such as shelter, protection, food, clean water, and health care must be addressed through the re-establishment of security, adequate governance and services. These responses must be purposely delivered in socio-culturally appropriate ways (safe and dignified) to set the foundations of promoting mental health and well-being (IASC, 2008; UNHCR, 2013). The second level focuses on community and family supports for those children who are not able to maintain their mental health well-being in the aftermath of a conflict or displacement. These thus enable affected children to access key community and family resources and services such as family tracing and re-unification, supportive parenting programmes and activation of disrupted social support networks (IASC, 2007; IASC, 2008). The third level deals with focused supports for children who require individual, family, school or community-based interventions such as psychological First Aid facilitated by trained and supervised health workers (IASC, 2008; UNHCR, 2013), as discussed in more detail below. Finally, at the top layer of the pyramid lie specialist services that targets children with more entrenched and impairing difficulties in their daily functioning, despite having accessed the supports already mentioned in levels 1-3. These children are normally referred for mental health interventions that target specific mental health problems or the more severe disorders (IFRCRCS, 2014).

**Figure 2.1**

**Intervention pyramid**



Pyramid intervention has been so instrumental in child mental health. The tiered intervention model provides guidance in designing and delivery of intensive evidence-based interventions which are appropriate in scaling up psychosocial and mental health of children (Fox et al., 2009). It provides a useful framework for understanding psychosocial reactions, needs and interventions taking into account cultural frameworks relevant to the local setting (UNHCR, 2013). However, there are various versions of the evidence pyramid existing implying there is lack of consistency. The structure of the pyramid is likely to influence what kind of study designs and interventions at each level. Weaker designs and interventions are likely to be at the bottom with best designs and effective intervention at the very top (Murad et al., 2016).

#### **2.4.1.2 Socio-ecological systems model**

The social-ecological systems model is based on the principle that there is no single factor that influences behaviour change. Instead, multiple factors at different levels (Figure 2.2), i.e. individual, family, community and societal interact, with equal importance, to affect the behaviour of an individual (Kohrt, 2013). The framework emerged from Bronfenbrenner's (1979) model of ecology of human development, and attributes violence to be a product of the complex interplay between multiple factors in the child's environment. There are four levels of such surrounding factors:



The first level, known as the *microsystem*, refers to a small, immediate environment in which a child lives. This includes the family and peers, with whom the child interacts. The way these surrounding individuals or groups interact with the child affects the child's development, mental health and quality of life. The mental health interventions that the child receives thus also depend on the relationship of the child with these surrounding groups (Betancourt & Khan, 2008). The second level is termed as the *mesosystem*, which describes the relationship that exists between surrounding groups at the first level for the sake of the child. The kind of interaction that takes place also affects the child's well-being. For instance, whether and how the parents and teachers, family and support networks, or family and services relate will influence the child's life either positively or negatively (Betancourt et al., 2010).

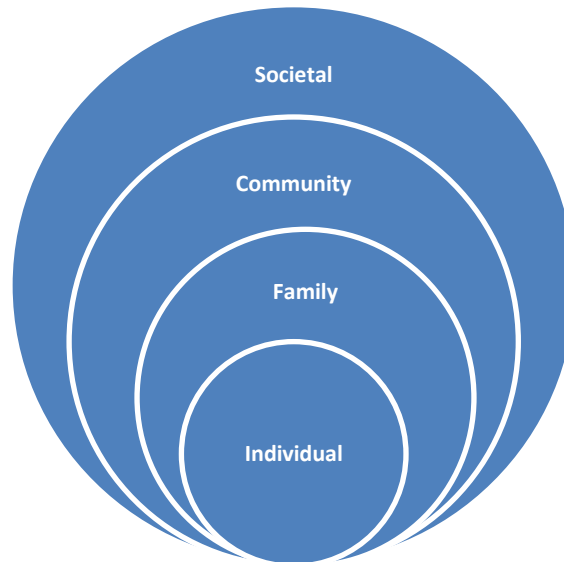
The third level named as *exosystem* refers to the systems or other groups of people existing within the environment. These do not interact directly with the child, though they have an influence on their life. These include extended family members, parents' workplaces, school departments and neighbourhood. Finally, the *macrosystem* describes the larger environment under which all the above named levels or systems exist within the child's surroundings. Such examples are the influence of cultural values, religious and spiritual beliefs, social and political economy, legal systems, and war (Fernando, 2008).

This increasingly influential model for research and service development illustrates that the environment in which children live and grow up plays a dynamic role in their growth. The risk of mental health maladjustment thus increases when resources at any of the levels are compromised such as damage to any extended support systems (Tol et al., 2008). In contrast, when resources are available across the levels, even in the face of extreme hardship, the risks are minimized and/or mitigated by building resilience within and around the child (IASC, 2007).

Consequently, the framework adopts a holistic approach to intervention focusing on the relationship between risk and resilience factors at different socio-ecological levels (child, family, peers, school, and wider community). Understanding the mechanisms underpinning these interactions between such factors across systems informs the development of effective multi-level psychosocial interventions tailored to vulnerable children's multiple needs

(Panter-Brick al., 2008). This rationale is particularly pertinent in addressing the complex and continuously mental health needs of children affected by ethnic conflict and displacement.

**Figure 2.2**  
**Ecological systems model**



#### **2.4.1.3 Universal/targeted model**

Psychosocial interventions for children may also be viewed within this model that includes universal, indicated (preventive) and selective (responsive) strategies (Marsac et al., 2014). The model has widely been used in health care, in order to rationalize the use of resources, and shares principles with the previously discussed pyramid model and adapted models of stepped care.

*Universal* interventions target an entire population or sub-system irrespective of their mental health correlates or presentations such as a group of schools in an educational authority, one school or one classroom (Kutash et al., 2006). Obviously, such a population or sub-system may carry at risk factors in the case of collective exposure to trauma such as after a nature- or human-induced disaster (Weisz et al., 2005; Dray et al., 2015). These interventions thus provide a platform for potentially addressing mental health problems at population level, without regard to individual risk factors (Masten et al., 2008; Domitrovich et al., 2010).

*Indicated* or *preventive* interventions target high risk children, for example if they have been identified with detectable but minimal mental health symptoms without currently meeting diagnostic criteria for a disorder (sub-clinical threshold) (Kutash et al., 2006). Without intervention, these symptoms of minor severity are likely to persist or escalate into more impairing conditions (Marsac et al., 2014). *Selective* or *responsive* interventions are designed for children who have already developed mental health problems or more severe disorders. These may be referred for treatment usually provided by specialist professionals, although different programmes are increasingly being developed and evaluated for different levels of severity of specific disorders such as adolescent depression (NICE, 2017). This model is based on the comprehensive continuum of prevention of mental health problems, starting from the general population of children at large, targeting those who are at particular risk, and treating those who have already developed mental health disorders.

The application of the universal, indicated and selective model is central to any public health system, and is of particular importance to child mental health, due to the continuum of most emotional and behavioural problems in young life. Such pathways to help are often called stepped models of care, as a child and their family can ‘move up the steps’ depending on the child’s response to the previous intervention level. In addition to health services, schools also play an important role in the mental health adaptation of this model. Schools can uniquely form the platform for both universal and targeted mental health interventions, including within-school specialist provision (Masten et al., 2008; Domitrovich et al., 2010). Reasons include their non-stigmatizing nature, accessibility and resource-effectiveness in addressing the needs of many children (Ertl & Neuner, 2014).

This model also has constraints, which are reflected in the literature review of interventions presented below. The components and goals of indicated and selective interventions often overlap and thus are not easily distinguishable (Marsac et al., 2014). A related argument is that interventions in the model cannot work efficiently in isolation, but rather as a comprehensive and seamless provision (National CAMHS Support Service, 2011). In particular, each step needs to have direct access to the next level of care, otherwise this is patchy and fragmented (Farmer et al., 2003; Weare & Nind, 2011).

It needs to be acknowledged that the above models are neither pure nor exclusive, as these are variably adopted in different countries and for different health care or welfare systems.

Considering their principles and applications in relation to the existing mental health literature on children who experience ethnic conflict in LICs, neither the pyramid nor the universal/targeted model was concluded to reflect the limited evidence for this group of children. For this reason, the ecological systems model, which was also adopted in Chapter I in reviewing the risk and protective factors that impact on children's mental health, was also followed in structuring this review of psychosocial interventions. According to this model, interventions were thus classified into: child-focused, which aim to re-process emotions, reframe cognitions, and improving adaptive behaviours by working with the child individually or in group settings; family-focused, where the aim is to change parenting or family-related factors; school and community-focused, where the onus is to change some of these factors as well as interpersonal functioning for large groups of children and often adults, by working with school or community groups (Figure 2.2). It is acknowledged that the term 'psychosocial' may not apply to all presented interventions, as some have only been described or evaluated at a single level (i.e. only psychologically), for which reason this term may be used intermittently with the term 'mental health' interventions.

## **2.5 Child-focused interventions**

These are applied directly with children, either individually or in groups, to support or help them to improve their mental health by preventing the deterioration or recurrence of mental health symptoms that impact on their everyday life. These interventions are considered in terms of psycho education (psychological first aid, writing for recovery), trauma re-processing (narrative exposure therapy, eye movement desensitization and reprocessing, cognitive-behavioural therapy, and testimonial psychotherapy); enhancement of resilience, mainly problem-solving skills or other coping strategies (education on symptomatic, building resilience, trauma with structures); and improvement of interpersonal functioning. These reported interventions with the target group of children for this thesis are discussed in detail in relation to their underpinning theory, goals, techniques and available evidence.

### **2.5.1 Psycho-education**

Psycho-education consists of first-stage and/or preventive interventions that provides basic information and strategies to children with emerging mental health problems and the ones around them such as family members, caregivers and peers, on how to understand thus manage their symptoms. Children and important adults are provided with a theoretical and practical approach on the nature, aetiology and consequences of a mental health problem.

This can help them to contain and manage symptoms of lesser severity before they escalate further (Ong & Caron, 2008). Such information and strategies enhance their awareness of symptoms and enhance their coping skills in normalizing their everyday functioning.

Psycho-education is in most cases used as a component of various empirically-supported therapies or approaches such as cognitive behavioral therapy (CBT) (Ong & Caron, 2008) creative art (Gupta & Zimmer, 2008) and trauma re-processing (Thabet et al., 2005) to help affected children and adolescents.

#### **2.5.1.1. Psychological First Aid**

Psychological First Aid (PFA) was developed by the National Child Traumatic Stress Network (NCTSN) and the National Center for PTSD (Betancourt et al., 2013), to support affected children, adolescents, adults and families in the immediate aftermath of disaster. The intervention is designed to reduce the initial distress (e.g. physical, psychological, behavioural, spiritual) caused by traumatic events, so as to foster either short or long-term adaptive functioning and coping strategies. The PFA enhances immediate and ongoing safety of the affected individuals and provides physical as well as emotional comfort by identifying the individual's immediate needs and concerns. Its fundamental principle is to provide the space for psychological recovery through creating a caring, calm and supportive environment. It also enhances coping strategies in order to normalize stress-related symptoms (Brymer et al., 2006). Finally, the PFA provides practical assistance to the child by connecting them with existing supports, identifying and referring them for more specialized support and services if required at the next step (WHO, 2014).

The PFA is cost-effective, as it can be provided by paraprofessionals and other disaster response or relief workers (Brymer et al., 2006). This also has implications for volunteers, teachers and community volunteers. However, despite its growing use in recent years as an evidence-based intervention, there have been no rigorous evaluation trials on its use among children and adolescents affected by war (Betancourt et al., 2013). In contrast, a six-week post-disaster PFA course was applied with children aged between 5 to 15 years who had been exposed to a natural disaster (Hurricane Katrina). Although this was not a controlled design, there was a statistically significant improvement in children's PTSD symptoms after the intervention (Cain et al., 2010).

### **2.5.1.2 Writing for Recovery**

Writing for Recovery (WfR) was developed by the Children and War Foundation, to reduce trauma-induced stress among adolescents between 12 and 18 years who had experienced trauma (Yule et al., 2005). The intervention is provided in groups, and includes six 15 minute- writing sessions over three consecutive days. This therapeutic tool offers children an opportunity to undertake a writing exercise focusing on emotions associated with traumatic experiences. The writing exercise starts in an unstructured format, before becoming more structured in children detailing their traumatic memories and insight (Kalantari et al., 2012). When children reveal their stressful events and experiences, the healing they experience (Pennebaker, 1997) may equip them with strategies to control their emotional or behavioural reactions (Hurley, 2006; Yule et al., 2013). This is also a cost-effective intervention in terms of resources and time, as it is flexible and easy to administer (Kalantari et al., 2012). The intervention has been suggested not to cause harm (Yule et al., 2005), and can be implemented by paraprofessionals with only one day of training, following the WfR manual (Lange-Nielsen et al., 2012). These factors facilitate its use in different accessible setting such as camps and schools, or in community.

Studies have reported varying results following the implementation of this intervention. Although there were no significant effects of the writing intervention found in a RCT among adolescents in Gaza, participants recommended the intervention for their positive experience of participating. It was not clear whether the ongoing conflict which continued to expose the children to traumatic experiences compounded the results (Lange-Nielsen et al., 2012). However, elsewhere a pilot study investigated its effects on Iraqi displaced adolescents in Jordan, and showed a short-term positive effect. Similar, positive results were established with bereaved Afghani adolescents in Iran. Those young people who received the writing intervention were less distressed than those in the waiting list control condition (Yule et al., 2013).

### **2.5.2 Trauma reprocessing interventions**

This largest and most utilized group of interventions mainly focuses on children's past traumatic experiences. The overarching principle is helping the child to re-experience past events in a safe therapeutic environment and to reframe that experience through different modalities that have evolved from the main psychotherapy schools in recent years, before being applied in vulnerable groups with complex needs, especially in LICs. Interestingly,

approaches from supposedly different fields such as psychodynamic therapy and cognitive-behavioural therapy (CBT) have converged to same extent in recent years in trauma-focused programmes, despite their different orientations and techniques (Warshaw et al., 2013). The most commonly evidence-based approaches include Narrative Exposure Therapy (Zang et al., 2013), Cognitive-Behavioural Therapy (Cohen & Mannarino, 2008), Eye Movement Desensitization and Reprocessing (Shapiro, 2014), Testimonial Psychotherapy, and creative or expressive therapies (Betancourt et al., 2013).

### **2.5.2.1 Narrative Exposure Therapy**

Narrative Exposure Therapy (NET) is a standardized short-term trauma-focused treatment for PTSD symptoms (Zang et al., 2013). One of its strengths is its application across different cultures (Morina et al., 2012) with children who suffered multiple and severe traumatic experiences, particularly survivors of war and torture (Schauer et al., 2011). The intervention has been adapted from its original adult version for war-affected children between 12 to 17 years (KIDNET). The therapeutic process involves the child constructing a narrative by focusing on entire life traumatic experiences and memories rather than a single episode or event (Betancourt et al., 2013). The child tells the story (narrative) of the trauma and consequently re-experiences thoughts and emotions associated with it. The therapist may use role-play or visual aids such as a rope, string, rocks, flowers and drawings to enable the child to symbolize and reconstruct the traumatic events that they have experienced (Gwozdziwycz, 2013). Evidence shows that disclosure of stressful events through either writing or story-telling has the potential of mitigating mental health problems such as PTSD symptoms (Pennebaker, 1997; Hurley, 2006).

Several studies have found NET to reduce PTSD symptoms in war-affected children and young people (Schauer et al., 2011). For instance, it has effectively been delivered in LICs countries with children orphaned in the Rwandan genocide and affected by war in Sri Lanka (Betancourt et al., 2013). The orphaned children in Rwanda significantly improved in PTSD symptoms in an RCT design (Neuner et al., 2008). Similarly, war-affected Sri Lankan children showed significant reduction in PTSD symptoms and impairment in functioning (Catan et al., 2009). In two RCTs on the efficacy of NET in Uganda, the intervention was shown to be superior in reducing PTSD symptoms when compared to psycho-education and supportive counselling (Neuner et al., 2008). The higher level of competencies and training required means that KIDNET is less cost-effective than the previously described psycho-

education programmes (Northwood & Orieny, 2014), which is a constraint in LICs. However, in recent years training has become available for non-mental health professionals in a number of LICs, whilst retaining its fidelity and efficacy (Robjant & Fazel, 2010; Betancourt et al., 2013).

#### **2.5.2.2 Trauma-focused cognitive-behavioural therapy**

CBT is broadly based on the theory that traumatic events lead to negative cognitive frameworks, which are challenged through both cognitive and behavioural techniques. This approach has expanded in the last decade to target a range of problems in adults and adolescents who have developed cognitive capacity. It has also led to a substantial body of evidence. Recent years have seen the emergence of trauma-focused CBT, with applications with refugee and other young vulnerable groups. Programmes are usually time-limited with about 10-20 sessions. Once negative cognitive patterns associated with the trauma have been identified, young people are encouraged to make links between these thoughts, their emotions and behaviours, before beginning to tackle them (Coull, & Morris, 2011). The intervention can be combined with trauma-processing, co-operative play, and creative expressive activities. It requires training, but different training levels are available for community paraprofessionals (Betancourt et al., 2013).

CBT has been used in LICs such as Indonesia, Nepal and Burundi to help war-affected children. Results from some RCTs have shown significant improvements in PTSD, other emotional symptoms and behavioral problems. For instance, a study in Sierra Leone investigated the effectiveness of a ten-session CBT with 436 war-affected youth aged 15–24 years. Pre-, post- and six-month follow-up assessments measured psychological distress, social support, emotional regulation, prosocial attitudes/behaviors and PTSD symptoms. Post-intervention results showed significant improvements in mental health and functioning; while the follow-up results indicated educational improvements such as enrollment in school, classroom attendance and behaviour (Betancourt et al., 2014). Similarly, the effectiveness of the intervention in reducing PTSD and anxiety symptoms among children and young people was noted in Indonesia, particularly among female participants (Tol et al., 2008).



### **2.5.2.3 Eye Movement Desensitization and Reprocessing**

Eye Movement Desensitization and Reprocessing (EMDR) was originally developed to treat PTSD in adults with traumatic memories and other negative life experiences (Shapiro, 2014). EMDR uses both narrative and CBT-based techniques in a physiological context of traumatic experiences, thoughts and somatic sensations being inter-linked. It is based on the theory that the primary foundations of mental health problems are unprocessed memories of earlier life experiences. The specific basis of EMDR in the treatment of PTSD is that physiological mechanisms underpin distressing symptoms (Cornine, 2013).

The adult-based manualized protocol was appropriately modified and adjusted (Fielda & Cottrell, 2011) to make it appealingly simple and suitable for use with children (Ahmad et al., 2007). A course typically consists of eight sessions of three phases, which facilitate a comprehensive evaluation, client preparation, and reprocessing of a) past traumatic events b) ongoing disturbing issues and c) future challenges (Shapiro, 2014). The therapeutic objective is to reduce subjective distress, thus strengthen adaptive cognitions related to the traumatic event. Since there is the potential for the child to be disturbed by the emotions brought up by the therapy, parents are encouraged to become involved as collaborators and help in fostering the child's trust in the therapist (Fielda & Cottrell, 2011).

Even though EMDR is increasingly being available to child mental health practitioners, and has been found to have positive effect on traumatized children such as refugee or victims of sexual abuse (Ahmad et al., 2007), there are no studies as yet on children exposed to ethnic conflict, particularly in LICs.

### **2.5.3 Resilience or coping skills interventions**

Resilience is construed as a dynamic developmental process that leads to the attainment of positive adaptation, despite exposure to adversity (Cicchetti, 2010). Resilience-focussed interventions thus aim to strengthen protective factors to foster or enhance coping strategies and positive mental health (Fergus & Zimmerman, 2005; Dray et al., 2015). These mechanisms incorporate both the child's individual's internal factors (i.e. self-efficacy, coping skills, and effective problem solving) and wider social external factors (i.e. family and peer relationships, school, or community) (Fergus & Zimmerman, 2005; Dray et al., 2015).

Resilience-building can encompass different approaches, although the most commonly reported programmes were designed to enhance children's problem solving skills. Their framework originates from cognitive and social learning theories although, unlike trauma-

focused CBT, this approach focuses on current life stressors rather than past traumas (Werner, 2012).

### **2.5.3.1 Problem Solving Skills Training**

Problem solving skills training (PSST) is such an application, with different versions of the predominant framework, which are also referred to as cognitive PSST, interpersonal PSST or social PSST (Bell & D’Zurilla, 2009). A course is delivered through weekly 50-minute sessions for about 8 to 14 weeks. PSST particularly trains children in developing effective coping skills in the aftermath of stressful events (Kazdin, 2011). An objective is to generate the use of acquired skills to all aspects of children’s lives after the intervention (Nguyen et al., 2016). Unlike trauma repossessing interventions (i.e. NET, CBT or EMDR), which address past traumatic experiences, PSST techniques aim to alleviate current or ongoing stressors by teaching children adaptive coping skills. Children thus learn to think differently on how to manage thoughts, feelings and how to interact appropriately (Chan & Fong, 2011). The skills they gain enable them to come up with multiple but constructive strategies to face future adverse situations that they encounter in their lives (Kazdin, 2010).

PSST has widely been used with children and adolescents (7 to 14 years old) particularly those with behavioural problems such as struggling to handle frustrations, instead reacting with aggression (Kazdin, 2010). There have also been some reported on benefits for adolescents with comorbid depressive symptoms (Bell & D’Zurilla, 2009). PSST is often combined with parent-focused interventions that will be discussed in the next section. For instance, in a study which was not conflict-related, combined PSST and parent management training (PMT) was used for children (aged 7-13 years) with antisocial behaviour and their parents. Unfortunately, there is no evidence on the efficacy of PSST in the LICs, even though there is a huge number of children and adolescents affected by conflict and living with disadvantage, i.e. who would fulfil the criteria for this approach (Kieling et al., 2011).

## **2.5.4 Interventions to improve interpersonal functioning**

### **2.5.4.1 Interpersonal psychotherapy**

The main representative from this group and with the strongest evidence-based is interpersonal psychotherapy (IPT), which was initially developed for adolescent depression. IPT is based on the principle that young people’s mental health status affects the way they

communicate and interact. Therefore, dealing with these issues will help the person to cope adaptively by building social skills, thus better organizing their lives (Layne et al., 2008). This is a short- to medium-term, manualized approach that helps the young person to regain control of their mood through improved social functioning. IPT is delivered individually or in groups, and over 12-16 weeks (MacKenzie & Grabovac, 2001; Markowitz & Weissman, 2004).

IPT has successfully been used to help affected children and young people in various settings in LICs. Positive findings have been established in war-affected areas. For example, a RCT of an adapted group intervention was conducted with war-affected youth aged 14 and 17 years, living in camps in northern Uganda. The interventions comprised 16 weekly two-hour group meetings. Results from this study indicated that the intervention had positive effects by reducing depression symptoms, largely in female participants (Bolton et al., 2007; Betancourt et al., 2013).

## **2.6 Family-focused interventions**

Family in the displaced child's environment (Mejia et al., 2015) plays a significant role in both preventing risk factors and enhancing protective factors for child mental health outcomes (Betancourt & Khan, 2008; Thabet et al., 2009; Tol et al., 2013). A nurturing family environment with secure attachment to the primary caregiver consistently enhances children's resilience in the face of adversity (Annan et al., 2017). The quality of caregiver support thus influences the child's adjustment to war stressors. Consequently, developing and providing family interventions can help break cycles of vulnerability among children and their parents (El-Khani et al., 2018). A range of modalities have been developed for universal and targeted use, and these have been adapted in recent years for children who experienced war trauma and displacement.

Overall, parenting programmes that are designed to promote positive parenting, which in turn can enhance the children's mental well-being, both in terms of emotional and behavioural functioning are crucial (Mejia et al., 2012). These are largely based on social learning theory, although they are increasingly mixed with other approaches such as attachment theory, as well as practical support for high need families. Training variably aims at empowering parents to strengthen parenting strategies (Knerr et al., 2013), attitudes (Desai et al., 2017), self-efficacy, couple interaction quality (El-Khani et al., 2016), parental mental health such as

anxiety and depression (Mejia et al., 2012), and reduction of family violence (El-Khani et al., 2018). These parental factors are obviously inter-related.

The large body of evidence highlights the effectiveness of parenting programmes on a range of parental and child outcomes (Eshel et al., 2006; Mejia et al., 2012; Knerr et al., 2013). Some of these outcomes include symptomatic improvement in feeding and sleep problems, conduct problems, drug and alcohol use, and anxiety (Cartwright-Hatton et al., 2011); as well contribution to the management of developmental conditions such as attention deficit-hyperactivity disorder, learning disabilities (Plant & Sanders, 2007), and autism (McConachie & Diggle 2007) through modified versions.

These implementations have prompted a call for culturally adapted family interventions targeting the prevention of behavioural difficulties and child maltreatment in LICs (WHO 2009). This need has been constrained by the lack of policy on prevention (Mejia et al., 2015), but also by methodological deficits in the emerging approaches. Most of the reported family-based programmes in have either not been empirically tested (Annan et al., 2017) or their evaluation has been methodologically weak, for example under-powered (Knerr et al., 2013).

As for the broader psychosocial models already discussed, family or parenting interventions can also be classified under universal, selective or indicated, by using a public health prevention framework (Marsac et al., 2014). Universal intervention programmes aim for whole population or community, without selection on the basis of risks involved. Selective programmes are, in contrast, directed specifically to a target group at risk such as families living in a disadvantaged area or pregnant mothers. Finally, indicated family interventions are aimed at families whose children have developed problematic behaviours (Kutash et al., 2006; Desai et al., 2017). Different formats, i.e. individual or group-based, multi-component, or home visiting, are applied in different settings such as homes, schools, primary health care, hospitals, or community centres) (Mejia et al., 2015). It is increasingly acknowledged that multi-modal programmes which target children, family members and support systems are more appropriate for vulnerable groups with multiple needs and living in disadvantage, are thus more likely to improve children's mental health (Bergner et al., 2008; Fridgen et al., 2013). The main types of interventions, particularly when delivered in LIC conflict settings and supported by evidence, were selected for this review.

### **2.6.1 Family support**

Family support is a broad term that incorporates a variety of material support and parenting skills, in either a preventive or responsive context. This combined approach has been found effective in promoting children's mental health by concurrently tackling their different needs. Another key role of family support is in co-ordinating agencies surrounding the child and their family, and in maximizing their input (Wieling et al., 2015). Such comprehensive approaches are not as yet available or evidence-based in LICs, but some of these components have been developed and evaluated, hence programmes reported in the literature are discussed in more detail below.

#### **2.6.1.1 Parenting skills training**

Parenting skills training (PST), also known as parent management training, is a behavioural approach that enhances positive parenting behaviours for the purpose of promoting their children's mental health (Gardner et al., 2006; McGrath et al., 2013). This includes a psycho-education component and has been applied with children exposed to armed conflict and war (Tol et al., 2013). Parent skills training particularly targets dysfunctional parental roles that are likely to cause or worsen children's problems, usually of conduct (externalizing) nature (Bradley et al., 2003; Jordan et al., 2010). Desired parenting strategies include interactive play, consistency, setting boundaries, and reinforcing positive behaviours (Cartwright-Hatton et al., 2005).

In a controlled evaluation of a brief parenting intervention in Burundi, parents of children with identified behavioural and emotional problems received two sessions of psycho education. This involved replacing harsh techniques with positive parenting practices (Jordan et al., 2013). This brief intervention led to significant symptomatic improvement. Parents perceived it as a positive experience that equipped them with appropriate strategies in managing their children's behaviours.

#### **2.6.1.2 Family skills training**

Family skills training (FST) is also a behavioural approach developed to teach parents adaptive parenting skills, and in addition to improve family functioning and relations (Kumpfer & Alder, 2003; Tolan et al., 2007). For this reason, this involves the family unit, initially working separately with the parents or caregivers and the children, before integrating

goals and providing joint feedback. Different applications of this approach have been reported in the literature such as the Happy Family Programme (HFP - Sim et al., 2014).

HFP is a modified version of the Strengthening Families Programme, a family skills intervention used internationally to promote the mental health of children faced with armed conflict (Ryzin et al., 2015). The program trains both the parents or caregivers and their children in developing coping skills in the event of a traumatizing situation (Kumpfer et al., 2010). Such a programme was evaluated with Burmese migrant and displaced families in Thailand (Annan et al., 2017). The RCT was implemented by the International Rescue Committee and recruited Burmese parents or primary caregivers (n=513; aged over 18 years) with their children (n=479; aged between 8 and 12 years). The intervention comprised of 14 weekly sessions (two hour sessions per day), where caregivers learnt parenting skills while children learnt social skills. During the first hour each day, the groups were separate before coming together in the second part of the session. Both groups interacted, practiced and received facilitators' feedback at the end of the programme. There was significant increase in pro-social protective factors in children, their behavioural problems decreased, while their attention and resilience improved. Also, there was improvement in family functioning, i.e. family cohesion and positive communication, and caregiver-child relationship; negative parenting practices such as harsh parenting and punishments decreased (Sim et al., 2014). This is one of the most interesting pieces of evidence on how a joint approach can achieve positive outcomes across parent, child and family domains (Knerr et al., 2013; Annan et al., 2016).

### **2.6.2 Attachment-based interventions**

So far, most described modalities were based on social learning theory, in promoting positive parenting strategies and attitudes without addressing the quality of the parent-child relationship particularly where there were impairment in the attachment style (Betancourt et al., 2013). This has been a longstanding gap in the child trauma literature, which has begun to be addressed in recent years through the expansion of attachment-focused interventions, predominantly for children who suffer maltreatment such as those in adoption or care. 'Attachment' constitutes the emotional relationship or bond between the parent or other caregiver and the child. A secure attachment style helps children to mitigate their negative emotions in the face of any adversity by seeking proximity with their parents or caregivers. In contrast, insecure attachment styles (including avoidant, disinhibited or disorganized types)

can lead to emotional dysregulation, and in turn a range of emotional, behavioural and interpersonal difficulties (Van Ijzendoorn, 2007).

An RCT in a South African peri-urban settlement assessed the efficacy of such an attachment-focused intervention provided by lay community workers to pregnant women. In total, 449 women were recruited from late pregnancy through to six months postpartum. Participants in the intervention group were provided with support and guidance in parenting, with particular focus on the quality of the mother-infant relationship, while those in the control group did not receive any therapeutic input. The quality of mother-infant interactions was measured at six and 12 months postpartum, while the infant attachment security was measured at 18 months. Both outcomes were found to improve significantly in the intervention group. Mothers in the intervention group were more sensitive in their interactions with their infants, and there were higher rates of secure infant attachment in the same group (Cooper et al., 2009).

### **2.6.3 Interventions to improve parental mental health**

Families where at least one parent has a mental illness face several inter-linked challenges such as family relationships difficulties, marital discord, impaired parenting capacity, financial hardship and social isolation, all of which are established risk factors for child mental health problems (Reupert & Maybery, 2007). This is a bi-directional relationship, as parents with mental illness may increase the likelihood of mental health problems in their offspring (Garber et al., 2009; Chemtob et al., 2013), which in turn act as additional stressors to the parents, thus compounding their ill mental health (Cluxton-Keller et al., 2015). This shows that parent and child mental health are inter-dependent (Silverman et al., 2008). This knowledge has led to the development of family-based interventions programmes (Reupert & Maybery, 2007) aiming to meet both children's needs by mitigating risks and building resilience, and parents' needs by treating the underlying mental illness and providing support with parenting responsibilities, (Reupert & Maybery, 2007). In contrast, parental mental health will not indirectly improve by only tackling parenting or family issues. For example, the previously mentioned South Africa RCT did not show any significant reduction in maternal depressive symptoms postpartum, although some improvement in mood was detected after six months (Cooper et al., 2009). These findings also demonstrate the importance of placing interventions in a service context, in this case by establishing direct links and collaboration between child and adult mental health services.

## 2.7 Community-based

The term '*community*' may refer to several typologies with different meanings. These include providing the central focus of an intervention; or serving as a setting, target, agent and resource to enable its implementation. '*Setting*' community-based interventions refer to the community as primarily being used as a geographical location purposely used for programme implementation. In this typology, the community is simply used as the vehicle for change. '*Target*' community-based interventions refer to programmes which use the community to implement broad systemic changes such as in public policy, or community-wide institutions and services. The community here is used specifically as the target for the change required (McLeroy et al., 2003). '*Resource*' community-based interventions are models mostly applied within the community with the focus being on soliciting community resources to achieve better health outcomes. They advocate for a high degree of community ownership and participation to foster culturally appropriate intervention implementation and sustainability. This can be achieved through collaboration with a wide array of institutions (Minkler et al., 2001). Community-based interventions using the community as an '*agent*' refer to programme that focus on the community capacity as a natural force of producing or obtaining specific health result or outcomes.

Whichever the selected type of community model, the key agencies which are important for promoting child mental well-being are the same, i.e. families, informal social networks, neighbourhoods, businesses, schools, religious bodies, voluntary agencies, community support groups, and other organizations and political structures (McLeroy et al., 2003). The body of evidence-based literature highlights the increasing importance of community-based interventions to improve help-seeking and consequently health care. These are particularly important in playing an important ameliorative role for conflict and war-affected children (Merzel & D'Afflitti, 2003; Betancourt et al., 2008), even though there is still limited research from LICs (Betancourt et al., 2010). In this review, community-based interventions will be considered in relation to their use as the key forum or natural resource in addressing children's psychosocial needs. It is acknowledged that this categorization is not exclusive and readily distinguishable in the available literature.



### **2.7.1 School interventions**

Some interventions in this section overlap with earlier categories but, as school was used as a base, setting or resource, these are also presented under community-based interventions but will only be mentioned in passing, without going into detail, thus avoid repetition. In the aftermath of war or disaster, schools are important safe spaces for the implementation of child mental health interventions, for various reasons. Schools serve as natural settings for the children, where their teachers play an important role in identifying and supporting those in need (Wolmer et al., 2003). They provide protective functions in monitoring children's physical and mental health in a systematic manner, and in referring those who require further attention (Persson & Rousseau, 2009). Schools act as hubs that reach the majority of children, thus school-based interventions can be more accessible and cost-effective than if provided within health care settings (Tol et al., 2008). Interventions, both structured and unstructured, can be delivered in a safe, informal and non-stigmatizing setting (Ungar et al., 2013). Accessibility and cost-effectiveness of programmes is further enhanced by training teachers and other educationalists in basic mental health techniques (Persson & Rousseau, 2009).

For all those reasons, offering mental health interventions within schools is a key World Health Organization policy (Persson & Rousseau, 2009). Interventions within the school setting are aimed either at preventing or managing emerging mental health problems through universal, indicated or indicated approaches. Despite this policy priority, so far few school-based interventions for children affected by armed conflict have been implemented and evaluated in LICs (Betancourt et al., 2013). In this review, the identified school-based interventions include psycho-education, classroom-based intervention, socio-drama, movement or dance, and playful group cohesion activities (Ertl & Neuner, 2014). However, it is acknowledged that some of these interventions appear to overlap with the previously discussed trauma reprocessing interventions.

#### **2.7.1.1 Psychosocial structured activities**

Psychosocial structured activities (PSSA) constitute a multi-phased approach that originates from the Classroom-Based Intervention Programme described below, in using children's natural resilience to help them cope with trauma. PSSA sessions typically include thematic activities to address concerns of safety and self-control, thoughts and reactions during danger,

self-esteem, identification of resources, and coping skills (Ager et al., 2011). Also incorporated in these sessions are drama, movement, art and play therapeutic activities, all of which are purposely included to improve emotional outcomes and feelings of stability after exposure to trauma. Similarly, community service opportunities and parental engagement are integrated, with the aim to attend to children's multiple levels of ecological needs (Betancourt et al., 2013).

This programme has been successfully used in a number of settings in Uganda (Ager et al., 2011), Sri Lanka (Somasundaram, 2007) and Palestine (Khamis et al., 2004) to help children recover from traumatic experiences. Positive impact on attendance rates, academic achievement and interpersonal relationships such as teacher–student interactions in the classroom are some of the reported achievements

For instance in Uganda, the programme was implemented with displaced children from 21 schools, following ethnic conflict. Children were randomly assigned to the intervention (n=203) and waiting list group (n=200). The intervention comprised of a series of 15 one-hour classroom structured activities, delivered over five weeks. These included movement, drama, music and art. Additional components addressed parental support and community involvement. The latter extended to digging boreholes, planting trees, and helping the sick and elderly. The intervention was associated with improved well-being over 12 months, particularly among girls, which extended to the control group too after they had also received the intervention (Ager et al., 2011).

#### **2.7.1.2 Classroom-based intervention**

Classroom-Based Intervention (CBI) is a widely disseminated school-based programme that aims to enhance children's resilience, a sense of hope and adaptive functioning; and in reducing in parallel mental health symptoms of PTSD, depression and anxiety (Tol et al., 2008; Ertl & Neuner, 2014). The CBI is manualized and delivered over five weeks in groups through 15 hourly sessions. Each of the five weeks has a themed focus, i.e. safety and control, stabilization and awareness; trauma narrative around thoughts and reactions during and after times of danger, and appraisal narrative, including resource identification and coping, and; finally, future orientation and social networks. The approach uses concepts from creative, expressive and experiential therapy, co-operative play and cognitive-behavioural

therapy; and combines several but specific techniques like psycho-education, group cohesion activities, socio-drama, movement/dance, stress inoculation techniques and narrative exposure (trauma-processing through drawings) (Jordans et al., 2010).

CBI has been applied by trained paraprofessionals and has been evaluated through rigorous cluster randomized controlled trials with war-affected children ranging between 7 and 17 years (Tol et al., 2008) in various countries such as Indonesia, Nepal and Burundi (Ertl & Neuner, 2014). Results from Nepal demonstrated moderate short-term beneficial effects. There was some improvement in social functioning, behavioural and resilience indicators. In girls there were increased pro-social behaviours, while in boys there was reduction in aggression and emotional symptoms. In Indonesia, the key finding was reduction in PTSD symptoms. Finally, in Burundi children showed decrease in both PTSD and depressive symptoms associated with the intervention group. These results demonstrate that CBI has the potential benefits for children in post-conflict settings (Jordans et al., 2016).

### **2.7.1.3 School mediation intervention**

Mediation is an impartial and intermediary model that helps to reconcile contending parties. It is a non-coercive approach that is task-oriented in facilitating a mutually acceptable negotiated settlement in a conflict between such concerned parties (Fisher, 2011). This operates on a theoretical rationale that interventions in war conditions that encourage shared problem solving, empathy, caring and positive social relationships can mitigate mental health problems such as PTSD (Peltonen et al., 2012). This intervention process requires skilled mediators and supervisors.

The school mediation intervention (SMI) is an application of this model through schools and for children exposed to conflict. For instance, this was conducted with Palestinian school children in the Gaza Strip. A total 225 children between 10-14 years and their teachers took part in the study, whose objective was to investigate the potential SMI effect on children's social functioning, peer relationships and group cohesiveness. The programme used dialogue skills, conflict resolution and problem solving. During the study some of the children were trained as mediators, while their teachers were trained as field supervisors. The procedures of the intervention included: identifying the nature of the problems, entering the conflict situation, determining the critical disagreements of the conflicting parties, helping children to

agree on the mediation rules, hearing, writing down, and offering solution options, enhancing their communication skills, motivating for looking diverse solutions, and making mutual plans to achieve agreed better practices in peer relationships. The results showed that children's mental health and social functioning did not improve (Peltonen et al., 2012). Possible explanations which merit further investigation include the continuation of war during the intervention, i.e. the importance of replicating it in other post-conflict contexts; and/or that the primary outcomes of mediation such as perception of and attitudes towards conflict were not sensitively measured, with instruments used reflecting secondary outcomes such as social functioning and mental health symptoms. The latter reason would indicate the importance of combining school mediation with a more established and targeted mental health intervention in the future.

#### **2.7.1.4 Dance and movement therapy**

Dance and movement therapy (DMT) is a psycho-therapeutic approach which predominantly aims to further an individual's emotional, physical and social integration, with the added advantage that it transcends cross-cultural boundaries, as it does not rely on language (Harris, 2007a). The therapy helps traumatized persons by equipping them with skills they need both for grounding themselves "in their bodies," and for understanding the relationship between traumatic memories and bodily sensations (de Tord & Bräuninger, 2015). Dancing and movement have been applied as creative artistic expressive activities that engage cultural resources to enhance children's and communities' capacity in the aftermath of conflict and disaster. As modes of psychosocial intervention, dance/movement programmes, if appropriately designed to maximize cultural relevance, have the potential of fostering resilience after exposure to ethnic violence, by sublimating inter-group tensions, while increasing interpersonal connection and strengthening solidarity (Harris, 2007b). The mechanisms behind DMT are based on the theory that brain, body and mind are linked, are thus impossible to disentangle. Movement during DMT sessions affects the total functioning of the individual, by using a safe space in the therapist's presence. Music helps participants to develop empathy, i.e. the ability to understand one another's feelings, thoughts and experiences. The body through movement subsequently communicates such developed empathy within and between participants.

In Sierra Leone, the effect of dance and movement therapy was evaluated among war-torn males aged 15 to 18 years. Sixteen 2-3 hour sessions were combined with improvisational dance to Sierra Leonean pop music. The objective was to improve young people's emotional regulation, thus build their self-confidence. At the time of recruitment participants were screened for a range of posttraumatic mental health symptoms, i.e. elevated arousal and intrusion, depression, anxiety, and aggressive behaviour. These symptoms were assessed thereafter at four points, i.e. after one, three, six and 12 months (Harris, 2007b). Although findings based on the quantitative data have not as yet been published (i.e. Getanda et al., 2017, whose research was only a feasibility study, therefore never meant to evaluate effectiveness) the qualitative data supported the feasibility of the intervention to be used in post-war contexts (Betancourt et al., 2013).

## **2.7.2 Other community interventions**

### **2.7.2.1 Traditional healing practices**

Traditional healing practices in many LICs have been perceived to play a role in social healing and justice at a community level in the aftermath of war (Akello et al., 2006). Traditional medicine is described as a combination of knowledge, skills and practices of different indigenous cultures that are based on their theories, beliefs and experiences applied to maintain health, i.e. improve, prevent, diagnose and treat physical and mental conditions (WHO, 2013). In many communities these approaches are administered by traditional healers. Such healers can make contributions to the social healing of the community through the various physical, mental and spiritual problems that people may experience (Al-Rawi & Fetters, 2012).

Traditional healers have played fundamental roles in many LICs to solve concerns affecting children in the community. For instance, in Zimbabwe, traditional healers have been used as a forum to facilitate reconciliation within families and communities concerning children's problems. They have engaged family and community members into groups in order to create restorative atmosphere within their societies (Betancourt et al., 2013). In Mozambique, spirits were used to defy the enemy. Culturally, traditional healers were used to manipulate the spirits to protect the soldiers when they went to war. After the war, soldiers sought the same healers, to appease any aggrieved spirits on their behalf, in case they killed innocent people.

Traditionally, in social healing only the spirit can decide how justice and reparation are best achieved in restoring peace and health in the community. Therefore, in order to avoid the spirit of the innocently deceased persons returning to haunt the living while seeking justice, spirits must be appeased (Igreja, 2003; Betancourt et al., 2013). Likewise, in Angola the same principles were applied by traditional healers conducting cleansing rituals on war-affected young people who were finally forgiven of the evils they had committed and were thus re-integrated in the community (Honwana, 1998).

Traditional healers and religious leaders' responses in these countries have been regarded as a critical means for trauma recovery among children exposed to conflict (Igreja, 2003; Betancourt et al., 2013). Notably, religion influences people's perceptions of health and their health seeking behaviours. Both traditional healing and religious beliefs provide frameworks through which health concerns are constructed and resolved according to sets of beliefs within the community. However, it needs to be acknowledged that traditional healing also carries significant controversies and risks such as ostracizing people with mental illness, that their boundaries with religion and its different healing powers are often unclear, and that their potentially positive effects have not been evaluated, especially how these could be integrated with scientific approaches (Stark, 2006).

#### **2.7.2.2 Social cohesion and reconciliation**

Reconciliation plays a fundamental role in post-conflict peace building. It is a strategy employed to bring together two or more parties previously involved in a conflict or an event of dispute and to restore their shattered relationships (Ioannou, 2014). This is not dissimilar to mediation, but it usually broader than working with individuals, instead adopting a collective approach. Disarming combatants and reinstating the rule of law (judicial process) often results in dealing with the perpetrators of human rights abuses after the end of violence (Lambourne, 2004). This theoretically promotes peace, security, stability and improves psychological healing in the society (Swartz & Drennan, 2000). In reality, however, large sections of a society remain divided through direct or by proxy alignment to perpetrators, and this prevents the society from moving through the healing process. This is why reconciliatory interventions are important adjuncts to reparations, any granted amnesty, and associated disclosures and confessions of human rights violations.

Forums such as the truth and reconciliation commissions were a central part of social cohesion and peace building efforts in several countries such as post-apartheid South Africa, post-genocide Rwanda and post-civil war Sierra Leone (Richters et al., 2005). For instance, in South Africa, the Truth and Reconciliation Commission (TRC) was established to assess the extent to which participation in reconciliation process was related to survivors' current mental health status and forgiveness. For this reason, an integral evaluation study was planned. Participants completed a battery of measures which included exposure to human rights abuses and other traumatic events, forgiveness attitudes towards their perpetrator(s), and current mental health problems. Findings indicated that low forgiveness was associated with poorer mental health, while there was no significant association between forgiveness attitudes or mental health problems and TRC participation (Kaminer et al., 2001).

Although mental health practitioners often hail TRC as a source of psychological healing (Swartz & Drennan, 2000), there is little evidence available that links it with improved mental health status. Therefore, the reconciliation process need not be exclusively a substitute for therapeutic interventions, but rather form part of the solution to the problem the survivors face. The combined process can lead to trauma healing through interventions based on the principle that the victim has choice and control over the inter-linked remembering, truth-telling, being accountable, forgiving and/or forgetting (Richters et al., 2005).

### **2.7.2.3 Mass media**

Mass media such as radio and television have been recognised as being instrumental in accomplishing a psycho-educational role to the public, especially children affected by war (UNICEF, 2010). Such as media programmes have innovatively been developed and broadcasted to target all levels of society. Some of those have actively involved children to deliver positive healing and reconciliatory messages to the public (Betancourt et al., 2013). This has been applied in several LICs such as Sierra Leone, Liberia, Angola and Mozambique (Tam-Baryoh, 2009).

In post-conflict Sierra Leone, the *Talking Drum Studio* was a youth-led weekly radio broadcast which focused on different themes such as positive youth leadership, adjustment to post-conflict environment, peace and reconciliation. The programme involved interesting music, exciting news stories, and other attracting information to young listeners, and its

messages were positively taken in by young people (Tam-Baryoh, 2009), although their impact on their functioning was not explored. In Mozambique a number of workshops were conducted to improve adult awareness and children's associated well-being. Radio personnel and children were invited to participate in the training on how to the design and produce child health education radio programmes. Five workshops were held in different places. Workshop participants varied between 5 to 10 adults and 8 to 15 children. These were invited by radio stations and were asked for each adult attending to snowball and find at least two more children to participate.

Following this selection process, groups of 6-8 children and adults combined were formed. Participants were asked to cover any health area of interest affecting the community, which ranged from street children, nutrition, diarrhoea, acute respiratory infections, malaria, accidents to road safety; and to prepare a 15-minute radio programme on a community action plan. The modes of radio transmission included discussion, stories, jokes, drama, interviews, quizzes, music and songs. Assessment through a follow-up workshop established that participants commended the improvement achieved by these programmes (Betancourt et al., 2013).

In both instances, these forums allowed children to voice their concerns (i.e. health and conflict) and their hopes (i.e. improvement, disarmament and demobilization of combatants, and their integration) in the community (Tam-Baryoh, 2009; UNICEF, 2010). If such forums (social media networks) can be utilised in the LICs, chances are there that impact of psychosocial interventions will be realised (Betancourt et al., 2013).

### **2.7.3 Multi-modal interventions**

Multi-modal interventions can be defined in different ways such as multi-level (Betancourt et al., 2013), multi-tiered or multi-phased (WHO, 2008), multi-layered (Jordans et al., 2011) or combined interventions (Rejani et al., 2012). Despite the different and constantly changing terms, their common objective is to achieve inter-linked and comprehensive changes across a child, their family and community by bringing together interventions and agencies that target different aspects of the affected children's environment. These are especially valuable for children with multiple and complex needs such as those living in disadvantage or who have established vulnerabilities such as living in care.



Multi-modal interventions are thus indicated for resource-poor settings, because of the wide-ranging impact of war, and the limited capacity of the informal and formal health care systems (Wessells & Monteiro, 2006; Jordans et al., 2011). When interventions are delivered in a variety of packages, instead of free-standing activities, and through different levels of the local health system (WHO, 2008), instead of single-intervention approach, a substantial scaling-up of these interventions can be realised, with far-reaching effects on the population (IASC, 2007; Jordans et al., 2009; Rejani et al., 2012).

Unfortunately, there are few reported multi-model interventions for children in conflict-affected settings. In practice, the majority of mental health policies and services, especially in LICs, adopt single-intervention approaches because of usually being set up to address their sector's (health, welfare, education or non-statutory) priorities in silo (Jordans et al., 2009). This despite the increasing international drive to develop inter-sector and interdisciplinary approaches of psychosocial and mental health care (WHO, 2008). In addition to barriers at policy and operational levels, there has been limited quality evaluation of those few multi-modal programmes that have been reported (Jordans et al., 2011). An example of such an intervention in LICs which was also evaluated was the care-utilization model for a community-based care package for children in war-affected areas in Indonesia, Sri Lanka, Sudan and Burundi. The care package was innovative and comprehensive by ranging from population-level (psycho-education) to referrals to specialist mental health services, according to children's level of need. This followed a public health model of primary, secondary and tertiary care, which was purposely applied to translate complex emergencies guidelines into a replicable delivery framework for LICs (IASC, 2007).

The different levels of care utilized in the care package involved: mental health promotion activities for the general population (level 1); peer-resilience group activities (recreational activities to peer group) targeting school-going children (level 2); classroom-based intervention for children with emerging psychosocial problems (level 3); treatment for children with more severe psychological distress that required more focused individualized care such as counselling or family/parental support) that can be delivered by training para-professionals (level 4); and, finally, access to specialist mental health services for the small number of children who had developed more severe disorders (level 5 - Jordans et al., 2011). Findings across all settings established high levels of user satisfaction that the model was accessible, and that it reduced costs and burden upon the practitioners (Wessells & Monteiro, 2006).

## **2.8 Children's needs and service gaps, and rationale for this study**

The literature, as critically reviewed in Chapters 1 and 2, has consistently highlighted that the evidence-base of efforts to develop, implement and scale-up interventions for children exposed to war and ethnic conflict in LICs remains nascent (Betancourt & Khan, 2008;). Yes, there is growing global attention to the large body of evidence on the impact of war and ethnic conflict on children's mental health and quality of life (Bowen et al., 2009; Tyrer & Fazel, 2014). However, the reality on the ground remains that policymakers and funding agencies hence pay little attention to the longer-term impact of psychosocial problems of displaced children due to ethnic conflict, with limited access to evidence-based interventions (Tol et al., 2008) and to adequately skilled professionals (Kohrt, 2013). Despite this increasing recognition of the importance of child mental health in Africa, especially its eastern regions where Kenya is not an exception, the gap between need and services provided remaining high (Barry et al., 2013; Jordans et al., 2013b; Tol et al., 2014). The purpose of this study was to assess the feasibility of delivering a psychosocial intervention for children in a post-conflict setting in Kenya. This research stage is particularly important before an intervention tailored (adapted) to be culturally sensitive and acceptable (Jordans et al., 2013a). Such knowledge would have important implications for policy makers and other stakeholders involved in the care of traumatized children, hopefully with generalizable conclusions for other LIC post-conflict contexts.

## **2.9 Chapter summary**

This chapter has critically reviewed child mental health policy and available evidence on a range of psychosocial interventions for children affected by war and ethnic conflict in LICs. Conceptual, practice, service and methodological gaps, barriers and constraints were identified and discussed in detail. The next Chapter 3 will provide the overarching methodology that will be used to answer the research questions of this study. Theoretical research frameworks, ethical theories and principles applied in research studies will be presented and discussed in order to justify the methodological decisions made.

## **CHAPTER THREE**

### **OVERVIEW OF METHODOLOGY**

### **3.1 Introduction**

This chapter presents the methodological overview of the study, providing a rationale for the mixed methods design adopted. The research design was complex and comprised two phases, which were conceptually and sequentially linked. The findings from phase I, i.e. the qualitative research on stakeholders' perspectives, informed the choice and adaptation of the intervention implemented in phase II, and the subsequent feasibility evaluation. This chapter explores the socio-cultural context for the study and the overarching research questions, aims, methodology and methods.

The researcher acknowledges that some information presented here may overlap to a small extent with subsequent chapters on the two phases. It was, however, considered important to present an overview of these two phases, how these are inter-linked, and the underpinning theories and mixed methodology approach that underpin it. This chapter thus discusses the justification of using a mixed methods approach in the study, as a whole, as well as ethical theories and principles relevant to vulnerable populations. Precise details and justification on the adoption of the specific design, sampling, data collection, research procedure and data analysis of each phase will be presented in their respective chapters, i.e. phase I in Chapters 4 and 5, and phase II in Chapter 6 and 7.

### **3.2 Socio-cultural context**

The study was carried out in Nakuru County, Kenya. Kenya is located in East Africa, and is one of the poorest countries in the world (Jenkins et al., 2010). It has a population of 46 million (Ayuku et al., 2014), half of whom are children people under the age of 18 years (WHO, 2011). Out of these children, approximately 2.4 million are orphaned and/or living in extreme poverty (Ayuku et al., 2014). It has been indicated that approximately one in five boys and one in three girls experience some form of sexual violence before the age of 18 years (UNICEF, 2012). Apart from the HIV/AIDS epidemic, recurrent droughts, economic disparities, concerns over access to ancestral lands and across border migration (Kiima & Jenkins, 2010; Jenkins et al., 2010), the country has experienced an unprecedented socio-political and ethnic violence, which led to massive population displacement of both adults and children. As discussed in the literature review, these multiple risk factors are associated with higher rates of mental health needs among the affected children.

Despite the consistent finding that the above mentioned risk factors are associated with higher rates of mental health problems in children, investment in mental health is among the country's lowest priorities, representing less than 1% of the total public health budget (De Menil, 2013). It is estimated that in the public sector there are only twenty five psychiatrists and five hundred psychiatric nurses in the country, with the majority working in cities. In some communities, particularly in rural areas, mental health is a tabooed and largely misunderstood concept (Getanda et al., 2015).

Nakuru County, which is found in the South Eastern part of the Rift Valley, is one of forty seven Counties in Kenya. It has approximately 1.8 million people, with half of the population being male and 16 % are under the age of five years (Getanda et al., 2015). It is estimated that there are 136 public, 118 private, 52 faith-based and 13 non-governmental health facilities the County. Only 27 % of the population is covered by the National Health Insurance Fund, with public services being provided by only 69 nurses, eight doctors and ten clinical officers per 100,000 people (Ministry of Health, 2015). The multi-ethnic County has the highest incidence of ethnic conflicts and displacements (Wangechi, 2014). This is reflected in higher mental health rates than other parts of country (Getanda et al., 2015). These reasons, in conjunction with the resulting high poverty levels, led to the selection of the area for this study.

### **3.3 Research questions**

#### **3.3.1 Overarching research question**

What is the feasibility of a selected psychosocial intervention for children exposed to ethnic violence?

##### **3.3.1.1 Research sub-questions**

###### **3.3.1.1.1 Phase I**

- i). How do key community stakeholders conceptualize mental health problems, contributing factors, and required psychosocial supports for affected children?
- ii). How do key community stakeholders identify the strengths and barriers of existing psychosocial supports and services for children with mental health problems?

### **3.3.1.1.2 Phase II**

- i). How can these stakeholders' perspectives be incorporated in a trauma-focused or other psychosocial intervention?
- ii). How feasible is it to deliver such a psychosocial intervention for this target group?

## **3.4 Research aims**

### **3.4.1 Overarching research aim**

To establish the feasibility of a psychosocial intervention for children exposed to ethnic violence and who experience mental health problems.

### **3.4.2 Specific research aims**

#### **3.4.2.1 Phase I**

- i). To establish how key community stakeholders' conceptualize child mental health problems, associated risk factors and required supports.
- ii). To examine how key community stakeholders identify strengths and barriers of existing psychosocial supports and services for children with mental health problems.

#### **3.4.2.2 Phase II**

- i). To establish how key community stakeholders' perceptions and recommendations can be incorporated to inform and select a culturally acceptable trauma-focused or other psychosocial intervention.
- ii). To evaluate the feasibility of the implementation of this intervention.

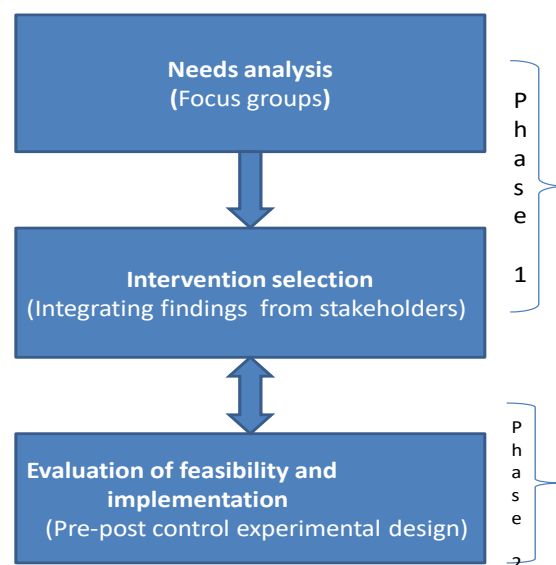
## **3.5 Research design**

The research design was guided by the overarching and specific research questions. As illustrated by the conceptual framework (Figure 3.1), this study consisted of two phases, which were sequentially linked. The research question and sub-questions influenced the choice of the appropriate approach for the overall study and the rationale for methods within the specific phases respectively. A sequential mixed-methods (MMs) approach was thus adopted for the overall research design. Sequential MMs designs involve the utilization of both quantitative and qualitative approaches in a single research project to collect and analyse

data (O’Cathain et al., 2008; Cameron, 2009; Farquhar et al., 2011; Tariq & Woodman, 2013). One method, either quantitative or qualitative, is used to inform the next stage of the study (Budosan & Aziz, 2009; Horn, 2009). This can be particularly relevant in mental health research and the development of interventions (Kettles et al., 2011). A qualitative approach was thus used to establish stakeholders’ views on children’s mental health and psychosocial intervention needs in phase I, the findings of which informed the design of phase II. A quantitative approach was subsequently used to evaluate the feasibility of the intervention implemented in phase II.

Consistent with previous intervention trials with similar groups of vulnerable children, this research design was considered to be appropriate, with the aim of capturing and incorporating user perspectives, maximizing objectivity and optimizing the intervention (Jordans et al., 2011).

**Fig 3.1 Conceptual framework**



Since the research consisted of a two-phase design, i.e. a qualitative (phase 1) and quantitative methods (phase 2), which were holistically incorporated under a mixed methods approach, it was considered important to outline a brief overview of the methodological components of each of these inter-linked phases, with details following in their respective chapters.

### **3.5.1 Phase I: Qualitative research design**

According to the conceptual framework (Figure 3.1), phase I of this study was concerned with the needs analysis (capturing the views of the community) to inform the selection of the intervention in conjunction of the existing evidence (integrating the views of the community). This was the participant-led and child-centred phase of the study, in order to ensure that this research was culturally appropriate and accounted for the perspectives and needs of the population being studied. The research aim of phase I was to establish community stakeholders' (young people, parents, teachers, professionals and community leaders in contact with children) views on children's mental health needs. The data, which was collected qualitatively by utilizing a thematic framework, informed the intervention selected and implemented in phase II. Community stakeholders' views were thus assessed and integrated in the selection of a culturally appropriate intervention to help children with mental health problems in the community.

A qualitative research approach is indicated in the investigation of data collected in a natural setting through participants' language and behaviours (Hilal & Alabri, 2013). This method allows natural interactions between the researcher and participants, hence it enables exploration of participants' values, motivations, beliefs, feelings and context that influence their behaviours. This process enables the researcher to understand how participants understand the world and their related experiences (Stewart et al., 2008). Phase I adopted a qualitative research design by using focus groups in collecting information, as these constitute an established tool in health research that provides a platform for sharing ideas. Focus groups are particularly useful for children, as they provide space to bounce ideas off each other and negotiate meanings (Willig, 2008).

Participants' personal views were crucial, were therefore taken to serve as a reflection of the 'real world' on the ground (Getanda et al., 2017), and as far as the children's mental health needs were concerned. In relation to the research aims, this approach identified both barriers to psychosocial interventions and suggested solutions on how to overcome those. The emerging findings informed the selection and planning of the intervention that was delivered in phase II.



### **3.5.2 Phase II: Quantitative research design**

The aim of phase II was to assess the feasibility and acceptability of the selected intervention in the target population. Different groups of participants took part in this feasibility evaluation, i.e. children, their parents and teachers. This formal and deductive method places considerable value on rationality, objectivity, prediction and control in problem-solving (Elshafie, 2013). It helps to discover new meanings, describe phenomena, and determine their patterns and relationships through statistical analysis; so that the findings reflect reality and are generalizable (Dash, 2005). Data was collected on children's selection, engagement and participation. Children also completed standardised rating scales of mental health problems before and immediately after the intervention, and at follow-up for the purpose of understanding the potential rather than establishing the effectiveness of the intervention. In addition, all participant groups completed free texts on the acceptability of the measures and the intervention. Although these free texts could be analysed through different thematic frameworks per se, in this study content analysis was used as complementary to the quantitative data, rather than as a mixed methods approach. This mixed methods framework was, however, adopted as the overall research study design of both phases I and II in conjunction. For this reason, this overarching method of choice and its alternative applications are discussed in more detail below.

### **3.5.3 Mixed methods approach**

In recent years, mixed methods (MMs) has been established as an approach in its own right, with growing applications across various disciplines such as health care, epidemiology, medicine, social work and education, among others (Greene, 2008; Evans et al., 2011). However, there is still no consensus in the methodological literature on what MMs research should entail (Cameron, 2011; Farquhar et al., 2011). Terms are interchangeably used to refer to 'multi-method' or 'multiple methods' research (O'Cathain et al., 2007), and this has created some confusion in its application. Nonetheless, there is relative agreement that a mixed methods study is generally conceived as a variable combination of quantitative and qualitative research methods, into a single study (Tariq & Woodman, 2013), and this can be achieved in various ways. De Lisle (2011) reported, for example, that MMs can be defined as a qualitative dominant, quantitative dominant or pure mixed approach. In other words, the qualitative component can inform and facilitate the quantitative one, or the quantitative component can provide a platform for the qualitative one, or they can operate on an equal

footing. Of course, the chosen modality of the mixed methods approach has implications for the way in which the data is interpreted, communicated and ultimately integrated.

Consequently, this approach is considered as an evolution of a ‘third methodological movement’ (Evans et al., 2011; Venkatesh et al., 2013), which aims at understanding complex research problems (Kettles et al., 2011). This is a particular reason for which it has been applied and increasingly gained importance within social, educational and health sciences (Palinkas et al., 2011). For instance, Robins et al. (2008) highlighted that the increasing influence of the method in contemporary mental health services research. Whilst qualitative methods are valuable in exploring the meaning of social phenomena, generating and refining a theory, or uncovering links among concepts and behaviours; quantitative research counts occurrences, establishes links among variables, and generalizes findings to the population under study (Bradley et al., 2007; Creswell et al., 2011). Crucially, MMs have distinct characteristics of integrating the two previous approaches in understanding complexity, rather than merely being the sum of qualitative and quantitative methods.

Several researchers have pragmatically tailored MMs in mental health research to answer innovative questions (Kettles et al., 2011). This has been particularly important in low-income countries with limited baseline evidence such as epidemiological findings. For instance, Horn (2009) used MMs to evaluate the Kakuma Emotional Well-being Interview (KIWI) in a Kenyan refugee camp. She used a qualitative approach to inform the development of a locally appropriate assessment of KIWI, while she opted for a quantitative design to evaluate its reliability and validity, in order to meet the needs of the target population. Similarly, Budosan and Aziz (2009) illustrated the usefulness of MMs in establishing population mental health needs in Mansehra, Pakistan, after an earthquake, through which informed choices of the training of mental health staff in the affected area were determined. Data collected by MMs complemented each other to identify the gaps and to inform the development of a training programme tailored to local mental health needs. A range of other indications for the use of MMs have been proposed in the literature (Farquhar et al., 2011; Kettles et al., 2011; Tariq & Woodman, 2013). These reasons are highlighted in Table 3.1 below. In this study, the exploratory sequential qualitative followed by a quantitative approach (qual→QUAN) was adopted to connect data between two phases.

**Table 3.1****When and why to use MMs in research**

Type of need	Design	Purpose	Example
<b>Complementarity</b>	Qual→QUAN	To enhance, deepen or broaden the meaning of a perspective or phenomenon, in order to enrich interpretations and conclusions (Farquhar et al., 2011; Tariq & Woodman, 2013).	Qualitative design helping to evaluate and interpret results from a quantitative study (Bolton et al., 2009).
<b>Triangulation</b>	QUAL+QUAN	To corroborate findings (Tariq & Woodman, 2013) to increase validity and confidence in conclusions reached (Cameron, 2011; Farquhar et al., 2011).	Qualitative and quantitative data merged to understand a research problem (Venkatesh et al., 2013).
<b>Development</b>	qual-QUAN	To develop and evaluate an intervention (O’Cathain et al., 2007; Tariq & Woodman, 2013) conceptual models (Palinkas et al., 2011), instruments, sampling and implementation (Farquhar et al., 2011).	Qualitative design used to develop constructs and hypotheses, and quantitative design conducted to test the hypotheses (Palinkas et al., 2011).
<b>Compensation</b>	qual→QUAN	MMs enable to compensate for the weaknesses of one approach by using the other (Venkatesh et al., 2013).	Qualitative analysis compensating for the small sample size in the quantitative study (Venkatesh et al., 2013).
<b>Exploratory</b>	QUAN + qual	Different types of data are collected in two separate phases (Kettles et al., 2011).	Quantitative data to test and explain a relationship found in qualitative data (Venkatesh et al., 2013).
	QUAN→qual	One type of data, usually quantitative, is collected, but the researcher wishes to follow-up the results with further qualitative research (Kettles et al., 2011).	Qualitative data to help explain or elaborate quantitative results (Venkatesh et al., 2013).
<b>Completeness</b>	qual→QUAN	MMs designs are used to ensure that a complete picture of a phenomenon is obtained (Venkatesh et al., 2013).	Qualitative data to provide rich explanations of the findings from quantitative data and analysis (Venkatesh et al., 2013).
<b>Expansion</b>	QUAN→qual	To assess different phenomena in order to expand the scope and range of the study (Farquhar et al., 2011), and to provide illustrations of context (Creswell et al., 2011).	Quantitative findings expanded or elaborated by examining the qualitative findings (Venkatesh et al., 2013).
<b>Diversity</b>	Qual +QUAN	MMs are used with the hope of obtaining divergent views of the same phenomenon (Venkatesh et al., 2013).	Qualitative and quantitative studies conducted to compare perceptions of a phenomenon of interest by two different types of participants (Venkatesh et al., 2013).

Although considerable advantages have been described in favour of a MMs approach, according to many studies (for example, Johnson & Onwuegbuzie, 2004; Onwuegbuzie & Collins, 2007; Tariq & Woodman, 2013), this paradigm also presents several challenges. In the first instance, Cameron (2011) highlights practical, philosophical, cultural and psychological (cognitive) issues as barriers to MMs research. When researchers hold different philosophical positions, there can be tensions because of their different beliefs (Creswell et al., 2011). Quantitative research is based on an epistemological stance, of positivism/post-positivism, whereby research proceeds in a scientific, objective and value-free way to enumerate generalizable findings. In contrast, qualitative epistemologies focus on social meanings, and the methodologies utilized to access these social meanings (Stewart et al., 2008).

It can thus be argued that these are different and incompatible paradigms. Consequently, according to some researchers, it is neither possible nor desirable to mix these methods within the same study, because each represents different and conflicting ways of data collection and views of the world (Tariq & Woodman, 2013). Other criticisms have been that MMs are mutually exclusive, therefore their use is inappropriate and counter-productive (Bradley et al., 2007); time-consuming, or requiring substantial experience and skills (O'Cathain et al., 2008); and are difficult in integrating, interpreting and disseminating data (Bryman, 2007). Lastly, it has been noted that many MMs studies fail to be published (Tariq & Woodman, 2013), simply because they lack a sound design, transparency of and theoretical justification for the use of the MMs components (O'Cathain et al., 2008; Venkatesh et al., 2013).

Other, more pragmatic researchers (Onwuegbuzie & Collins, 2007; Cameron, 2011) propose how to overcome such challenges when using MMs. For instance, Cameron suggests the consideration of the 'Five Ps', i.e. paradigm, pragmatism, praxis, proficiency and publishing of mixed methods research (Table 3.2). This framework, in the Table below, incorporates philosophical foundations, competencies, practicalities, political considerations, and methodological choices to be applied when making decisions of using MMs in research. It also underpins the philosophical foundations and paradigmatic stance for applying mixed methods research.

**Table 3.2****Conceptual framework of MMs research (Cameron, 2011)**

<b>Five Ps</b>	<b>Description</b>	<b>Challenge</b>	<b>Requirements</b>
<b>Paradigm</b>	Mental models (De Lisle, 2011), or consensual set of beliefs and practices that guide a field (Morgan, 2007)	Paradigmatic stance (Cameron, 2011)	Understanding of the philosophical basis of research (Cameron, 2011)
<b>Pragmatism</b>	Mental model (De Lisle, 2011) bridge between paradigm and methodology (Cameron, 2011)	Philosophical and methodological stance and choices (Johnson & Onwuegbuzie, 2004)	Key literature and debates in mixed methods; justification of risks and choices made (Creswell et al., 2011)
<b>Praxis</b>	Practical application of theory, methodological and data integration (Cameron, 2011)	Designs, methods and data analysis choices (Onwuegbuzie & Collins, 2007)	Selection of appropriate method (Kettles et al., 2011); working collaboratively with other researchers to mix skills (Farquhar et al., 2011)
<b>Proficiency</b>	High degree of skills and expertise in the method (Cameron, 2011)	Skills and competencies in MMs approach (Cameron, 2011)	Developed skills in MMs approach (Kettles et al., 2011); knowledge of CAQDAS
<b>Publishing</b>	Issues with dissemination in academic journals (Cameron, 2011)	Acceptance levels, word limitations (Cameron, 2011)	Concurrent or sequential publications, or an integrated single article that draws overarching lessons (Cameron, 2011)

Others recommend that researchers should work with agreed protocols; in multidisciplinary teams; and with versatile, innovative and appropriate research skills that demonstrate proficiency and competence in order to benefit from MMs designs (Farquhar et al., 2011). The use of MMs can be usefully informed by the guidelines outlined by Creswell et al. (2011). They recommend that researchers are clear about their philosophy and theory; and that they carefully consider their resources (time, costs and skills); research questions, aims and design before embarking on data collection and analysis. Consequently, the researcher received appropriate MMs training before conducting this study.

### **3.5.3.1 Rationale for using MMs in this study**

In as much as MMs present some philosophical and methodological stance challenges, this approach has gained ground in gathering or analysing data in a single research project (Farquhar et al., 2011; Tariq & Woodman, 2013). Since this study had multiple aims, a sequentially MMs framework was adopted while recognizing arguments of theoretical incongruence. Therefore, having considered the overarching and sub-questions; the required design for the current study, which was complex and comprised sequentially linked phases;

and in line with the evidence from the literature (Johnson et al., 2007; O’Cathain et al., 2007; Cameron, 2011; Farquhar et al., 2011; Tariq & Woodman, 2013; Venkatesh et al., 2013), a sequential MMs approach was selected as the most appropriate in addressing the research questions. In this case, an exploratory (qualitative) phase was first necessary to ensure that the subsequent quantitative phase was based on evidence within the Kenyan sociocultural context, which was lacking in the literature. Of the available MMs approaches, a sequential research design was considered as the most appropriate for this purpose.

### **3.6 Ethics theory and issues across the two phases**

Research on human subjects is fundamentally and ethically challenging, because of the difficult ethical dilemmas encountered, particularly when making informed decisions (Abdur-Rab et al., 2008; Kalichman, 2009; Bracken-Roche et al., 2017). According to the British Psychological Society (2010), a human participant includes the use of embryos and fetuses, human tissue and bodily fluids, human data, and records from either the living human beings or those who have recently died. The rights and welfare of these subjects need to be protected from planning, conducting and disseminating any research that they take part. The protection of these participants can only be achieved through observation of research ethics principles (Singh, 2012). These are based on a set of moral principles and rules of conduct, which should be promoted or enforced (Prasad et al., 2011; Powell et al., 2012). Awareness of these principles helps to identify and balance the conflicting moral principles which are likely to create any ethical dilemmas in planning and conducting research (Hoop et al., 2008).

#### **3.6.1 Ethics theories**

As explained earlier, research ethics provide the basis on which moral conduct and judgments are applied in difficult ethics situations (Prasad et al., 2011). However, for these ethics to inform and support the thinking and decision-making in research, it is important to be underpinned by a conceptual framework as the foundation for analysis of moral issues in question (Hoop et al., 2008; Kalichman, 2009). Some of these theories include, but are not limited to consequentialism (utilitarianism), deontology and virtue ethics. These are briefly discussed below.

### **3.6.1.1 Consequentialism (utilitarianism)**

The theory of consequentialism, also referred to as utilitarianism, focuses on the consequences of an action taken by professionals in research (MacKenzie, 2009). It argues that, in order to achieve better results, decisions should be based on the balance of value over disvalue. This implies that the value of the outcome must be considered in conjunction with the moral worth of an action. The extent of 'right or wrong' that such an action contributes to patients or subjects is thus crucial in making a research decision (Finnerty et al., 2000). The usefulness of research is consequently required to be clear to all who take part (Hoop et al., 2008). Therefore, the researcher must focus on the consequences of the study as guiding factors when making decisions, other than simply following mere rules and moral duties (MacKenzie, 2009).

### **3.6.1.2 Deontology**

The theory of deontology is based on rules and moral duties that enable a researcher to make decisions. This posits that the duty, obligation and intention of the professional (physician or researcher) determine the rightness or wrongness of an action but not its consequences, as argued in the theory of consequentialism (Hoop et al., 2008). Appropriate decision-making can be arrived at if the researcher follows existing rules of a moral nature. Higher standards of morality are only determined or judged through right actions taken on decisions (MacKenzie, 2009). Deontology thus helps the researcher to realise their duties to the participants' rights, thus keep them safe. For instance, it enables researchers to adhere to a strict policy in protecting and keeping participants' information confidential (Finnerty et al., 2000; Edelsohn, 2012).

### **3.6.1.3 Virtue ethics**

This theory focuses on issues of professional character and conduct when making decisions in research (Holland, 2011). It addresses the moral character virtues or traits (fidelity to trust, prudence, honesty and self-effacement) that influence the conduct and judgments of an individual in carrying out a research, rather than looking into the rules or consequences of an action or a study (Goldberg, 2008; Meagher, 2011). This theory is different from both

consequentialism, where action emphasizes its consequences, and deontology, which focuses on moral rules (Sakellariou, 2015). It, therefore, shapes the professional's virtues in making decisions, instead of concentrating on consequences or rules when dealing with an action (Meagher, 2011).

### **3.6.2 Ethics principles**

Research in many LICs raises a number of ethical issues, particularly within the complexity of humanitarian settings. For example, ethnic conflicts are often compounded by resource-constraints such as shortages of healthcare providers and limited access (House et al., 2015). Consequently, the delivery of healthcare and conduct of research are often disrupted and compromised, may thus be challenging their integrity (Berman et al., 2016). Such disruptions threaten both resources and personnel, hence enhancing further the level of patients' unmet health needs. Such barriers can be exacerbated by barriers such as ethnic and community violence, as indeed in Kenya during the 2007/2008 post-election conflict. The unprecedented and rampant ethnic violence experienced at the time made it unsafe (roadblocks, lack of public transportation and closure of businesses) for both patients and staff to access or deliver health care services respectively (Vreeman et al., 2009).

In the case of research, participants may be particularly prone to issues of trust and exploitation (Benatar & Singer, 2010), which can adversely affect their adherence to the research protocol as well as to the completion of the research itself (House et al., 2015). It is worth noting that healthcare and research in LICs are often delivered in the same setting (Anyangwe & Mtonga, 2007), which poses additional ethical dilemmas in separating participating research from receiving care. These issues call for thorough consideration on how to balance any conflicting obligations and responsibilities.

A substantial proportion of studies are funded and/or conducted in collaboration with international centres, as indeed this PhD research. Consequently, as recommended by principles for international collaborative research, independent review, approval and oversight of the research must be compliant with both international and national standards and governance procedures (Marshall, 2006). These can be related to research protocols, language barriers, cultural conflict and scepticism (Schopper et al., 2009). For this reason, it is important to actively consult and engage with local stakeholders, so that participants do not



misconstrue their research involvement with receiving material or other benefits, hence prevent coercion and even exploitation.

Research serves an important purpose in ultimately helping to improve the health of individuals or population groups (Pratt & Loff, 2012). However, health-related research is subject to many ethics standards or principles in order to protect the interests, wellbeing and rights of researchers and subjects (Kalichman 2009). These principles are a fundamental base in formulating an ethical assessment of a proposed health care study, because they provide the theoretical framework according to which moral judgment and decisions are made (El-Dessouky et al., 2011). Ethics principles are thus guiding expressions of moral ideals and values that professionals need to follow in carrying out any research involving human subjects (Hoop et al., 2008). Consistent with other studies, this research was ethically principle-based and led. Ethics principles were applied to identify and solve any ethical dilemmas encountered by researchers (Page, 2012). For instance, the deontological principles and a protectionist agenda tend to guide ethics committee decisions, and to guide researchers in their practice and application of ethics (MacKenzie, 2009). The key ethics principles which were considered in this study included; autonomy, non-maleficence, beneficence and justice (MacKenzie, 2009). These are also briefly discussed.

### **3.6.2.1 Autonomy**

This principle allows individuals to make their own informed decisions about their health care, without any external interference (Entwistle et al., 2010). Likewise in research, this values the dignity, privacy and worth of all subjects who take part in a study. This principle argues that, regardless of researchers' socio-economic status, cultural and role differences, disability, gender, sexual orientation, disability, education, age, ethnicity or religion, experience, insight, and expertise or knowledge, they must be treated with the same respect (British Psychological Society (BPS), 2010). The principle of respect for autonomy posits that research participants are entitled to fully understand the purpose of the study. Clarification of the research objectives and anticipated benefits should enable them to make an informed decision whether they wish to take part or not. Their decision must be treated as final, without any attempt of coercion. According to Schröder-Bäck et al. (2014), this principle fundamentally recognizes that every subject in any study is an individual of high

value, therefore they cannot be used for the gains of others. Valid consent of participants must thus be sought, their confidentiality and anonymity preserved, and fair and equal treatment should be exercised throughout the research (BPS, 2010). It is considered good ethics practice to seek children's assent, even if consent is only legally required from their parents or guardians if under 16 years of age (Skelton, 2008).

In this study, the participants came from poor and diverse ethnic backgrounds. Their valid consent was sought and treated with dignity. They were encouraged to understand the purpose of the research, so that they could make informed choices on whether to take part. The researcher continued to keep participants informed, as well as monitor their option to engage throughout the study (House et al., 2015).

### **3.6.2.2 Non-maleficence and beneficence**

Non-maleficence or "do no harm" is concerned with the commitment of research to avoid harmful or adverse impact on participants. This prevents subjects from exploitation, incompetence or malpractice during a study. It also enables subjects to take part only when fit, without any personal circumstances such as illness compromising their decision and involvement (British Association for Counselling and Psychotherapy - BACP, 2010). Similarly, this principle emphasises that, apart from the participants, other people, groups or indeed society as a whole should consider whether the study could be of potential harm or not (BACP, 2010). Harmful actions or procedures towards subjects, even if these appear comfortable on request to take part, should be avoided at all costs (Schröder-Bäck et al., 2014).

In such instances, the researcher has a major role to play. Ethically it is their responsibility to strive to mitigate any harm caused to subjects, be it they are unavoidable or unintended, from the inception of the research until the dissemination of the results. Robust risk assessment and management protocols are mechanisms to mitigate against such untoward outcomes. Nevertheless, researchers also have a duty and obligation to promote the subjects' welfare, whilst refraining from causing harm to them. This is driven by the principle of beneficence (Edelsohn, 2012). Researchers should make positive decisions based on their professional assessment in the best interest of their subjects. This process can be ascertained through adequate training and supervision (BPS, 2010).

The current study ensured that the context and procedures were safe for research participants. The research was conducted after ethnic conflict had taken place, but at a time when normality in the environment had been restored. This ensured that research participants were not exposed to harmful actions or procedures leading to any unnecessary risks without any benefit.

### **3.6.2.3 Justice**

The principle of justice, also known as social justice, refers to fairness. It focuses on equal moral worth and impartial treatment to all participants in a study. It has been found that research subjects feel more engaged to take part in research if they believe that they are treated fairly and equally; and that they have access and potential benefit from the research contributions equitably to other groups (Edelsohn, 2012). Researchers can promote justice by upholding applicable laws and legislation such as respecting human rights and dignity when making choices before, during and after conducting the research. They must be committed to avoiding discrimination against people or groups by appreciating any differences between them, thus promoting equal opportunities.

This principle of justice is particularly important for developing countries, and vulnerable groups, like those in the current study. The local institution (NACOSTI) reviewed and approved the study alongside the principal investigating academic centre (University of Leicester). Participants in the research were equally treated and given the same informed choices, irrespective of their age, gender or ethnic background (House et al., 2015).

### **3.6.2.4 Truthfulness**

The principle of truthfulness also refers to fidelity or high respect for the trust placed upon the researcher. It argues that the aims and objectives of a research must be transparent and well defined to the subjects for them to understand. Participants are entitled to know every relevant information about the research. Their concerns must be answered truthfully, agreements and promises honoured, and confidentiality and obligations guaranteed. This would enable them to make their own informed decision whether to take part or not. Integrity promotes accuracy, honesty and truthfulness of the research under investigation and the

practice as a whole. It is a crucial condition in establishing a relationship of trust with the participants and people around them such as gatekeepers and practitioners (BPS, 2010).

Participants in this study were informed of every relevant aspect of the research. It was ensured that their concerns were truthfully addressed. Their expectations and concerns were honoured, and their confidentiality was safeguarded until the completion of the study. Increased risk to participants' autonomy was avoided by reducing their susceptibility to taking part in the study as their only way to access care and support. Likewise, the completion of the study in itself demonstrated the researcher's commitment, confidence and trust towards mental health research as well as the participants (Malmqvist et al, 2011).

The consideration of all these ethics theories and principles in conjunction is important in identifying, understanding and solving moral conflicts experienced in research. No single theory or principle on its own right can be applied entirely to solve ethical dilemmas (Page, 2012). Consequently, in this study the researcher seriously took into account the above ethics theories and principles, and their potential implications, as the fundamental basis of making ethical decisions throughout this study. These ethical theories and principles thus formed the conceptual and theoretical frameworks on which ethical challenges were identified and resolved. These applied to all the stages of the research process, i.e. sampling and recruitment, data collection and analysis, and dissemination. However, in addition to these general ethics issues that apply to all research with human participants, there are additional implications for research with vulnerable groups, which need to be acknowledged (Hurst, 2008).

### **3.6.3 Ethics issues for research with vulnerable groups**

Certain population groups carry particular vulnerabilities which can adversely affect their involvement in research (Bracken-Roche et al., 2017). These include children, people with mental disorders and learning disabilities, patients with incurable disease, living in institutions, homeless, elderly persons, and those without legal status (i.e displaced and refugees- El-Khani et al., 2013) (Hurst, 2008). All these groups are ethically vulnerable because of being incapable of protecting their own interests, lacking full competence to give informed consent, being less likely to gain benefits from research, or being liable to coercion or undue influence (Edelsohn, 2012). Consequences of their vulnerabilities include lack of

capacity, health status, and societal attitudes, pressures or stigma (Bracken-Roche et al., 2017). Such ethically vulnerable populations require special protection by taking additional measures to safeguard their fundamental rights (MacKenzie, 2009). The target population in this study carried several inter-linked vulnerabilities, namely their young age, exposure to trauma, and experience of mental health problems. Each of these characteristics was carefully addressed by the researcher.

### **3.6.3.1 Children and young people**

Children are described as persons under the legal age to consent to take part in any procedures involved in research studies (or indeed treatment). However, the legal age differs from one country to another. For instance, The British courts, by convention, regard all persons under 18 to be minors. They describe persons under 16 as children, while those who fall between the age of 16 and 17 years to be young persons. Consequently, those of 16 years and above do not require parental consent (Matutina, 2009; Griffith, 2016). On the contrary, countries in Africa have different ages of legal child consent, i.e. South Africa: 12, Kenya: 15, and Zambia 18, for medical treatment. On average, the legal age of consent in most African countries is 18 years, the age limit under which a child is defined. However, the Child Care and Protection Act spells out clearly that, whatever the legal age, the child must be mature enough to comprehend the benefits, risks, and implications of such treatment before consenting.

Research with children thus raises a number of ethical concerns, because of their developmental capacity and their position within society. Children are regarded as a vulnerable class of subjects who lack developmental capacity to fully understand and evaluate the information, therefore cannot make an informed decision (Edelsohn, 2012). In this case, it is argued, at least from a legal perspective, that in the best interest of the child, their parents or guardians need to make decisions on their behalf. There is, however, a counter-argument that such dependence can increase further children's vulnerability in research by denying willing children the chance to participate or, vice versa, force unwilling children to take part. Children thus need to be also given the opportunity to make decisions. Edelsohn (2012) argues that children from around seven years of age possess a level of cognitive maturity to assent together with their parent's or legal guardian's permission.

Another argument has been that data collected directly from children maybe be unreliable (Skelton, 2008; Poole et al., 2014). It must be noted, however, that children, like adults, possess different and unique experiences and knowledge. They are, therefore, competent social actors, who need to be actively involved in responding to and shaping their social worlds. Consequently, they need to be constructed as active agents rather than passive objects in research, whilst using developmentally appropriate tools to capture their unique voices and perspectives (Kirk, 2007). It is now widely recognised that research directly involving children is as important as any other carried out with adults. To achieve this, children should be allowed to experience the same rights accorded to adults (Skelton, 2008). This process requires though developmentally sensitive regulatory considerations when inviting children to take part in research (Paulson et al., 2006).

In humanitarian, emergency and fragile contexts such as following ethnic conflict, particularly in LICs, undertaking research involving children is further compounded by the breakdown of healthcare systems and social structures needed for their support and optimal growth (Berman et al., 2016). The ethics principles (as explained in section 3.4.2) and possible necessary steps were followed to ensure children's protection and that their needs were not compromised by taking part in the study (Malmqvist et al, 2011).

### **3.6.3.2 People with mental health problems**

Research in mental health raises various ethical issues (Siriwardhana et al., 2013). Ethical dilemmas may arise because of differences in personal and societal values, beliefs and concepts (Hoop et al., 2008) about people with mental health problems; as well as potentially lacking full competence to consent to in research or treatment (BPS, 2010; O'Reilly & Parker, 2014). Research conducted with mentally ill subjects must ensure that they are protected from any exploitation in line with the Convention on the Rights of Persons with Disabilities (CRPD 2009). Article 3(a) of the CRPD highlights that the dignity, autonomy, freedom to make one's own choices, and independence of individuals with disability should be respected. The same principle applies to safeguarding confidential information, and ensuring full inclusion and participation of persons with disabilities in research (Schulze, 2016).

According to Rid and Schmidt (2010), in case of a potential research participant deemed not able to give informed consent because of their vulnerability – such as a physical or mental condition, it is ethically acceptable, but only as the last resort, for the investigator to seek informed consent from a responsible family member or a legally authorized representative. However, such a decision will only be carried out when a study has a likelihood of benefiting and promoting the health of the potential subject or the represented population. In addition, the researcher must ensure that the study entails only minimal risk and minimal burden, for example not causing distress to participants (CIOMS, 2002; Helmchen, 2012). Therefore, the researcher must conduct skilled interviewing, be sensitive to employ techniques that alleviate distress, and if necessary, provide information to access mental health services for those who need it (Whiting & Vickers, 2010).

The study ensured that all children and their families were protected from any exploitation, unnecessary risks, and that their confidential information was kept safe (Berman et al., 2016). In as much as it was taken to account that when studies are approved by research ethics committees, they expect them to be completed or without being compromised (House et al., 2015), participants were allowed to withdraw at any point of the study.

### **3.6.3.3 Exposure to traumatic events**

In addition to well-established impact on mental health discussed in chapter 1, exposure to multiple and recurrent traumatic events such as abuse and neglect, domestic violence or war conflict poses specific ethics issues (Siriwardhana et al., 2013). It is thus important that special precautions are taken before and during participants' enrol in research. These potentially adverse effects on traumatized individuals could involve inconvenience, psychological discomfort, breach of confidentiality, self-harm, loss of dignity, legal action, unwanted media attention, and economic hardship. In particular, researchers should mitigate the risk of re-traumatization or exploitation of participants during research or treatment (Collogan et al., 2004). A number of steps should be taken in that respect, starting with sufficient and clear information on the scientific value of the study, and the benefits for them or other people (Newman & Kaloupek, 2009). They should also be provided with information on how to access required services in case of those who might be distressed (Whiting & Vickers, 2010).

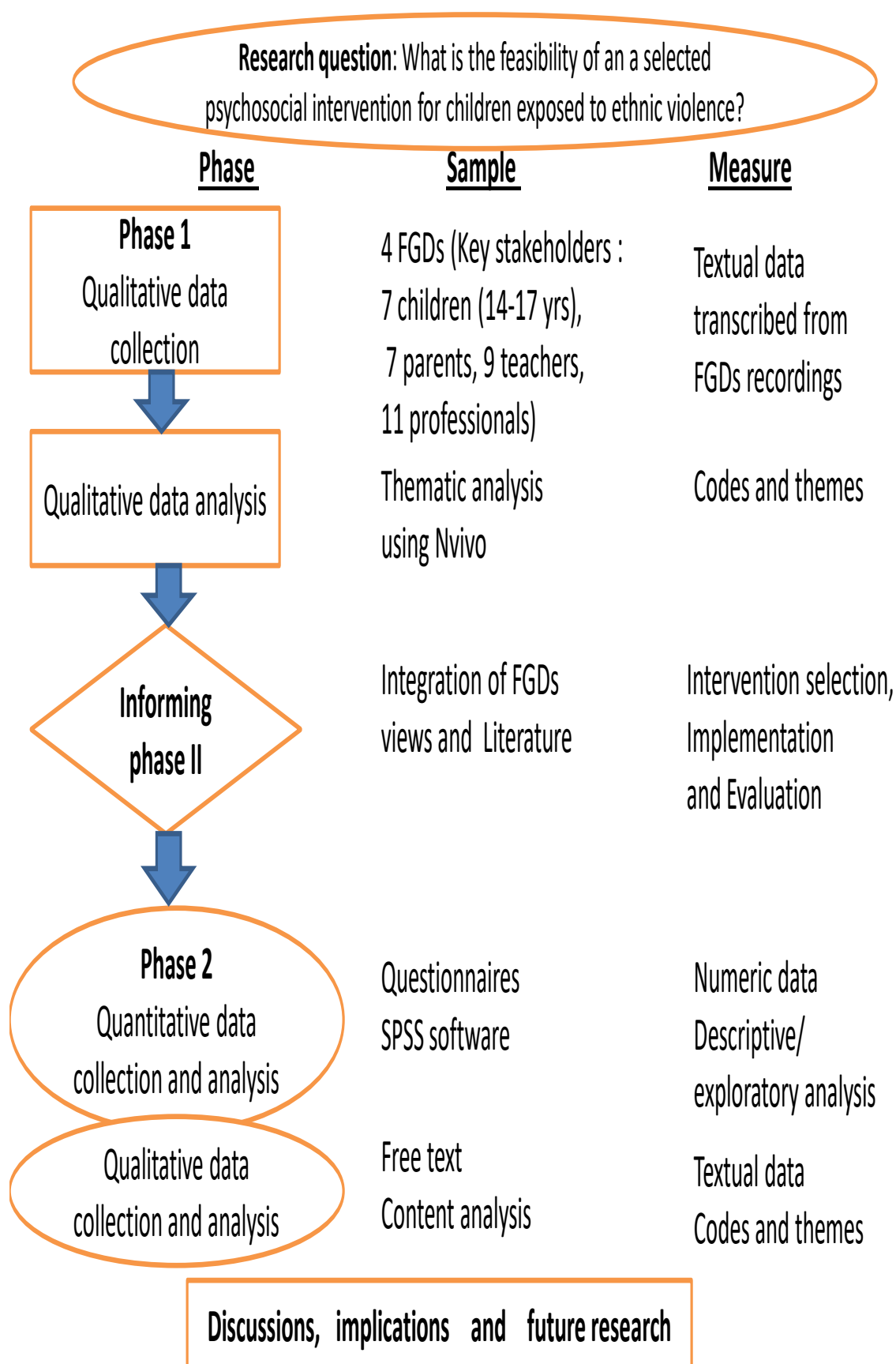
The safety of the participants was assured and maximized by mitigating the risk of re-traumatization or exploitation. No potentially adverse effects were encountered that could inconvenience or cause psychological discomfort to already traumatized individuals, or to breach their confidentiality that was encountered. All research subjects were provided with essential information to make up informed choices throughout the study (Malmqvist et al, 2011).

### **3.5 Chapter summary**

This chapter has presented the methodological overview of the study. The socio-cultural context in which the study was conducted was initially described. Different methodological approaches were considered to address the overarching and research sub-questions of the two sequentially linked phases I and II. It was concluded that a sequential mixed methods framework was appropriate, as presented below in Figure 3.2. The ethical theories and principles underpinning the overall study were also explored in detail. The specific methodological components of each phase will be discussed in detail in subsequent chapters



**Fig. 3.2 Mixed-Methods, Sequential Exploratory Design**



## **CHAPTER FOUR**

### **PHASE I - STAKEHOLDERS' PERSPECTIVES OF CHILD MENTAL HEALTH NEEDS AND SUPPORTS: METHODOLOGY**

## **4.1 Introduction**

Detailed information on the research sub-questions, research aims and methodology adopted in phase I is presented in this chapter. The theoretical framework guiding the methodology and the rationale for the research design employed is justified. Other areas covered in this chapter include specific information on the sampling, research procedure and data collection, ethical issues related to phase I, data management, and analysis. The step-by-step analytic process based on the thematic model and indexed by NVivo is illustrated.

## **4.2 Research sub-questions**

This phase was concerned with the key community stakeholders' perspectives of mental health, strengths of and barriers to current children's psychosocial supports and services, and their recommendations on how interventions could meet children's needs. The following were the research sub-questions that key community stakeholders' views explored:

- i). How do they conceptualize mental health problems, contributing factors, and required assistance for children with mental health problems?
- ii). Which are the strengths and barriers of existing children's psychosocial supports and services?
- iii). How can these barriers be overcome?

### **4.2.1 Research sub-aims**

- i). To establish how community stakeholders' conceptualize mental health problems, and associated risk and protective factors.
- ii). To examine views of community stakeholders on strengths and barriers of existing supports and services for children with mental health problems.
- iii). To establish community stakeholders' recommendations on how barriers can be overcome, in particular in providing culturally acceptable psychosocial interventions.

### **4.3 Theoretical framework**

The choice of a research design is guided and directed by a philosophical paradigm that illustrates the beliefs and practices which regulate the inquiry of the specific research questions of the study. Paradigms, basic belief systems and worldviews, all influence the choice of epistemology and subsequently guide the methodology of the research. These inform the nature of the relationship between the researchers and research, as well as illustrate the strategy or plan of action applied to investigate realities (Evans et al., 2011). According to interpretivism philosophy, realities from a study, which involves the researcher's interpretation, are regarded to be multiple and complex. These realities do not exist independently, but are socially constructed and accessed; especially through shared meanings, language and consciousness. Since interpretivism studies usually focus on meaning, a naturalistic approach of data collection such as interviews and observations are usually employed. These qualitative methods of data collection allow the researcher, as social actor, to appreciate differences between the participants, thus leading to a collection of varied and rich information, which is child-centred and participant-driven. When this variety of information reflecting different aspects of the issue is integrated, it increases the chances of better understanding the perceptions and meaning of phenomena.

Qualitative research adopting an interpretive philosophical approach, places significant importance on subjectivity. The epistemological stance posits that it is only through the subjective interpretation that reality can be fully understood, experienced, produced or constituted (Elshafie, 2013). Truth about issues investigated is both complex and dynamic. However, this can only be established by studying individuals, as they interact within their socio-historical or natural settings (Astalin, 2013). Consequently, in qualitative methods the researcher interacts with the participants in their naturalistic setting, to explore their thoughts, beliefs, behaviours, feelings, perceptions and expectations, for the purpose of gaining knowledge about the phenomena under investigation. Quality interactions between the researcher and subjects in qualitative research thus provide in-depth insight on subjective realities, but not on their generalization (Hilal & Alabri, 2013; O'Reilly & Parker, 2013).

#### **4.4 Research design**

The study adopted a qualitative research design, using focus groups to collect the data. The research questions and objectives of this phase of the study determined the design selection (Evans et al., 2011). The purpose of phase I was to establish the key community stakeholders' (children, parents, teachers, professionals and community professionals/leaders) perspectives on their understanding of mental health, strengths and problems facing children's support services available, and their suggestions on how to improve interventions. Participants' personal views, which serve as a reflection of the 'real world' on the ground, were thus needed through a qualitative research approach (Stewart et al., 2008; Hilal & Alabri, 2013). This design allowed the participants to define the key barriers to mental health interventions, and to suggest ways to address them through selecting, designing and planning the delivery of culturally acceptable interventions (Sofaer, 2002; Pound et al., 2005).

As briefly discussed in Chapter 3, qualitative research methods are widely used in health and social care research because of their contribution to evidence-based interventions, service planning and policy development (Hilal & Alabri, 2013). They are useful in exploring and understanding phenomena or answering research questions in natural settings. Participants' behaviours, experiences, beliefs, attitudes and interactions provide useful, detailed and holistic viewpoints (PLoS Medicine Editors, 2007; Neergaard et al., 2009), which can be interpreted subjectively according to the meanings they attach (Pope et al., 2002; Pathak et al., 2013). This method is flexible, thus enabling different experimental techniques to address the research questions (Shuttleworth & Wilson, 2008).

#### **4.4 Sample**

##### **4.4.1 Recruitment of research participants**

The setting and its context were described in Chapter 3. The target population for phase I consisted of all stakeholders related to children's mental health, namely children themselves, their parents or caregivers, teachers, other professionals and community leaders. A purposeful technique, also referred to as selective or subjective sampling, was crucial in selecting the participants for this research. The method is significant in qualitative research in recruiting individuals into a study who have knowledge about or experience of a phenomenon under investigation (Palinkas, 2015). In that effect, the researcher used the approach to identify and select specific participants (community stakeholders) rich with required information to answer the research questions.

Children aged between 14 and 17 years were selected, who belonged to a relatively developmentally homogenous group of late adolescence, which is also at high risk of developing mental health problems (Kessler et al., 2005; Patel et al., 2007a; WHO, 2018). The age range (14 - 17 years) was also selected because it could easily be sampled from the same school, while maintaining homogeneity according to demographic variables (Dworkin, 2012). The selected school, Mwariki Secondary School, is located in a deprived area, affected by ethnic violence and displacement, in Nakuru County. During the recruitment of participants, the first three children on the register of each school year (14, 15, 16 and 17), from Form One to Form Three, were invited to take part in the study.

Seven children were invited to take part in the focus group. The parents (either mother or father) of every participating child, once consent was granted, were also invited to take part. Thirteen teachers from Mwariki Secondary School were invited to participate in the study. Nine teachers accepted to take part, while the rest were busy with school administrative roles. Finally, professionals (nurses, medics, psychologists and social workers) and community leaders (chiefs, police officers, church leaders) who worked with and supported children in the surrounding community were also invited. This category of participants was identified by teachers. Two members from each group (i.e. nurses, medics, psychologists, social workers, administrative chiefs, police officers, church leaders) were invited. All the invited participants accepted to participate apart from three (i.e. one medic, police officer and psychologist), who declined because of professional commitments elsewhere.

#### **4.4.2 Sample size**

Relatively small sample sizes are normally used in qualitative compared to quantitative studies. What matters in qualitative research is the emergence of themes rather than frequencies from a given dataset during the analytic process (Mason, 2010). The concept of thematic saturation thus determines the sample size. This is defined as the point of data collection when no new data does necessarily shed any more relevant information on the issue under study (Dworkin, 2012). However, there are debates on when and how saturation is reached (O'Reilly & Parker, 2013). In as much as there is lack of consensus, Guest et al. (2006) argue that saturation achievement depends on the number and complexity of the data, selection criteria, heterogeneity of the population, as well as the expertise of the researchers and analysts involved.

The aim of this qualitative phase I was to establish emerging themes of stakeholders' perspectives, experiences and perceptions, rather than quantify magnitudes (Fugard & Potts, 2015). Therefore, to avoid labour intensity in large data collection and analysis leading to unnecessarily repetition, the saturation concept served as a guiding principle and gold standard in determining the sample size in phase I (Francis et al., 2010). Saturation was considered and achieved within as well as across groups (Hancock et al., 2016). Hence, the frequencies and patterns of opinions or the people who took part in the research did not matter in addressing the research questions. Instead, it was the exploration of the range of opinions and different representations of the issue under investigation that were crucial. The background and availability of the participants were also given consideration in determining the sample size (Doody et al., 2013).

Participants were purposefully selected (Dworkin, 2012) not only because of some common characteristics in the children's background, but also because of the relative heterogeneity in their age range and contacts with professionals. A purposive sampling strategy, instead of using probability-based techniques, was applied in this study to select key stakeholders who could provide insight into the research topic (Palinkas, 2015). As postulated in many studies (Heary & Hennessy, 2002; Gill et al., 2008; Ayala & Elder, 2011; Alulis & Linn, 2013), 6-12 participants were the intended sample for a focus group. Therefore, a total minimum of 24 participants was deemed to be an appropriate number in phase I (Billingham et al., 2013; Viechtbauer et al., 2015). However, a total of 34 participants eventually took part. The size was reasonably large enough to capture a variety of viewpoints, yet small enough for participants to have opportunities to express themselves (Fugard & Potts, 2015). The number of participants was manageable to facilitate the discussion in the context of the research resources (finances and time) available (Doody et al., 2013). It was decided that the size and number of groups were sufficient when the point of saturation was reached, i.e. when little or no more new information emerged from the participants (Hancock et al., 2016).

Four focus groups were deemed adequate in this study, in as much as there are no rules concerning the optimal number of stakeholder groups. The groups represented key stakeholders in child mental health research. Previous studies in child mental health have shown that different informants contribute unique, but rich and often complementary information. Such multiple sources of information have proved to be useful in understanding child mental health needs and in planning interventions (Van der Ende et al., 2012). The

groups in phase I were also justified to be sufficient, as data was saturated within and across the samples. O'Reilly and Parker (2013) argue that the general marker of saturation applied to individual interview studies can as well be modified for research involving focus groups. The groups were segmented into children, parents, teachers, and other professionals in contact with children.

#### **4.5 Data collection**

There are several methods of data collection in qualitative research. These include, but are not limited to; observations, interviews, textual or visual analysis (Pope et al., 2002; Bradley et al., 2007; Pathak et al., 2013). Overall, the research questions determine the appropriate design, measures and research procedure to be adopted. In this study, focus groups were selected as the most appropriate approach to answer the research questions of Phase I. Focus groups are 'collective conversations', which can be brief or lengthy, and are arranged to examine a specific set of topics (Onwuegbuzie et al., 2009; Liamputtong, 2011) determined by the researcher (Plummer-D'Amato, 2008; Doody et al., 2013; Tadajewski, 2016) to gather information about insights, feelings, expertise and experiences from a small group of subjects (Daneva, 2015; Knowles, 2015). These enable participants to explain and clarify their beliefs and attitudes towards the topic (Leung & Savithiri, 2009). In this study, focus groups used a combination of interviewing, group interaction, and participant observation in terms of taking field notes to obtain comprehensive data. The facilitator thus guided, monitored and recorded the discussions between participants (Gill et al., 2008).

Focus groups have been instrumental, in health and social care research, in the assessment of needs of target populations (Heary & Hennessy, 2002; Gill et al., 2008), development of evidence-based interventions to address these needs (Liamputtong, 2011), and evaluation of these interventions (Knowles, 2015). They have been used to determine the changes required to inform acceptable strategies, and to design the delivery of interventions from the initial stages of their development (Ayala & Elder, 2011). Since many of the interventions are culturally tailored (Heo & Braun, 2014), focus groups allow data to be collected in a culturally (Stacciarini, 2008) and linguistically appropriate manner (Nguyen et al., 2006), thus increasing the likelihood of success of intervention programmes (Kruger et al., 2012; Heo & Braun, 2014).



Focus groups were preferred in this study for a number of reasons. First, they were an economical (Leung & Savithiri, 2009) and efficient method of obtaining data from different participants to yield a range of perspectives on the core issue under study (Onwuegbuzie et al., 2009). Second, the discussion forum was less threatening to the participants, an atmosphere that enabled them to freely express their views, thus providing rich information. Third, they collectively identified group norms, sub-cultural and cultural values (Grønkjær et al., 2011), which were especially valuable in this study. Fourth, they explored what, how and why participants thought the way they did, thus generated information on collective views; as well as the meanings that lay behind those views, experiences, beliefs, and concerns (Knowles, 2015; Tavener et al., 2016). Finally, they allowed participants to develop their own questions and frameworks, in their own words and on their own terms (Liamputtong, 2011).

The researcher also took into consideration potential criticisms about focus groups in order to mitigate those, where possible. According to Sylvetsky et al. (2013), focus groups rely heavily on assisted discussion in order to yield the results required. Sometimes discussions can be challenging in terms of quality. For instance, some participants are usually more vocal during discussions, thus making others find it harder to share genuine views (Putcha & Potter., 2004). Data processing, during the transcription and analysis, can sometimes lack depth, particularly if the moderator does not have the expertise to lead the groups, collect and analyse the data (Bloor et al., 2001). It is also argued that, since focus groups participants are self-selected in some studies and constitute a small sample, results may not be representative and generalizable (Leung & Savithiri, 2009).

The researcher tried to address some of these challenges by considering the structure, focus group guide, facilitation process, and process of data collection, which are the key issues identified by researchers such as Ayala and Elder (2011). The moderator was trained before conducting the focus groups, as directed by Bloor et al. (2001). He also adhered to Heary and Hennessy's (2002) principles and selected small groups of 6-12 participants, which were relatively homogeneous, thus manageable to facilitate (Putcha & Potter, 2004). Finally, as the aim of qualitative research is to establish the transferability rather than generalizability of the findings (O'Reilly & Parker, 2013), the purpose of using focus groups in this study was to obtain a general overview of the stakeholders' perspectives, which was subsequently used to inform the selection, planning and delivery of a culturally and appropriate intervention in phase II (Doody et al., 2013; Daneva, 2015). Data were comprehensively collected

continuously until a point of saturation, i.e. when there was no new substantive information obtained from the participants (Palinkas, 2015).

## **4.6 Ethics procedure**

The general ethics principles and issues for vulnerable groups were discussed in Chapter 3. Ethics approval was granted by the University of Leicester Psychology Research Ethics Committee; and by the National Commission for Science, Technology and Innovation of Kenya. The ethics approval was sought and granted in two stages, i.e. separately for the phase I and phase II studies. In each case of approval, a letter was sent to the to the Head Teacher of Mwariki secondary school by the Nakuru County Ministry of Education, who referred the researcher to the School Counselling Department. The Head of the Guidance and Counselling Department in the school introduced the researcher to the class teachers, who helped him to gain access to children and parents. The teachers in turn identified the professionals who worked with children in the surrounding community. The following ethical procedures were applied, for participants to take part in the study:

### **4.6.1 Informed consent**

Informed consent was sought from all the participants before being allowed to take part in the study. Information letters and consent forms were sent directly to all the selected parents. Considering the UN Convention on the Rights of the Child (2009), which defines children and young people as persons under the age of 18 years, the researcher sought written consent from parents or appropriate adults such as guardians as well as of participating professionals. However, the same information was circulated in developmentally appropriate language to children too, who were given the option of withdrawing from the study, even if their parents had given written consent. Ethically, individuals must be allowed to make their own informed decisions about their health care, without any interference (Entwistle et al., 2010). Information letters were clearly written in English alongside Swahili (local language) for those who could not read and understand simple English. These explained the purpose and procedures of the study. Participants were informed that the researcher was available and willing to have a verbal discussion with them about the research project alongside the written material, if this was requested. The same procedure was followed for teachers and other professionals invited to take part in phase II.

#### **4.6.2 Participants' rights**

It was made clear to all participants that their involvement in the study was entirely voluntary, without undue pressure or coercion. No participant who was uncomfortable with the topic of discussion was included in the research (Fielden et al., 2011). No financial or other compensations were given to participants. They were free to withhold any information they were uncomfortable to share, and had the liberty to withdraw from the study at any time, without giving any reasons to the researcher. It was made clear that the young person's education or other support services would not be affected if they decided not to participate or to withdraw from the study.

#### **4.6.3 Participants' protection from harm**

The degree of risk and inconvenience of the study to research participants was managed and minimized. The researcher was careful and sensitive in planning and conducting the focus group discussions. There were no questions related to either symptoms experienced, or exposure to trauma. In case a participant (particularly a young person) was distressed when answering any question during the group session, it was made clear that the facilitator would suggest a break and, if need be, would reassure the participant during this break. If this could not resolve their anxieties or distress, the participant would be encouraged or allowed to leave the group before its termination, and assistance would be offered outside the session. Otherwise, they were free to withdraw from the study at any point (Thabet et al., 2005) without giving any reasons. In case of any serious mental health concern, the affected participant (young person or adult) was to be referred to the local mental health service for help. Confidentiality of all information shared by the participants was highly accorded. It was clarified that confidentiality would only be breached if any concerns arose on risk to the young person (such as self-harm) or others (such as threats of violence). The researcher was CRB-checked from the UK for the purpose of protecting children (Furey et al., 2010).

#### **4.6.4 Participation benefits**

The researcher explained to the participants that there were no immediate benefits in taking part in the study. However, it was hoped that the emerging findings could be used to inform future interventions and supports to help other young people and their families in similar circumstances. The findings could also be useful for policy makers and other stakeholders in improving services for many more vulnerable children and young people in the community.

#### **4.6.5 Data management**

Qualitative data collected from the focus groups were recorded and transcribed. The researcher subsequently checked and entered the data into a computer database. This assured and accorded the participants' privacy, anonymity and confidentiality throughout the study. No identifiable data were collected, as each participant was given a unique code, and no names or other identifiable information such as names were transcribed. The same principle applied in the analysis, writing up and dissemination of the qualitative findings. All information collected was kept securely under lock and key, only accessible to the principal investigators. Data will be kept securely for five years from data collection before being destroyed or stored on encrypted devices.

#### **4.7 Data analysis**

There are several analytical approaches used in qualitative data analysis (Bradley et al., 2007; Elo & Helvi, 2008; Gale et al., 2013). These include, but are not limited to, narrative, constant comparative, content, discourse and thematic analysis (Barnett-Page & Thomas 2009; Snilstveit et al., 2012). These frameworks are influenced, shaped, and underpinned by or aligned with particular epistemological, philosophical and theoretical ideas where they utilize the analysis of words and language used, and participant's experiences (Gale et al., 2013; Mogashoa, 2014), for example the thematic framework which is theoretically flexible (Braun & Clarke, 2006). Ultimately, the specific choice of adopted framework depends on the research questions and aims of the topic under investigation (Alhojailan, 2012). The principles of each type and their indications are briefly presented below, before identifying the analytic framework of choice for the phase I data.

#### **4.7.1 Narrative analysis**

Narrative analysis is a systematic framework of recorded and transcribed stories (structured units for interpretation) that gives meaning to research findings (Onwuegbuzie et al., 2012). The framework focuses on how participants, as whole, make sense of events and actions that they have experienced in their lives, using language and narratives (Barnett-Page & Thomas, 2009; Ahmed, 2013). It has been argued that the method may sometimes lack transparency and clarity on its process. There is no formal guidance on identifying commonality of emerging issues from a dataset (Barnett-Page & Thomas, 2009; Snilstveit et al., 2012). However, some researchers have counter-argued that transparency of most methods of narrative synthesis can be enhanced by other tools such as evidence tables, and specialized software like Nvivo and matrices (Snilstveit et al., 2012). The validity of the findings from the analysis of narratives and the language used may also raise some concerns. Narratives are regarded as active constructions, which may not be accurately representing an individual experience (Ahmed, 2013), while language may not be a transparent medium making, thus rendering analytic and interpretive findings invalid (Barnett-Page & Thomas, 2009).

#### **4.7.2 Constant comparative analysis**

Constant comparative analysis systematically establishes similarities and differences of incidents or data (Gale et al., 2013). The approach generates concepts from the data by coding and analyzing codes concurrently. This process works through various stages, which include comparing incidents applicable to each category, integrating categories and their properties, determining and writing up the theory (Kolb, 2012). The method iteratively and inductively reduces the data through constant recoding, while concurrently comparing the data (Fram, 2013). The framework is useful in theory-building, where reviewers relate categories with the previous ones for further testing and refining. However, the method is labour-intensive, hence requires adequate investment of time and resources (Kolb, 2012).

#### **4.7.3 Content analysis**

Content analysis is a procedural framework that involves categorizing and indexing (coding and classifying) verbal, written, or visual communication data (Elo & Helvi, 2008). This reduces concepts that describe a research phenomenon (Onwuegbuzie et al., 2012) by

classifying, summarizing and tabulating important data to interpret their meaning (Elo & Kyngäs, 2008). This process can be used either inductively or deductively to prepare, organize and report the findings (Elo et al., 2014). This approach is regarded useful, as it is content-sensitive, in distilling words into fewer content-related categories, with the purpose of understanding their meanings or intentions (Elo & Kyngäs, 2008). It is also relatively simple and flexible in terms of the research design, thus allowing the researcher to use it in testing theoretical issues to enhance the understanding of the data. However, this flexibility and lack of clear guidelines also carries some constraints, as it over-relies on the researcher's insight or intuitive action, skills and analytic style (Elo & Helvi, 2008).

#### **4.7.4 Discourse analysis**

Discourse analysis evaluates the relationships among relevant texts from selected lines in a dataset, with the purpose of establishing causes and consequences of related issues (Mogashoa, 2014). These lines are examined for rhetorical accountability, organization, positioning and variability (Onwuegbuzie et al., 2012). The framework views language as a social performance or a social action. It thus regards language as a significant tool that represents the speakers' beliefs, positions and ideas through spoken or written means (Morgan, 2010), whose choice, role and usage must be accounted for (Brisbois & Plamondon, 2018). This framework is useful in making hidden unacknowledged and unspoken aspects of human behaviour salient through the analysis of the words and language used. The method is context-specific, which can be applied at any given time, place or context (Morgan, 2010). As any other approach, it also has certain limitations. Analysis of similarities and differences between concepts can cause confusion when explaining and justifying those (Van Leeuwen, 2018). The meaning of the results obtained is not conclusive, can therefore be open to further interpretation (Mogashoa, 2014).

#### **4.7.5 Thematic analysis**

Thematic analysis can identify and present meaningful categories or themes (patterns) within any given dataset (Boyatzis, 1998; Braun & Clarke 2006). This framework searches for relationships among categories, and their links to the overall cultural context in which they exist or emerge from (Onwuegbuzie et al., 2012). It interprets various aspects of the research

topic, by organizing and describing data in detail through defined series of steps (Thomas & Harden, 2008; Fugard & Potts, 2015). This approach is considered to be the most appropriate and systematic analytic method for any study that seeks to discover phenomena by using interpretations (Alhojailan, 2012). It places emphasis on the content of texts, but not on how these were communicated; hence focuses on the description of both implicit and explicit ideas identified, rather than counting words or phrases (Barnett-Page & Thomas, 2009).

In line with the research questions and aims of phase I in establishing stakeholders' perspectives of children's mental health needs and supports, the thematic analytic framework was adopted. The simplicity of the methodological procedures involved in the process of identifying and analysing the dataset, without compromising the flexibility tied to the epistemological position of the method, was regarded particularly suitable for the purpose of this study (Braun & Clarke, 2006; Fielden et al., 2011). It was considered an appropriate choice for the researcher in achieving the aims of the study through its underpinning analytic process. The method was also found to be flexible, straightforward and accessible to the researcher (McLeod, 2011).

#### **4.8 Data analytic process**

Thematic analysis indexed by Nvivo software (Thomas & Harden, 2008; Tavener et al., 2016) was subsequently used to analyse the data. Nvivo is widely as the main Computer Assisted Qualitative Data Analysis Software (CAQDAS) to manage, analyse and interpret qualitative data (Shuttleworth & Wilson, 2008). According to various studies (Burnard et al., 2008; Ayala & Elder, 2011; Zamawe, 2015), CAQDAS is particularly useful in managing, sorting and organizing large volumes of data; storing, annotating and retrieving text; locating words, phrases and segments of data; preparing diagrams, and extracting quotes.

Nvivo makes the analytic process easier and, arguably, more flexible, accurate and comprehensive for the researcher (Jones, 2007). In line with other studies (Baugh et al., 2010; Hilal & Alabri, 2013), Nvivo reduced manual tasks and gave the researcher more time to discover tendencies, recognize emerging themes, and derive transferrable conclusions. The performance of the software thus helped to increase the transparency, trustworthiness, efficiency, accuracy and rigour of the analysis.

Using the guidelines developed by Braun and Clarke (2006), thematic analysis procedures were followed to identify, analyse and report themes and sub-themes that emerged from the focus groups (Table 4.1). The initial stage involved familiarization with the data through repeatedly reading the transcripts (Liamputtong, 2011). Useful meaning of data was created during the transcription, which was the initial stage of data analysis (Bailey, 2008; Wainwright & Russell, 2010). The analytic process was guided by the coding framework of first, second and third order coding, to determine the core themes that were salient in the data and which addressed the research questions (Boyatzis, 1998). Several potential themes were identified, whilst ensuring that the context in which the concepts occurred was preserved (Braun & Clarke, 2006).

Interpretative analysis of the data was followed by exploring the emerging themes. At this stage, some codes were combined to form overarching themes, whereas those which were not relevant to the research questions and the aims of phase I were discarded from the analysis reported in this thesis (Bernard & Ryan, 2003; Fereday & Muir-Cochrane, 2006). The candidate themes were further refined. Categories were created, with some themes further merged, keeping only those with sufficient data. Identified themes were further refined until the final themes were obtained.

There was external validation throughout the coding process, by discussing the analytic steps with the two supervisors and the PhD peer group. The identified themes and sub-themes, with supporting representative quotes to illustrate salient points that were relevant to answering the research questions, are presented in the next Chapter 5. These themes were presented for all stakeholders together, in order to understand the overall pattern of findings, and how these could inform the selection of an appropriate intervention in phase II. However, where a certain theme or sub-theme was prominent in a particular stakeholder group, this was highlighted in the presentation of the findings.



**Table 4.1**  
**Steps in thematic analysis, using Nvivo software**  
 (Braun & Clarke, 2006)

Step	Procedure	Action using Nvivo
1	Familiarization with data	Uploading, reading and re-reading the data
2	Generation of initial codes	Production of initial codes
3	Search for themes	Analysis of codes
4	Review of themes	Refinement of candidate themes
5	Definition and naming of themes	Definition and further refinement of themes
6	Production of report	Use of final themes for report writing

#### **4.9 Chapter summary**

This chapter has described in detail the methodological choices made in phase I. The chapter initially highlighted the research sub-questions and aims, which guided these decisions. The adopted research design was justified in relation to its underpinning theoretical framework. The sampling strategy, method of data collection, specific ethical issues for phase I, choice of analytic approach, and steps of data analysis were subsequently considered. The next Chapter 5 will present the focus groups findings of phase I. The participants' socio-demographic characteristics and an overview of the emerging themes will initially be listed, followed by a detailed presentation and interpretation of each theme and its sub-themes.

**CHAPTER FIVE**  
**PHASE I RESULTS**  
**STAKEHOLDERS' PERSPECTIVES**

## **5.1 Introduction**

This chapter will present and discuss the findings of the phase I study, which aimed to establish stakeholders' (children, parents, teachers, professionals and community leaders) views on children's mental health needs and required interventions. These findings demonstrate why stakeholders' perspectives were important in informing the selection, planning and delivery of a culturally acceptable intervention in phase II. The chapter starts with the presentation of the demographic characteristics of the sample. The detailed coding and analytic process is subsequently presented. The rationale for using thematic analysis and its different stages are described to demonstrate how themes were generated. The key findings are briefly discussed at the end of the chapter, in particular in relation to how these informed the design and implementation of the phase II study. The findings of both Phases will be revisited in conjunction in the overarching discussion chapter 8.

## **5.2 Demographic characteristics**

The demographic characteristics of stakeholders who participated in the focus groups discussions are presented in Table 5.1. There were four focus groups, which were balanced (21% young people, 21% parents, 26% teachers and 32% other professionals), with a total of 34 participants. The children were aged between 14 and 17 years, while the rest of the participants were above 40 years old. Apart from the children and parents, the rest of the participants represented different professional groups, which included; teachers (44.2%), health and social care (21.4%), administration (11.3%), business (11.3%), evangelism (7.9%) and clerical (3.9%).

Most of the participants in the study were of Christian religion, with two describing themselves as non-practicing. They came from five ethnic groups; Kisii (47%), Kikuyu (32%), Luo (15%), Luhya (3%) and Kalenjin (3%); where 44% of the total were females while 56% were males. These ethnic communities were among the most dominant (more than 40 ethnic communities) in Kenya, which is a multi-ethnic society. The Kisii and the Kikuyu sampled were the majority in the area, where the ethnic Kalenjin communities are the supposedly indigenous group (Yieke, 2010).

**Table 5.1**  
**Demographic characteristics of focus groups participants**

<b>Participants</b>	<b>Gender</b>	<b>Age range</b>	<b>Religion</b>	<b>Ethnicity</b>	<b>Occupation</b>
<b>Young people</b>					
<b>YP1</b>	Female	14-17	Christian	Luo	Student
<b>YP2</b>	Male	14-17	Christian	Kisii	Student
<b>YP3</b>	Male	14-17	Christian	Kikuyu	Student
<b>YP4</b>	Female	14-17	Christian	Kikuyu	Student
<b>YP5</b>	Female	14-17	Christian	Kikuyu	Student
<b>YP6</b>	Male	14-17	Christian	Kikuyu	Student
<b>YP7</b>	Female	14-17	Christian	Luo	Student
<b>Parents</b>					
<b>P1</b>	Female	40-45	Christian	Kisii	Teacher
<b>P2</b>	Female	45-50	Christian	kikuyu	Clerical
<b>P3</b>	Female	40-45	Christian	Kisii	Teacher
<b>P4</b>	Male	50-55	None	Kikuyu	Business
<b>P5</b>	Male	45-50	Christian	Kisii	Teacher
<b>P6</b>	Female	45-50	Christian	Luo	Business
<b>P7</b>	Female	45-50	Christian	Kikuyu	Business
<b>Teachers</b>					
<b>T1</b>	Female	40-45	Christian	Kisii	Teacher
<b>T2</b>	Male	40-45	Christian	Kisii	Teacher
<b>T3</b>	Male	45-50	Christian	Kisii	Teacher
<b>T4</b>	Female	40-45	Christian	Kisii	Teacher
<b>T5</b>	Female	35-40	Christian	Kalenjin	Teacher
<b>T6</b>	Male	45-50	Christian	Kisii	Teacher
<b>T7</b>	Male	55-60	Christian	Kisii	Teacher
<b>T8</b>	Female	25-30	Christian	Kikuyu	Teacher
<b>T9</b>	Female	25-30	Christian	Luo	Teacher
<b>Professional</b>					
<b>Chief 1</b>	Male	50-55	Christian	Kisii	Chief
<b>Chief 2</b>	Male	50-55	Christian	Kisii	Chief
<b>Church Elder</b>	Male	45-50	Christian	Kisii	Evangelist
<b>Pastor</b>	Male	50-55	Christian	Kisii	Pastor
<b>Nurse</b>	Female	45-50	Christian	Kikuyu	Nurse
<b>Clinical Officer</b>	Male	35-40	Christian	Luo	Clinical officer
<b>Doctor</b>	Male	55-60	None	Luhya	Doctor
<b>Policeman</b>	Male	45-50	Christian	Kisii	Police
<b>Psychologist</b>	Male	50-55	Christian	Kisii	Lecturer
<b>Social worker1</b>	Male	50-55	Christian	Kikuyu	Social worker
<b>Social worker2</b>	Male	50-55	Christian	Kikuyu	Social worker

### 5.3 Theme generation

A thematic framework, indexed by Nvivo software, was used to analyse the transcribed data from the four focus group discussions. The analysis yielded five emerging themes, which were identified, analysed further and tabulated (Table 5.2), using the guidelines developed by Braun and Clarke (2006). For the purpose of this study, as illustrated in Table 5.2, codes are presented on the left, categories in the middle and themes on the right.

**Table 5.2**  
**Generation of themes from the transcribed data**

<b>Codes</b>	<b>Sub-themes</b>	<b>Theme</b>
1. Ability to cope 2. State of the mind	1). Understating of mental health	<b>1. Knowledge of mental health</b>
3. Environment 4. Poor background 5. Poor coping skills 6. Poor parenting	2). Causes of mental health problems	
7. Behavioural changes 8. Emotional changes 9. Physical changes 10. Psychological changes	3). Recognition of mental health problems	
11. Behavioural effects 12. Emotional effects 13. Physical effects 14. Psychological effects 15. Social effects	4). Consequences of mental health problems	
16. People offering support 17. Where support is available	5). Mental health support sources	
18. Negative attitude/taboo 19. Poor approach/rebuke	1). Ambivalence	<b>2. Barriers to mental health interventions</b>
20. Attitudes	2). Stigmatization and discrimination	
21. Broken culture 22. Peer influences 23. Exposure to technology 24. Geographical region 25. Uncaring society 26. Untrained personnel 27. Left to find own coping alternatives	3). Environment with lack of support	
28. Financial constraints 29. Limited personnel 30. Limited facilities	4). Lack of resources	
31. Risky coping alternatives 32. Lack of information 33. Lack of training 34. New concept	5). Limited mental health information	

Codes	Sub-themes	Theme
35. Lack of collective responsibility 36. Stakeholders negative attitudes 37. Fear to approach and help 38. Low implementation profile	6). Poor collaborations	
39. Ignorance 40. Poor attitudes and approach 41. Competing duties 42. Mentally challenged parents 43. Delay of support	7). Poor parenting	
44. Poverty 45. Inequalities 46. Poor housing	8). Socioeconomic challenges	
47. Compromise 48. Weak institutions	9). Lack of mental health policies	
49. Government to create jobs 50. The rich to help	1). Alternative sources of living	3. Suggested changes
51. Better coping strategies 52. Better supported programmes 53. Structured ways of help 54. Integration 55. Research	2). Sourcing for evidence-based programmes	
56. Change of attitudes  57. Change of strategies 58. Training counsellors 59. Peer counsellors 60. Passionate and committed personnel	3). Improve guidance and counselling services	
61. Child friendly initiatives 62. Equal resource distribution 63. Mental health budget 64. Open centres/clinics	4). Increase of mental health facilities	
65. Financial contribution	5). Sourcing for funds	
66. Change of approach 67. Role modelling 68. Family setup 69. Mental health of parents 70. Sensitizing parents	6). Improve parenting	
71. Team work 72. Training all stakeholders	7). Promoting collective responsibility	
73. Media coverage 74. Schools initiatives 75. Church support 76. Family support 77. Appreciate mentally challenged	8). Raising mental health awareness	
78. Enforcements of laws 79. Strong institutions	9). Strengthening mental health promotion policies	
80. Strengthening policies 81. Collective responsibility 82. Follow-ups	10). Sustaining programmes	

Codes	Sub-themes	Theme
83. Believing and trusting 84. Back to the roots of culture 85. Love of Jesus	11). Faith in religion and culture	

As depicted in Table 5.2, there were 85 second order codes generated from the overall data corpus, which were refined into 25 broad and initially overlapping themes. Following further exploration and closely engaging with the relevant literature, these 25 broad themes were analysed. They were further refined and categorized into three main themes (Table 5.3), which included: knowledge of mental health; barriers to mental health intervention programmes; and suggested changes and adaptations of mental health intervention programmes. These themes and their relevant sub-themes are discussed below.

**Table 5.3**

**Emerging themes**

Theme	Sub-themes
<b>1. Knowledge of mental health</b>	Definitions and breadth of mental health; causes and consequences of mental health problems; responsibility for child mental health; supporting structures for the children
<b>2. Barriers to mental health interventions</b>	Socioeconomic challenges and lack of resources; limited or lack of mental health information; stigma and discrimination; lack of culturally appropriate interventions; impaired parenting; systemic issues; poor collaborations
<b>3. Suggested changes to mental health interventions</b>	Evidence-based programmes; consultation with stakeholders; well-structured programmes; mental health awareness.

### **5.3.1 Theme I: Knowledge of mental health**

Participants positioned knowledge of mental health as central to mental health services. In their discussions, they highlighted several issues that demonstrated how they conceptualized mental health and services available in the community. These aspects of mental health,

included, but were not limited to; definitions and breadth, causes and consequences, responsibility for child mental health, supports and services available.

#### **5.3.1.1 Sub-theme I: Definitions and breadth of mental health**

Participants tried to define mental health and mental health problems, and to describe their scope. They conceptualized them in different ways, which illustrated their diversity of understanding. Mental health was defined through positive characteristics, although some participants defined it as absence of problems.

*“I think that mental health is when you are sober minded, you are not, you don’t have stress.”*  
**(Parent 2)**

*“Maybe it is the sound state of mind. When our mind is sound, it has no strings attached, we are mentally healthy.”* **(Teacher 4)**

*“To feel comfortable, nothing in your mind is disturbing you.”* **(Child 5)**

*“Good mental health is, it is anything that does not disturb you physically, emotionally just like that.”* **(Child 2)**

Mental health was described as a “*sound state of mind*”, in which individuals “*don’t have stress*” because “*nothing in your mind is disturbing*” them in any way, be it “*physically*” or “*emotionally*”. These comments show that participants were linking mental health with the ability to make good decisions because of having sober mind and “*feel comfortable*” to do so. These descriptions demonstrated that children who were mentally healthy had resilient behaviours and positive adaptation that gave them the ability to manage any stressors they encountered in their daily lives. Vice versa, mental health problems were related to a child not being able to express positive emotions. Other presentations included having many thoughts, thus becoming confused, and not being able to concentrate on usual tasks.

*“The child is scared.”* **(Parent 7)**

*“We are seeing very angry children...they are angry and bitter with the society.”* **(Social worker 1)**

*“You will be very confused.”* **(Child 3)**

*“Lack of concentration.”* **(Parent 3)**



Participants noted that children who had mental health problems were understood to be “*confused*”, “*scared*”, “*angry and bitter*”, without knowing what to do. They linked these signs and symptoms to negative emotions that reflected the problems that children were perceived to experience.

### **5.3.1.2 Sub-theme II: Causes and consequences of mental health problems**

When asked what they thought could be the causes and impacts of these problems that they identified in children, participants considered a range of issues. Across the groups, factors related to individual, family, community and societal factors, which had an influence on child mental health problems.

*“I have also found out that, um, there are many young people who are having an identity crisis.”* (Church elder)

*“Let us say that their parents, their parents abuse them or call them names...”* (Child 2)

*“The most immediate providers for mental health should be, who? The mother and the father.”* (Psychologist)

*“It has been discovered some take advantage for example if it is a girl, male teachers take advantage. In the attempt wanting to guide and counsel, befriend these children, they lose track, become pregnant and is left helpless.”* (Teacher 2)

*“No-one cares about them...they are forgotten.”* (Teacher 4)

Participants believed that some children did not understand themselves. It was reported that some were “*having an identity crisis*”, which was attributed to their body developmental changes. Children argued that some of the problems they experienced were caused by their parents. They noted that “*parents abuse them or call them names*”, instead of protecting them. Parents were positioned to play a central role in meeting children’s needs, because they are the “*most immediate providers for mental health*”. Crucially, they are supposed to initiate help-seeking for children displaying mental health problems. Teachers complained that some of their colleagues take “*advantage*” over children seeking for help when “*wanting to guide and counsel*”. They instead abused them and left them “*helpless*”. They also realised that these children were neglected by the society, as “*no-one cares about them*”. Generally, and to a large extent, these comments from participants illustrated that causes and

implications of mental health problems in their society were considered in terms of multidimensional components (i.e. individual, family, community and societal factors).

### **5.3.1.3 Sub-theme III: Responsibility for child mental health**

In their discussions, participants recognised that there was a burden of mental health services, because of the large number of children affected in the community. Participants had varying opinions on whose responsibility it was to support these children. In as much as they had different views, more especially where many participants believed that the family had a bigger role to play, it was generally agreed that child mental health was everyone's responsibility in the community.

*"I also think the issue of family should be enhanced, because it is the basic unit of any society."* **(Social worker 2)**

*"Usually it's the parents' responsibility, because he or she stays with the children for long hours."* **(Parent 4)**

*"Uhhh, even teachers have a role to play. Like when they have issues at home, the only place they can find, aah, refuge is with the teachers."* **(Parent 3)**

*"So, teachers have a big task with children. Listening to them and not knowing what to tell them about a certain issue."* **(Teacher 4)**

*"Many a times counselling is done by teachers, not professional guidance and counselling."* **(Teacher 6)**

Professionals argued that dealing with child mental health should be the parents' responsibility, because they were immediate providers for their children *"for long hours"*. In that case, they strongly suggested that families should be supported and sensitized to meet their obligations, since they were seen as *"the basic unit of any society"*. However, professionals' views were challenged by parents who recognised that *"even teachers have a role to play"*. They noted that *"like when they have issues at home"*, the other *"place they can find, aah, refuge is with the teachers"* in school. However, teachers argued that they *"have a big task with children"* making them *"overburdened"*. They also believed that *"counselling is done by teachers, not professional guidance and counselling"*, thus implying that teachers were undertaking pastoral care within their role, although they received limited training and support (also see below).

This responsibility was attributed widely to the government and the public.

*“The government has a role to play and, in fact, a major role.” (Teacher 7)*

*“According to me, I think it is the responsibility of the government...to take their part, because they, they are the ones act for the citizens. I think even the community members, let us say the people in our country can contribute to help those people who have mental problems.” (Child 2)*

Considering all these arguments across all the groups, participants’ suggestions implied that responsibility for children’s mental well-being should be shared across all stakeholders involved in child care.

#### **5.3.1.4 Sub-theme IV: Supporting structures for the children**

Participants reported that there was a deficit of mental health supporting structures for children. These were attributed to socioeconomic challenges and lack of resources, alongside lack of government commitment and investment in mental health.

*“So, aah, if we would have a professional guidance and counselling.” (Teacher 6)*

*“Give them enough funds or resources to fulfil their needs. (Child 2)*

*“Governments in Africa should also set a budget specifically for what? For mental health, because without that, then actually Africa is awaiting a very serious disaster.” (Psychologist)*

*“I am to recommend for lifestyle change. If their lifestyle is changed first from our homes before we go outside, it can lead or it can make a child to be at a state of being changed easily.” (Teacher 3)*

Guidance and counselling requires trained and qualified “*professionals*” as specialists. This was thought to improve the quality of support and treatment that children receive. However, it was critically assessed that lack of trained professionals was due to insufficient facilities, which were the result of limited government funding. Participants warned that “*a very serious disaster*” will be experienced if governments will not “*set a budget specifically*” for child mental health.

It was recognised that meeting children's mental health needs should not only target symptomatic presentations, but should rather be guided by a preventive philosophy. Change of lifestyle and attitudes, especially towards children with mental health problems, were crucial. Children need "*lifestyle change*" to promote their well-being, thus enable "*a child to be at a state of being changed easily*". This was viewed as a step towards creating more tolerant attitudes, which in turn would encourage children to access mental health services without fear. Generally, even if participants defined the scope of mental health and associated problems, as well as their causes and impacts, their responses indicated that the level of mental health knowledge of people in Kenya was not similar to theirs.

*"Mental health is actually a relatively new issue in, in Africa."* (**Pastor**)

*"You know, mental health is a new concept in Africa. And many people are ignorant on the issue, on the issue of mental health."* (**Psychologist**)

Professionals argued that mental health was not understood well in Kenya, and Africa as a whole. The reason for such poor understanding was associated with mental health being "*a relatively new issue*", or "*concept*", therefore, relatively misunderstood, as many "*people are ignorant*" about it.

### **5.3.2 Theme II: Barriers to mental health intervention programmes**

The overall theme 'barriers' to mental health intervention programmes consisted of several sub-themes and arising key issues. These related to societal attitudes, resources and infrastructure, culturally appropriate interventions and skilled workforce.

#### **5.3.2.2 Sub-theme I: Socio-economic challenges and lack of resources**

Participants noted that poverty and lack of resources affected the community, especially children. Poor housing conditions and nutrition were considered as contributing risk factors. It was also noted that caregivers from poor backgrounds were not able to provide quality support to these children, because they were busy working hard to earn a living.

*"Some of these things and some of the problems that have been faced due to issues related with poverty. Some of these children live in poor houses, single rooms, where all of them stay and have no food to eat before coming to school."* (**Teacher 6**)

*“May be I want to tell somebody my problem, she or he will tell me to do what? To just give him something what is much so that he can assist me. Maybe I don’t have, so that could really be a problem.”* (Child 7)

*“We are extremely busy and preoccupied with trying to do what? Preoccupied trying to create a living. So in the process our children, our young people are left on their own.”* (Church elder)

Teachers reported that the emotional and mental health problems experienced by children were *“due to issues related with poverty”*. Some of the highlighted common problems were, *“children living in poor houses, single rooms”* and having *“no food to eat”*. Children expressed their frustration in trying to access free or affordable mental health services. They reported that when *“I want to tell somebody my problem”* with much anticipated hope *“that he can assist me”*, they ended up being asked to *“give him something (money)”* which is a real *“problem”*, because they *“don’t have”* that money. The church elder also observed that poverty pushed caregivers to be *“extremely busy and preoccupied”* at the expense of children *“trying to create a living”*. These observations by participants reflect the well-established evidence that poverty and mental health problems are strongly inter-linked (Patel et al., 2007b; Lund et al., 2011).

Across the groups, participants highlighted that lack of resources hindered access to quality child mental health services. These included lack of facilities, health professionals (human resources) and adequate skills. Limited mental health facilities emerged as one of the barriers to service access. Children and health professionals in particular noted that child mental health services were lacking. They pointed out that many children with mental health problems failed to receive the support they needed, because the centres which offered treatment were scarce.

*“These child friendly initiatives are only in the urban centres where we have several international NGOs and national NGOs who are championing this cause.”* (Psychologist)

Professionals in particular, argued that lack of mental health facilities was attributed to unequal distribution of resources, either between regions and/or within local communities. For instance, a psychologist pointed out that facilities *“child friendly initiatives are only in the urban centres”* as opposed to poor rural environments where services were needed most.

Children observed that lack of equal distribution of facilities in all areas was partly influenced by poor decision-making.

*“Community they are the only ones, who are going to be assisted and the other communities they are not going to be assisted.” (Child 7)*

Children made it clear that it was so frustrating to learn that local communities and decision-makers, who were supposed to allocate the resources equally, were biased in deciding, at their own discretion, which communities were *“going to be assisted”* and which ones were *“not”*. Children also reported that the imbalance of child mental health facilities was compounded by limited funds available. For example, parents were financially unable to contribute to child healthcare costs, particularly as they already had to pay school fees for young people in secondary education (only primary schools are free in Kenya and other African countries).

*“The funds that people are contributing, is not enough to open those places.” (Child 1)*

*“Parents are not financially stable.” (Child 2)*

They reported that *“funds that people are contributing”* to set up mental health services were *“not enough”*, thus unable to accommodate the number of children with mental health problems. They also noted that *“parents are not financially stable”* to help in establishing those facilities or affording private treatment for their children, when they were working hard to earn a living to meet other family obligations. In that effect, professionals blamed the government for both shortage and unequal distribution of child mental health facilities. For example, it was argued that the few facilities available in urban areas were set up by *“national and international NGOs”* who were *“championing this cause”* of child mental health care. This point illustrated how government allocation and spending on mental health is not a priority of many government budgets in low-income countries (Kakuma et al., 2011; Amuyunzu-Nyamongo, 2013).

*“The governments should also set a budget specifically for mental health.” (Psychologist)*

Participants believed that the government should take a leading role in enhancing service equity across the country. It was suggested that for the purpose of promoting child mental health, the government must set up and increase the *“budget specifically for mental health”*. They thus implied that the government should prioritize mental health equally to other health

conditions. There was also recognition that mental health services had shortages of adequately trained mental health professionals. Limited capacity affected in turn staff morale. *“Many a times counselling is done by teachers, not professional guidance and counsellors...sometimes we are not so much well versed with it. So, there are things that we may assume, or there are things that we may do the wrong way.”* (Teacher 4)

Teachers raised concerns about the scarcity of mental health professionals in schools. They reported that *“many a times counselling is done by teachers”* who are *“not professional guidance and counsellors”*. They find it difficult to handle children’s problems because they *“are not so much well versed with”* child mental health issues. Teachers also noted that when they do offer guidance and counselling alongside their teaching duties, they become burdened and thus deliver poor quality support to the children. Similarly, the police reported that children with mental health problems, in some institutions, were neglected. They argued that these children did not receive the right support and interventions because of negative staff attitudes.

*“But how many people do we have in those institutions that have the passion with the children? Working with children, it requires people with passion and commitment.”* (Police officer)

*“What you are going to guide the children or the community should come from the heart, so that you can be able to deliver what is right.”* (Teacher 8)

Participants argued that some professionals do not *“have the passion with the children”* to provide quality and genuine support. Services require motivated, trained and qualified mental health professionals who will offer quality support and interventions. For instance, schools play a vital role in identifying and supporting children with mental health problems. When teachers are not well trained, *“there are things”* that they *“may assume”* or fail to detect, particularly identifying affected children and referring them for professional input. Lack of skills or failure to detect these problems will deter children from accessing mental health care services, and often lead to secondary impairments (Williams et al., 2007).

### 5.3.2.2 Sub-theme II: Limited or lack of mental health information

Lack of information about mental health was positioned to be problematic in accessing mental health services, which in turn affected both children and caregivers.

*“Friend of mine came and asked me what she should, what she should do, if she can commit suicide. And I really, I didn’t, **sikujua chenye naweza kumuambia** (I didn’t know what to tell her)!” (Child 1)*

*“The aunt was abusing the boy sexually. So the boy came to me and I was not in a state of helping.” (Child 2)*

Participants, especially children, admitted that many of them had limited information about mental health and services available. For instance, they pointed out how they were not able to help their peers when faced with mental health challenges; *“I didn’t know what to tell her”* and *“I was not in a state of helping.”* This equally affected caregivers, thus diminishing further their capacity to seek help.

*“Even people, maybe the elders, they do not have that full idea of what to be done or what to do.” (Child 1)*

*“And even when we are with them, we are ignorant. We do not know what to do with them.” (Church elder)*

Children failed to access support and treatment because they realised that their caregivers *“do not have that full idea”* about challenges and solutions. Participants argued that poor coping skills could also be attributed to lack of mental health information. When children are unable to manage their problems independently, they are easily influenced by peers into alternative but maladaptive coping strategies.

*“You can find sometimes that one of the reasons why people have all these problems have to do with the poor thinking and reasoning and decision-making. So, if you make wrong decisions, then you are likely to, to have a problem which is a result of poor decision-making.” (Social worker 1)*

*“In the process they may be misguided by others that you can have this one and settle the mind. That’s what they think. That if they take those drugs, they are able to solve problems they perceive to be having.” (Teacher 6)*



Social workers observed that children had mental health problems, because of “*poor thinking and reasoning and decision-making*” resulting from poor coping skills. Children make wrong choices when they lack adaptive coping strategies. Similarly, teachers argued that children with poor coping were liable to be “*misguided by others*” into using dysfunctional coping strategies such as taking drugs.

### **5.3.2.3 Sub-theme III: Stigma and discrimination**

Stigma of mental illness and discrimination against sufferers were identified as key barriers in accessing mental health services. Participants pointed out that children with mental health problems were scared to seek help openly, because they were not sure how they would be viewed by the rest of the people in the community

*“They will not, will not share it with other people, because they feel that those people may laugh at them, and may know them as well as their parents.” (Child 1)*

*“They don’t want, they don’t want to share, because they fear maybe what if I tell this person, and this and this, how will he think about me may be there is, they don’t like, may be you may make fun of them.” (Child 2)*

*“When they go to the teacher, there is guidance and counselling, when they go they tell the teachers, then they feel when they are counselled then that becomes an example to the others. They feel rejected.” (Parent 2)*

Participants across all the groups observed that most children with mental health problems were not ready and willing to seek help and treatment. They were worried about what “*they will think about me*” or they might “*make fun of them*”. Parents were also concerned that teachers contributed to stigma and discrimination, often because of lack of knowledge and training. For example, they argued that their children “*feel rejected*” and betrayed by guidance and counselling at school because of breach of confidentiality after support sessions. They claimed that these children were used to serve as “*an example to the others*”, thus making them to stop seeking any future support. Although stigma against mental illness applies to all societies, cultural influences were also acknowledged.

*“Africa has grown up in, that is associated with the stigma of having a mentally challenged child in, in our midst.” (Pastor)*

Participants argued that prejudice and misinformation in which the society “*has grown up in*” and existed “*in our midst*” was the cause of stigma and discrimination. For instance, the pastor’s argument demonstrates that stigma arises from culturally perceived stereotypes in regard to children with mental health problems. These contributions by the participants indeed illustrated that stigma can decrease children’s self-esteem and self-confidence, hence making them apprehensive and avoiding to “*share with other people*” their mental health concerns. Ways of addressing stigma and discrimination in the community were consequently discussed.

“*We need to appreciate the mental problem that we have in our society, and we need to begin speaking about it. That’s when we get a solution to it. But the more we keep quiet, the more the society is going ill.*” (Police officer)

“*If they open up their mind, their hearts and, and, and talk about those problems, there, there will be help given to them.*” (Child 1)

Professionals suggested that individuals in the community needed “*to appreciate the mental problem*” that exists in the society. They argued that stakeholders must find solutions, otherwise, if they “*keep quiet, the more the society is going ill*” on stigma and discrimination. Children agreed that for them to be supported well they need to “*talk about those problems*”, so that professional can help them. It is well established that stigma and discrimination are associated with lack of knowledge on mental health issues (Killion & Cayetano, 2009). Raising community awareness can thus mitigate misperceptions and stigmatizing beliefs, and enable children and their families to seek and utilize available mental health services (Rickwood et al., 2007; Knifton, 2012).

#### **5.3.2.4 Sub-theme IV: Lack of culturally appropriate interventions**

Participants across the four groups identified lack of culturally appropriate and acceptable interventions as a barrier to children receiving appropriate help. They recognised that use of culturally insensitive methods or approaches adversely impacted on the quality of support and interventions children received.

“*We have tried many of these solutions, sometimes they are still failing us.*” (Social worker 1)

*“We are always doing very little, and sometimes irrelevantly, and sometimes with wrong responses to the mental challenges that our youths are facing in the society.” (Pastor)*

Participants acknowledged that, on the whole, available intervention programmes did not appear to be working. For instance, the social worker argued that *“we have tried many of these solutions (interventions), but “they are still failing us”*. It was argued that these programmes often resulted in *“wrong responses to the mental challenges”*. These reports indicated that interventions were not conforming to and reflecting the reality of child mental health problems. Several reasons were put forward as explanations, including families seeking traditional healing and other inappropriate responses.

*“The root causes of some of these problems, are never handled well.” (Teacher 8)*

*“I have seen cases of youths suffering from hysteria in, um, in our schools in many, many areas here. When you see, um, pastors being invited to go and conduct prayers and exercise spirits which are imaginary leads to a wrong, um, solution, because hysteria really has nothing to do with a spiritual dimension. It’s a problem that requires to be assessed carefully.” (Pastor)*

Apart from *“doing very little and sometimes irrelevantly”*, participants argued that the main causes of mental health problems were *“never handled well”* before seeking professional help. They explained that, if the underlying causes were not *“assessed carefully”*, this could result in *“a misdiagnosis of the problem and which leads to a wrong solution”*. This observation could indicate that interventions used were perceived as ineffective and/or culturally inappropriate. The latter explanation was supported by more specific quotes that some of the programmes available were not in line with the children’s culture.

*“There is a lot of confusion, there is an element of cultural transformation now.” (Social worker 1)*

*“Africa as a continent had its own values. Those values have now been ignored completely, and now we have actually brought in western, what? The western values, western concepts; Africa had its own system of regulating mental health, that’s no longer happening.” (Psychologist)*

*“Africa is in a state where actually the centre has broken and things have, I mean things have, fallen apart and the centre can’t hold.” (Pastor)*

Professionals expressed concerns that some interventions caused *“a lot of confusion”* in their implementation because of the *“cultural transformation”* that has taken place in Africa. For instance, as pointed out earlier by the pastor, children’s mental health had *“nothing to do with a spiritual dimension”* only; instead it was viewed as *“a problem that requires to be assessed carefully”* in order to have the right treatment. It was, however, argued that Africans had their *“own values”* and *“own system of regulating mental health”*, without those values necessarily being in conflict with western interventions. Nevertheless, the non-adapted introduction of such western interventions would often bring them into conflict with local culture. African cultural safety and instability were thus experienced when *“the centre”* was completely *“broken and fallen apart and the centre can’t hold”*, because of the inappropriate imposition of western interventions.

These arguments demonstrate how the transformation of western mental health ideology and treatment failed to account for national and local context, values, beliefs and culture. Transporting interventions from high- to low-income countries settings, is only effective when these interventions are adequately adapted and tailored to be culturally relevant (Bolton et al., 2007; Park et al., 2011). Similarly, cultural and religious beliefs on mental health should be embraced, respected and understood, rather than confronted (Henderson et al., 2011), as this dialogue and integration of cross-cultural concepts and ideas is a firm foundation towards appropriate and effective interventions (Bhui et al., 2007).

Young people and teachers also argued that the way available interventions were implemented was not appropriate and did not sufficiently address their mental health concerns. They noted that the so-called *“counsellors”* were not adequately qualified to fulfil their role.

*“We have a counsellor here, may be in school; calling together different people, different problems, one counsellor! He will not be able to help all of us at once. He will talk to us, some will be helped, some will not.” (Child 2)*

*“At some point, some of the issues they are not handled in the right way. A child might go to a counsellor whom he or she believes is going to help her, but at the same time may be this counsellor is known to be talking things out. So this child will start withdrawing from going to ask for assistance from that person.” (Teacher 8)*

Children reported that they were not happy with the way counselling was delivered in their schools. They complained that “*calling together different people, different problems, one counsellor*” was not sufficient or effective. They argued that it was not practical to “*be able to help all of us at once*”, as “*some will be helped, some will not*”. In agreement with the children, teachers also noted that mental health problems in their schools were “*not handled in the right way*”. They were particularly concerned about children’s privacy and dignity. Some school-appointed counsellors, with whom children shared their problems confidentially, were “*known to be talking things out*”. When children realise that their confidentiality and trust have been breached, they “*start withdrawing from going to ask for assistance*”, thus limiting even further their access to appropriate supports.

These comments illustrated that problems encountered by the children were both extensive and diversified and, therefore, no individual counsellor was sufficient to manage them as he/she “*will not be able to help all of us at once*”. At the same time, they stressed that confidentiality and respect should not be compromised, as this was incongruent with the universally accepted child-centred approach to mental health care. Therefore, upholding respect and dignity for these children was realised to be an assurance in engaging them and meeting their needs (Bjorkman et al., 2008).

Participants also expressed their concerns about language use during support and treatment sessions. They noted that this barrier could alienate children from professionals and services. Such language appeared to reflect lack of understanding on the reasons behind child mental health problems, hinting at blame towards the individual child.

*“If a counsellor does see that if a person is not catching up, may use abusive language and the person may feel neglected. And he will not want to change his behaviours.” (Child 6).*

*“You know when you talk to your child, the language you use is very important.” (Parent 3)*

Children argued that some counsellors used “*abusive language*” when supporting them, something that made them “*feel neglected*” and taken for granted. This discouraged them “*not want to change his behaviours*” and thus stop seeking support. Parents also recognised that the choice of “*language you use is very important*”. These observations demonstrate that

empathy and interpersonal skills between caregivers and professionals with the children are essential in developing a nurturing and trusting relationship (Bhui et al., 2007).

The lack of following-up initial counselling sessions was also raised as a challenge. Children and teachers in particular were concerned that progress of support and treatment offered was rarely assessed. Consequently, this hindered sustainability of improvement for those children who had engaged with services.

*“There is no one who is following up if they are working or not.” (Child 2)*

*“Talking about making a follow-up, we use the peer counsellors, so that we can be able to know how the child is progressing; then we can be able to know whether we have achieved whatever we are doing.” (Teacher 1)*

*“Without continuous follow-up, eventually the person will go back.” (Teacher 6)*

Lack of continuity made children feel abandoned and think that their problems were not taken seriously. Teachers agreed that ongoing support by mental health services was important. They observed that *“if there is no proper follow-up”*, it was difficult to assess *“how the child is progressing”*. They warned that *“without continuous follow-up”* interventions, children will either not improve or relapse *“will go back”* in experiencing the same mental health symptoms, thus requiring further initiation of treatment for more entrenched problems.

### **5.3.2.5 Sub-theme V: Impaired parenting**

The association between ill parental and child mental health is well established (Panter-Brick et al., 2014). This is often mediated by parenting difficulties. Participants pointed out that both parental mental illness and poor parenting were challenges in children seeking and receiving quality mental health care (Betancourt & Khan, 2008). It was thus acknowledged that it was difficult for a parent with mental health problems to support their children.

*“Mental cases, is not only for the children.” (Teacher 7)*

*“We have a problem with us the society, the parents also, are the victims of mental problem. So, we try to address a child who has mental problem, yet I myself I have a mental problem.”*

*So, it becomes difficult to address the issue of the child while I myself I am sick, I am a victim of it.” (Police officer)*

*“So, in a nutshell, um, mental health will start with the parents.” (Doctor)*

Participants, especially teachers, identified that mental health problems were “*not only for the children*”, they also affected caregivers. For example, it was pointed out that “*parents also are the victims of mental problem*”. When parents suffered themselves, it was difficult “*to address a child who has mental problem*” (Sriskandarajah et al., 2015) or support them in seeking help, especially as parents usually initiate requests for support (Thabet et al., 2008). These findings strongly support the need for co-ordinated family interventions (Jordan et al., 2010; Abera et al., 2015).

Addressing impaired parenting was especially highlighted by participants. This was perceived to contribute to the development of child mental health problems, as well as hinder their early recognition and prompt management.

*“Sometimes, **unaweza ongea kwa sauti** (you may shout), even a child who would have opened up, they decide to block up completely. You don’t bother to talk to the young people to know what’s, what’s happening.” (Parent 3)*

*“They are born of parents who are ignorant...some parents are so ignorant that they are not able to identify....these children.” (Teacher 4)*

*“Parents have become reluctant. When she’s quiet, when they are not quiet, we really don’t care.” (Parent 2)*

Participants noted that some parents did not understand their children’s needs. This could be related to their own difficulties, socioeconomic strains, and lack of mental health awareness. They “*are not able to identify*” any problems in children, because they “*are so ignorant*” about child mental health. They are thus not able to detect any mental health symptoms. However, it was also argued that, even if some parents are able to detect any problems, they “*don’t bother to talk to the young people*” to find out “*what’s happening*”. Participant were concerned that some parents were “*reluctant*” and “*really don’t care*” to help their children. Some parents were perceived as being harsh in their rearing strategies, thus making those “*who would have opened up*” subsequently “*to block up completely*”. It was, therefore,

recognised that help for these children sometimes “*don’t start earlier enough*” because of negative parental attitudes. The church elder noted that many parents were not concerned about their children’s problems “*until when there is a crisis*”, when they are more inclined to act.

*“Sometimes may be we don’t start earlier enough. We don’t tell them the right thing earlier enough.” (Parent 3)*

*“Until when there is a crisis and they are found in the institution (rehabilitation centres) where my brothers serve, then that’s when many people wake up. What happened to my child? They don’t know when the rain started beating them.” (Church elder)*

Some parenting attributes such as being “*reluctant*”; “*don’t care*” or “*don’t bother*” could be associated with the cultural conceptualization of mental health. In some African cultures mental health is a misunderstood topic, especially in rural areas where it is regarded as a taboo. In contrast, this is associated with evil spirits, therefore, people in the community, parents inclusive, do not dare talk about it (Getanda et al., 2015). Improved awareness can instead help parents to cross these cultural barriers and support their children in accessing appropriate mental health care (Abera et al., 2015).

#### **5.3.2.6 Sub-theme VI: Systemic issues**

Parenting difficulties were also linked to socioeconomic hardships. Caregivers’ reluctance, competing priorities or other pressing family commitments were viewed as additional barriers.

*“We don’t have a lot of time with our children. You are busy out there with your business, your work place.” (Parent 1)*

*“We are extremely busy and are preoccupied with trying to do what? Preoccupied trying to create a living. So, in the process our children, our young people, are left on their own. (Church elder)*

*“We are being so much preoccupied with wealth-looking than attending to the problems which might been raised. (Chief 2)*

Parents agreed that they often “*don’t have a lot of time with our children*” because of other pressures and commitments. The church elder particularly noted that most caregivers were “*extremely busy and are preoccupied*” elsewhere with “*wealth-looking*”, while “*our children, our young people, are left on their own*” without receiving positive parenting and



nurturing. Difficulties in communication within the family compounded mental health problems.

*“Parents have become reluctant. When she’s quiet, we really don’t care. When they ask questions we run away. We don’t want to answer them directly.” (Parent 2)*

Parents themselves acknowledged that sometimes they did not take their responsibilities seriously. They agreed that they could thus *“become reluctant”* to help their children. When children raise any concerns, parents can fail to *“answer them directly”*, because either they *“don’t care”* or do not know how to handle the challenge.

### **5.3.2.7 Sub-theme VII: Poor collaborations**

Participants identified the lack of good collaboration across communities and services as a major factor in children’s problems not being detected and/or not receiving appropriate care. The key areas they pointed out included lack of community readiness and engagement, and children being left to create their own coping alternatives. It was recognised that many community stakeholders were not ready to engage in working together to promote child mental health. Some of these stakeholders did not accept any responsibility for children’s mental health, despite supposedly signing up to the principle that everyone in the community has a role to play in protecting children’s wellbeing.

*“We always try to see if we can work together to help these children. It’s difficult, because other parties don’t want to co-operate in helping them. If all were involved, it would be better.” (Social worker 1)*

*“So, people expect school, the teacher will take care of, people expect the teacher in school will take of the children’s mental health, that does not happen. And those of us who come from Christian societies, they expect that someone in church is going to take care of that. But, unfortunately, there is very little time for that.” (Church elder)*

*“The children act, it bestows the responsibility to protect the children on every individual, but what do we do? We see where we come from, we see children who are being abused, but we do nothing about it.” (Police officer)*

Professionals, especially social workers, did not hide their frustration in trying to forge community partnerships *“to see if we can work together to help these children”*. They felt

that community togetherness was the key “*if all were involved, it would be better*”. However, they realised that their efforts proved to be “*difficult because other parties don’t want to co-operate*”. The church was also concerned that there was no co-ordinated approach in the way children were supported in the community. For instance, the church elder noted that lack of communication among institutions and caregivers frustrated their efforts of helping children. He argued that the community expected that at “*school the teacher will take care*” of the children, while others “*expect someone in church is going to take care*” of them, when in reality “*that does not happen*”, because every party finds that “*there is very little time for that*”. The police officer pointed out that the society did not realise that “*the responsibility to protect the children*” rests “*on every individual*” in the community.

Children’s mental health care is a collective responsibility that needs to be shared across various agencies. As in the African context the general upkeep and health-related care of children has traditionally lain with the whole community, the same approach needs to be adopted by community leads and members. It is thus everyone’s “*responsibility to protect the children*” and support them in accessing and receiving the right kind of mental health support.

Across all societies, it is evidenced that fragmentation of care pathways leads to a range of adverse psychosocial outcomes (Williams et al., 2007; Gould et al., 2012).

Across all groups, participants were concerned that children with mental health problems did not receive the attention that they need, for a variety of reasons. These included lack of awareness, communication, availability and opportunities for social interaction. In this process, they may be left to find their own coping strategies, which can lead them to dysfunctional alternatives within their peer group such as drug use and antisocial behaviour.

*“There is nobody who is there to role model for the young ones, etc; so, there are people, um, I want to say that the young people are at their own.” (Psychologist)*

*“We run away. We don’t want to answer them directly. So, they try to check somebody who can teach them or just try to explain to them what they want to know. And because I was not ready to tell them, the other one will teach them wrongly. So, they go astray, may be they check what they want to know from wrong people. They give them wrong information, they start...they start looking them from internet because of the digital world we are living today. Then they get it wrongly.” (Parent 2)*

*“The area of technology that is many times used by our youths, it centres a lot on mental challenges to them. Especially because of their young minds, they begin to grab on with issues online, on internet which are well beyond their abilities.” (Pastor)*

Participants argued that, when children are left unattended *“there is nobody who is there to role model”* and provide them with the support to find adaptive solutions to their mental health needs. These children then feel neglected and thus resort to either *“try to check somebody who can teach them”*, or *“begin to grab on with issues online, on internet which are well beyond their abilities”*; and/or *“start taking drugs”* thinking that *“they are able to solve problems they perceive to be having”*. Children with mental health problems need close supervision and support, without which they will *“be misguided by others”* and receive *“wrong information”*, hence making their situation worse. Some of the strategies that they perceive to solve their problems in the short-term include alcohol and drug use, which lead to additional impairments.

### **5.3.3 Theme III: Suggested changes to mental health interventions**

Apart from discussing the challenges facing mental health services, participants also reflected on required solutions. The first and urgent step would be the open acknowledgement of the nature and extent of the problem.

*“Let’s not just speak about it, let’s speak to it, let’s speak about it. Let’s face it. And accept it speak about it, speak to it.” (Pastor)*

Participants argued that it was not only the time to *“speak about it”*, but rather the time to *“face it”* and find solutions. This comment indicated that the scale of the problem was enormous, therefore immediate action was needed. To that effect, participants recognised that there were *“many ways that you can use to solve the problems”*, therefore they suggested a variety of ideas and strategies. A starting point was the understanding of vulnerability factors that underpinned the onset and maintenance of mental health problems.

*“I think there is, there are so many ways that you can use to solve the problems.” (Child 2)*

*“We need to get to the root cause of the problem, then we need to deal with the problem, and finally we need prevent it from happening again.” (Nurse)*

### 5.3.3.1 Sub-theme I: Research for evidence-based programmes

In the process of searching for effective and appropriate solutions to children problems, it was recommended that research for such intervention programs was a priority. Such research would help understand, define and develop acceptable and effective programmes.

*“I think we need to do a bit of benchmarking in terms of trying to understand what is happening in other places, because we have tried many of these solutions, sometimes they are still failing us. There could be a problem with our society itself. And that’s why I feel we have to go outsource for ideas. Ideas which can really work for our situation.” (Social worker 1)*

Professionals argued that, since they had *“tried many of these solutions”* but were consistently *“still failing us”*, there should be guidelines for intervention programmes which were evidence-based. They recommended first *“a bit of benchmarking”* to be carried out *“in other places”* to determine empirically working interventions that must conform to the context or culture. The professionals’ suggestions demonstrated, consistent with the body of literature, that for interventions from *“other places”* (high-income countries) to work in the local context, these should be culturally tailored and acceptable (Bernal, 2006; Wiley-Exley, 2007).

### 5.3.3.2 Sub-theme II: Consultation with stakeholders

Related to the selection and adaptation of empirically tested and proven interventions, was the suggestion for ongoing involvement of stakeholders in their planning, implementation and evaluation.

*“We consult the various groups that are responsible; parents, teachers, we also consult the church, even students themselves. We, after talking to them, then come up with content or format on a way to help these students.” (Parent 5)*

*“It is the responsibility of everybody combined. One, the parent has a role to play in the mental upkeep of this kid. The teacher has a very great role, as he has said, because most of the time the teacher preoccupies the child’s time. More than everything, the child himself, whether of age or not of age, has a part to play in his life. The government out there has a part.” (Teacher 2)*

*“May be through the church or some institution, we are able to have structured programmes that are just social for them to just come and interact, give their mind, share their ideas.” (Parent 1)*

Participants suggested that, if new and different support and treatment programmes were to be tried, this had to be achieved through consultation with all stakeholders. In suggesting so, they acknowledged that childcare was the “*responsibility of everybody combined*”, and this was the only way to facilitate the selection of effective and culturally acceptable interventions that could be easily implemented and sustained.

#### **5.3.3.3 Sub-theme III: Well-structured programmes**

In identifying, adapting and implementing new interventions, participants stated that consistency and structure in their approach would make it more likely that these would be generalizable, transferrable and sustainable across different staff groups and settings.

*It would help if we had a structured way of, of making these children or youths understand some things...a structured way of like passing on this information on and on. So, that they are able to try to integrate what they have learned, which good is from home and what they have learned which is good from school.” (Parent 1)*

*“Establish professionals’ guidance and counselling activity levels. One at school, two at church level and three at the community level, which is going handle the issue to do with guidance and counselling on both the parents and the children.” (Teacher 6)*

A “*structured way*” should thus be construed collaboratively and integrated into available programmes in order to ensure their fidelity rather than dilution. Interestingly, different levels of implementation were also considered. For example, it was suggested interventions such as “*guidance and counselling*” should be established and become available at different levels “*one at school, two at church level and three at the community level*”, to ensure that they meet different children’s needs and through agencies being involved accordingly.

#### **5.3.3.4 Sub-theme IV: Training**

Mental health awareness and promotion were recommended as essential steps in improving the quality of child mental health provision. It was thus suggested that all stakeholders involved in childcare should first be exposed to appropriate training forums and events, before developing skills according to their agency remit. Such awareness should also involve parents and the wider community. Children and young people should integrate mental health principles in their school curriculum.

*“We need to appreciate the mental problem that we have in our society, and we need to begin speaking about it. That’s when we get a solution to it.” (Police officer)*

*“The parents must be sensitized through various awareness programmes, so that they can take their rightful roles on issues of mental health.” (Psychologist)*

*“We need to have life skill classes” (Child 7)*

It was recommended that all stakeholders were supposed “to appreciate the mental problem that we have in our society”. The society was to start “speaking about it” and this could only be done through awareness. For instance, children were recommended to learn “life skills” to help them cope with stressors; whilst parents needed to be “sensitized through various awareness programmes”, so that they could “take their rightful roles on issues of mental health”.

#### **5.4 Discussion**

The main aim of phase I was to establish key community stakeholders’ views on ways of improving awareness and response to child mental health problems in Kenya. To achieve this aim, it was first important to understand their concepts of child mental health, factors involved in the development and continuation of problems, existing supports and services, as well as gaps and challenges. The barriers identified reflected the participants’ rich experience of the challenges that many of the poor communities in low-income countries such as Kenya encounter. In line with the existing body of literature, these included: limited mental health knowledge; stigma against mental health; economic disadvantage and lack of resources; parenting and systemic issues across communities; lack of culturally appropriate interventions; and poor community and service collaborations (Patel et al., 2007a; Saxena et al., 2007; Kleintjes et al., 2010).

Findings from the study identified socio-economic disadvantage such as poverty, scarcity and inequities in the distribution of community and mental health resources and facilities to challenge the children’s mental health and experiences of services. Shortage and poor housing, as well as lack of food, were highlighted as some of the common problems. Consistent with the literature, socio-economic disadvantage has been found to impact on both child mental health and care received through different mechanisms (Benova et al., 2015). For instance, in this study poverty was positioned to affect both children and their caregivers. Research argues that poverty is a strong risk factor for the development and outcome of mental health problems (Patel et al., 2007b). Particularly in low-income countries, this increases exposure to adversities such as shortage of food, malnutrition, disruption of social

networks, poor housing, inadequate education and community violence (Amuyunzu-Nyamongo, 2013). Funk et al. (2012) and Reiss (2013) found that children from poor backgrounds were three times more likely to develop mental health problems than the general population. Lund et al. (2011), among others, demonstrated that poverty and mental health problems are intertwined and influence each other negatively. Consequently, children who live with mental health problems are more likely to experience and be trapped in poverty (Ehiemua, 2014). A number of mechanisms are involved in this vicious cycle such as lacking the capacity and opportunities for education and later employment, stigmatization and discrimination at school and in the community, and exposure to criminality and other risk factors such as drug use within their peer group (Gureje & Jenkins, 2007; Saxena et al., 2007).

In addition, shortage of mental health facilities was identified and attributed to unequal distribution of resources within local communities. For instance, child-friendly settings and initiatives were reported to be located only in urban centres, unlike poor rural environments where mental health provision was almost non-existent. According to Jenkins et al. (2010), scarcity and inequities in distribution of community and mental health resources and facilities are prominently experienced in low-income countries. Lack of these resources prevents children from accessing and utilizing appropriate help (Saxena et al., 2007). It is, however, argued that such shortages relate to funding, human resources, policy and infrastructure (Ehiemua, 2014). For instance, concerns about the scarcity of mental health professionals in services and schools were raised. Poor quality supports and interventions were associated to the lack of motivated, trained and qualified mental health professionals. This connection has also been reported in the literature. Particularly in terms of human resources, there is a critical lack of qualified mental health professionals required to meet demand (Eaton et al, 2011). It has been argued that the few professionals available are not sufficiently skilled and supported to offer quality services (Kiima et al., 2009; WHO, 2012), as they are poorly paid, work in adverse conditions (Gureje & Jenkins, 2007; Jenkins et al., 2010), and lack appropriate training and continuous professional development (Williams et al. 2007; Killackey et al., 2008).

Likewise, scarcity of funds for child mental health services hampered efficient support and interventions. In line with the findings, previous studies reported that the small budget allocated to mental health is concentrated on crisis response towards severe mental illness,

with limited if any early intervention services (Prince et al., 2007). Many low-income countries spend less than 1% of their allocated health budgets on mental health services, which are not perceived as a public health priority (Kakuma et al., 2011; Amuyunzu-Nyamongo, 2013).

Limited information about mental health and services available was another challenge elicited by this study. It was realised that children often made wrong choices if they lacked information and help on how to develop adaptive coping strategies to mitigate mental health problems. They were thus reported to be either misguided or unable to support their peers in most need. These findings also conform to previous studies, which identified lack of mental health awareness and knowledge as affecting access to mental health services. A number of studies have shown that limited mental health knowledge particularly compromises mental health services utilization in low-income countries (Rickwood et al., 2007; Eaton et al., 2011).

Arguably, when families and communities are poorly informed about existing mental health problems and available types of help, both care pathways and service provision are inevitably affected (Lauber et al., 2005; Patel et al., 2007a). If children's emerging mental health problems are to be detected early, so that they receive prompt attention, mental health awareness and knowledge play fundamental roles in facilitating families' help-seeking and professionals' responses (Lam, 2014). Such knowledge can enhance access, followed by prompt assessment and intervention (Lauber et al., 2005; Patel et al., 2007a). This should include an understanding of children's development, risk and protective factors, and the nature of common mental health presentations. In turn, this will contribute to children's own awareness, and likelihood of seeking related information and appropriate help (Lam, 2014).

Findings from the study indicated that children with mental health problems were not ready or willing to seek help and treatment. Both children and their parents were worried about what the community might think about their conditions. In particular, they feared being segregated and discriminated against. A number of studies have established that poor mental health knowledge is strongly associated with stigma and discrimination (Knifton, 2012). Stigma includes negative attitude (beliefs, thoughts and behaviours) towards children (and indeed adults) with mental health problems, as well as their families (Bjorkman et al., 2008). These can subsequently lead to social exclusion and suffering, thus further affecting access to and utilization of services available (Ehiemua, 2014). In the developing world, especially in



Africa, mental illness remains a taboo subject, with a negative cycle of implications for affected children (Amuyunzu-Nyamongo, 2013).

Consequently, children with mental health problems may be perceived to be unpredictable, difficult to talk with, violent and dangerous, for which reasons they are often subjected to exploitation and victimization in the community (Lauber & Rössler, 2007; Knifton, 2012). For example, they are more likely to be marginalized, maltreated through harsh physical punishment such as physical restraint, chained to trees or locked inside the house, thus making their mental health conditions worse (Killion & Cayetano, 2009; Klasen & Crombag, 2013). Such kinds of stigma and discrimination in the community not only affect the way children with mental health problems are perceived; but also their families, mental health workers and the institutions in which they work. Studies argue that negative attitudes towards mental health can reinforce health decision-makers' reluctance to invest in mental health care (Lauber & Rössler, 2007; Sartorius, 2007). However, evidence also indicates that awareness programmes such as through psychoeducation can mitigate stigma and associated beliefs (Killion & Cayetano, 2009; Kiima & Jenkins, 2010); consequently encourage children and their families to seek and utilize available mental health services (Rickwood et al., 2007).

The study established that prejudice and misinformation in the society were attributed to stigma and discrimination within communities. It was reported that stigma arose from culturally perceived stereotypes in regard to children with mental health problems. These reports illustrated that stigma can decrease further children's self-esteem and confidence, thus making them apprehensive and avoiding to seek help from mental health services. Wider cultural beliefs and practices have been identified in literature to influence the way individuals and communities understand and conceptualize mental health (Bolton et al., 2007; Park et al., 2011), thus affecting the way they approach mental health services (Coast et al., 2016). Culture in its own right plays a significant role in determining how mental health symptoms are experienced, expressed, recognised, treated and prevented (Kirmayer et al., 2012; Chalmers et al., 2014). This can influence the direction and development of policy, services and interventions (Patel et al., 2007b; Henderson et al., 2011).

Mental health problems were not only identified to affect children but also their parents and caregivers. It was recognised that when parents suffered themselves from ill mental health,

their parenting capacity was compromised. A number of studies have demonstrated that impaired parenting can both compound children's mental health and hinder their access to mental health services. Parents' mental health problems reduce their parental capacity in meeting their children's needs, especially those who experience emotional and behavioural problems. Also related to parental mental health problems are domestic violence, family breakdown, alcohol and substance abuse all, of which often result in child maltreatment (Wieling et al., 2015). Parents experiencing such problems find it difficult to engage, be sensitive and emotionally involved, recognise their children's mental health needs, and seek appropriate help (Thabet et al., 2008; Bayer et al., 2011; Panday & Fatima, 2016). A number of studies have shown that parents' mental health may mediate attachment relationships with their children (Betancourt & Khan, 2008; Abera et al., 2015). When parents cannot adequately manage life stressors, ignore their children's needs and use negative strategies (Sriskandarajah et al., 2015), children are more likely to experience trauma-related, anxiety, depression or behavioural problems (Vostanis et al., 2006). In contrast, parental mental health stability, emotional sensitivity, safety, and well-being all serve as predictors of children's positive mental health (Betancourt et al., 2010; Jordans et al., 2010; Werner, 2012).

In addition, the findings indicated that parents who were ignorant of unaware of mental health issues were unable to detect mental health symptoms in their offspring. Even among those parents who did recognise emerging mental health concerns, help-seeking could be hindered by their own mental state and/or parenting skills. In contrast, parental understanding of children's worries and concerns, treating them fairly, expressing affection and emotional support, as well as friendly and warm communication can act as buffers in the face of adversity (Sriskandarajah et al., 2015).

Overall, this study established that evidence-based and culturally appropriate interventions were lacking. The available intervention programmes were failing to provide sustainable solutions, because they were not conforming to and reflecting the reality of child mental health problems in the community. Lack of thorough assessment to understand the underlying causes, delayed response and lack of follow-ups to evaluate the progress of the child were barriers to children both accessing help and benefiting from it. A growing body of literature demonstrates that for mental health care to become accessible, engaging, effective and

sustainable, intervention programmes should be evidence-based (Jordans et al., 2011; Park et al., 2011).

Likewise, the uncritical application of western mental health ideology and approaches fail to account for national and local context, values, beliefs and culture, which permeate families, communities and the society as a whole. Research also shows that most evidence-based mental health interventions originate from high-income countries (Bolton et al., 2007). These interventions may not be feasible or acceptable in low-income countries, where they offer partial solutions because of being culturally insensitive and inappropriate (Bhui et al., 2007). A number of researchers consequently argue that for such interventions to be relevant, appropriate and culturally sensitive, they should be adapted and co-produced in different cultural contexts (Bernal, 2006; Wiley-Exley, 2007). Such adaptation should consider a number of factors such as language, beliefs, cultural identity and religion (Persson & Rousseau, 2009; Heo & Braun, 2014).

The study found that there was poor collaboration between communities and agencies in scaling up child mental health services. Improvement of child mental health was reported to be a collective responsibility, but this could not be achieved because of lack of community partnerships. It is argued child mental health promotion can play a central role in engaging communities; understanding and reframing attitudes towards children's mental health, and forming a link between those communities and evolving services. When this crucial link is missing through lack of communities inter-agencies collaboration, children and families are less likely to trust and approach services when in need (Rothi & Leavey, 2006). Inter-agency fragmentation and poor communication have been found to frustrate and delay referrals and decision-making in relation to children's treatment (Patel et al., 2007a; Andvig et al., 2014). These challenges on the ground often reflect similar fragmentation at government level, especially in Africa (Lebowitz, 2015). These are compounded by lack of political will resulting in absence of mental health policies and limited funding for mental health services (Eaton et al., 2011).

In contrast, effective collaboration at central and local government level can guide inter-agency partnerships and trust in mental health services among the population (Langholz, 2014). Constructing mental health services should thus be based on collective responsibility,

shared decision-making, feedback provision and effective communication, if this were to substantially enhance the quality children mental health care (Michener et al., 2008). Acknowledging that these challenges exist in child mental health services and understanding how they affect delivery of services (Gould et al., 2012), is a fundamental step towards the selection, design and delivery of an appropriate intervention (Asprey et al., 2013). It is recognised that such knowledge is crucial for researchers, policymakers and all stakeholders invested in promoting and improving child mental health services (Lamb et al., 2014).

#### **5.4 Chapter summary**

This chapter presented and discussed the findings regarding stakeholders' views on children's mental health needs and required interventions. The demographic characteristics of the sample, coding and analytic process, and generation of themes were presented accordingly. The key findings that were briefly discussed above demonstrate the importance of taking into consideration these stakeholders' perspectives in informing the selection, planning and delivery of a culturally acceptable intervention, to be implemented in the next phase II of this study.

## **CHAPTER SIX**

### **PHASE II**

#### **FEASIBILITY STUDY: METHODOLOGY**

## **6.1 Introduction**

This chapter provides detailed information on the research sub-questions and aims that informed the methodology adopted in phase II. This includes the choice of theoretical framework guiding the methodology and design employed in this study. This is followed by description of the sampling frame, selection of the intervention, research procedure, ethics, and data collection. The chapter is concluded by justification and description of the statistical and content analytic processes.

## **6.2 Research sub-questions**

This phase was concerned with the delivery of a trauma-focused or other psychosocial intervention, as informed by the findings from phase I and the research literature, and the evaluation of its feasibility. The following research sub-questions were explored:

- i), How can community stakeholders' recommendations on overcoming barriers be incorporated in a trauma-focused or other psychosocial intervention?
- ii). How feasible is it to deliver such a psychosocial intervention for children with mental health problems?

## **6.3 Research sub-aims**

- i). To establish how key community stakeholders' perspectives and recommendations can be incorporated to select, inform and adapt a culturally acceptable trauma-focused or psychosocial intervention.
- ii). To evaluate the feasibility of the implementation of this intervention with children with emerging emotional problems in an area of internal displacement and disadvantage in Kenya.

## **6.4 Theoretical framework**

Understanding the research paradigm and its underpinning philosophy is fundamental in any research project (Elshafie, 2013). A paradigm provides a framework and comprehensive process through which a research study can be carried out. In answering the research questions, a paradigm identifies the methods applied to collect and analyze the data, and to interpret the results. Such a process must be directed by an epistemological stance to justify

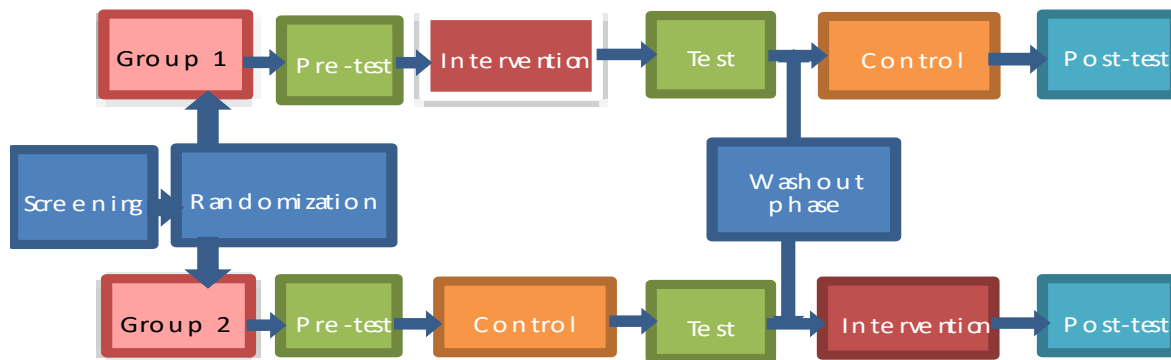
its validity and scope. The philosophy of positivism points out that reality needs to be observed and described from an objective viewpoint (MacKenzie & Knipe, 2006). It argues that factual and trustworthy knowledge can only be gained through observation, experiment and measurement (Dash, 2005). To that effect, an epistemological assumption claims that knowledge can be defined and explored through careful measurement of the phenomenon of interest. Subsequently, as a philosophy it adopts a deductive approach, with the aim of explaining and generalizing quantifiable observations through statistical analysis (Elshafie, 2013).

The quantitative approach emerges from a positivist paradigm that places considerable value on rationality, objectivity, prediction and control (Elshafie, 2013). It uses instruments and statistical analysis to ensure that the research findings accurately reflect reality and are generalizable (Dash, 2005). Quantitative research thus aims to discover new meanings, describe what exists, and determine the frequency of phenomena. For these reasons, a quantitative approach was considered appropriate for phase II.

### **6.5 Research design**

Phase II thus adopted a quantitative approach, using crossover or changeover randomized controlled trial design (Figure 6.1). The choice of this approach was influenced by the research questions (Evans et al., 2011). Although at this early stage of development, the aim was not to test the effectiveness or efficacy of the intervention (Huey & Polo, 2008), a crossover or changeover randomized controlled design was selected, as this has been found useful for the feasibility or pilot evaluation of new interventions or interventions tested for the first time in a particular context (Nolan et al., 2016). This has the additional ethical advantage of allowing all participants to eventually receive the active component (Mills et al., 2009). It is also argued that, compared to other trials with parallel designs, fewer subjects are required, since the design allows them to act as their own controls, with adequate statistical power (Ding et al., 2015).

**Figure 6.1**  
**Crossover or changeover randomized controlled trial**



However, apart from the general constraints of RCT designs such as being complex, time-consuming and thus costly (Cooks & Torgerson, 2013; Teare et al., 2014), the researcher noted that crossover trial designs can also have potential risks of bias in the findings and their interpretation, considering the carryover effect between the two periods (washout) of the treatment (Li et al., 2015). Nevertheless, in this study the researcher ensured that subjects had a long washout period of two months, a time when no intervention was administered, in order to control for any carryover effect of the intervention (Wellek & Blettner, 2012).

## 6.6 Sampling

### 6.6.1 Advisory groups and recruitment of research participants

This study was aided by three advisory groups that consisted of the key stakeholders, i.e. five young people, five parents and five professionals working with children. They provided advice throughout phase II on engagement, recruitment and completion of the intervention. It is now well established that involving stakeholders in a study enhances ownership, acceptance, implementation and sustainability of the intervention implemented (France, 2000; Ayala & Elder, 2011; International Committee of the Red Cross (ICRC), 2011). This is



even more important for vulnerable groups and children or young people, who cannot easily access services and have their voices heard (Bone et al., 2015).

Children aged 14-17 years (i.e. from form 1 to form 3) from Mwariki secondary school in Nakuru County, were invited to take part. In total, 150 children were eligible according to the school register to take part. Of those, parents of 66 children consented for them to be involved in the study. Unfortunately, as many as 70 children were absent from school due to lack of tuition fees, and 14 children reported that their parents or guardians had not signed their consent forms. The 66 participating children gave verbal consent, following which they completed three standardized self-report measures of emotional problems, which are described below in more details: Revised Child Impact of Event Scale 13 (CRIES-13), Revised Children's Manifest Anxiety Scale (RCMAS) and Depression Self-Rating Scale for Children (DSRS). The Stressful Life Events Scale (SLES) was also used as screening measure for traumatic experiences. A child was included in the feasibility study if they had experienced at least one traumatic event in the last one year and scored within the clinical range for at least one emotional problem to be selected.

As in previous studies (e.g. Barron et al., 2013), and because of the high comorbidity between emotional problems (Thabet et al., 2004), a broad threshold was adopted for scoring above the cut-off score for likely PTSD, anxiety or depression problems on any of the three respective measures, to be invited to the feasibility study. Also used in the study was the KIDSCREEN-10 as measure of Health-related Qualities Of Life (QoL) (social functioning). These instruments, as described below, were selected because of their psychometric properties, being easy for children to complete, and their previous use in research in conflict or disaster affected low-income countries such as Afghanistan, Pakistan and Palestine (Panter-Brick et al., 2009).

Screening was conducted at one secondary school, in order to ensure relative sociocultural homogeneity (McMullen et al., 2012). As tabulated in Table 7.3, cut-off rates for standardized screening measures were: PTSD  $\geq 17$ , depression  $\geq 15$ , anxiety  $\geq 18$  and SLEs = at least one traumatic event) (Lange-Nielsen et al., 2012). Any participant who had experienced at least one traumatic event, and who scored above the established cut-off score for PTSD ( $\geq 17$ ) was recruited in the study. Sixty six children were screened, out of which 54 screened positive. The eligible children were randomly assigned to either the intervention

( $n_1=27$ ) or the waiting list group ( $n_2=27$ ). However, by the end of the study, all children received the benefit of the intervention, after the control group had completed their participation in the study (Wellek & Blettner, 2012).

**Figure 6.2**  
**Research design**

Enrolment	Assessment for eligibility (n=66)	
	Excluded (n=12)	
	Randomized (n=54)	
Allocation	Intervention group (n=27) Post-intervention assessment after one week	Waiting list group (n=27) No intervention, only usual classes Re-assessment after one week
Follow-up	Assessment after two months (n=25 completed the study)	Intervention (for ethical reasons) after two months (n=26 completed the study)
Analysis		

### 6.6.2 Sample size

Sample size calculation (Kadam & Bhalerao, 2010) and its optimization (Noordzij et al., 2010), especially in detecting a clinically relevant treatment effect (Wang et al., 2013), is important for a number of reasons. This prevents wastage of resources and unnecessary exposure of participants to any potentially harmful risks (Whitley & Ball, 2002; Billingham et al., 2013; Teare et al., 2014), as well as adding strength to the emerging findings on their generalizability in similar contexts. To achieve a sufficient sample size, factors such as the number of interventions (trial arms), primary endpoint, outcomes, and, crucially, the study design, have to be taken into account (Wang et al., 2013). Sim and Lewis (2011) argue that the level of statistical power and the chosen level value of standard deviation of the outcome variable in the main RCT also contribute in determining the sample size.

CRIE-13 was used in calculating the sample size for this study (Lange-Nielsen et al., 2012), where a standard confidence level of 90% was selected, which was equated to a 1.645 Z-score. The estimated percentage of the sample that was to respond in a given way was taken to be 95%, which was converted to a decimal point and taken as a proportion (0.95). The confidence interval was thus estimated as 5%, which was computed to a decimal point (0.05).

To that effect, the following formula was applied to calculate the sample size (Hanlon & Larget, 2011);

$$\text{Sample size} = (Z^2) (P) (1 - P) / I^2$$

Where:

- Z was the computed Z-score (based on 90% confidence level),
- P was the estimated percentage of the sample who were to respond in a given way, and
- I was the computed confidence interval in decimal form.

Therefore, substituting the values, the sample size was calculated as follows:

$$N = (1.645)^2 (0.95) (1 - 0.95) / (0.05)^2 = 52 \text{ subjects}$$

The appropriateness of the sample size of each study is related to its specific research questions (Whitley & Ball, 2002). The aim of the current study was to assess the feasibility of a selected psychosocial intervention. Tickle-Degnen (2013) describes feasibility studies as those designed to evaluate or build foundation for a planned intervention evaluation study. This preliminary work can ensure that the implementation of the intervention is practical and reduces threats to the validity of the expected outcomes (Cooks & Torgerson, 2013). A number of studies suggest that feasibility trials require adequate sample size in order to estimate crucial parameters which include, but are not limited to, recruitment challenges, adaptability, acceptability and practicality (resources required, delivery and randomization) of the intervention (Craig et al., 2008; Bowen et al., 2009; Arain et al., 2010; Mollart et al., 2016). Since this was a feasibility study that used a crossover design, where each participant acted as their own control, a relatively small sample size was required (Nolan et al., 2016). Sim and Lewis (2011) and Billingham et al. (2013) recommend a sample size of 40-50 participants in a feasibility study. Therefore, having a minimum of 52 participants as the sample size in this study was considered as justifiable.

## **6.7 Psychosocial intervention**

### **6.7.1 Selection of the intervention**

Phase I explored how key community stakeholders' perspectives and recommendations can be incorporated to inform and select an appropriate and acceptable trauma-focused or psychosocial intervention, based on the existing research literature and emerging evidence. Key findings were that many intervention programmes were practice- but not evidence-based

as yet (that had been shown to be effective in similar contexts), not collaboratively planned (without consultation with stakeholders to make them culturally acceptable), inadequately structured to enable non-specialist staff to use them without losing fidelity, or not easily implemented - thus not resource-effective. These barriers have been established by several researchers (Conn et al., 2013; Heo & Braun, 2014).

Chapter 2 of this thesis reviewed a number of psychosocial interventions. Overall, various types of evidence-based interventions available were transported from high- to low-income countries without adaptation. It was thus recognized that, in deciding on the preferred psychosocial intervention, certain factors had to be taken into consideration. Firstly, the quality of evidence available in support of its effectiveness (Ingraham & Oka, 2006). Secondly, the generalizability and transferability of the intervention to the intended setting and sociocultural context (Conn et al., 2013). Finally, the flexibility of the intervention in its implementation needs to be considered, so that it can be used in a variety of settings, either as stand-alone or as a component of a multi-modal programme; and that it can be implemented individually or in groups, and by a range of professionals, including non-specialists, which is the main workforce in LICs (Jhanjee, 2014).

Considering the relevant findings from the literature in chapter 2, suggestions by community stakeholders and the above criteria (Michener et al., 2008; NICE, 2016; Loza & Effat, 2017), the Writing for Recovery (WfR) intervention was selected (Lange-Nielsen et al., 2012). WfR is a psychoeducational group intervention that was developed by the Children and War Foundation to help children and adolescents who have experienced trauma (Yule et al., 2005). This adopts principles of a testimonial/narrative approach, based on studies that demonstrated how communicating and re-processing an emotional experience can be powerful in normalizing the distressing reactions among a significant proportion of affected children. A range of psychoeducational and trauma-reprocessing programmes have been based on children turning their silent and internalized suffering into stories to build their resilience (Taylor et al., 2014). Despite the influence of these frameworks, WfR does aim to help children work through their experiences, for which reason it is not considered as a specialist type of therapy. Although writing was selected as the main mode of reflective communication, the intervention is flexible to allow for verbal interactions with the facilitator, or use of creative means such as drawings (Yule et al., 2005).

According to Kalantari et al. (2012), WfR focuses on sensory aspects of traumatic events, which trigger emotional memories, hence leading to PTSD and other symptoms of distress. The authors argue that information stored in the traumatic memory is perceptual and implicit. Normally, affected individuals strive to avoid memories activated by trauma reminders, images that elicit strong emotional reactions and intrusive thoughts. It is recognized that PTSD symptoms can persist when traumatic experiences are not consolidated into verbally accessible representations, because of avoidance (Brewin, 2001). The authors of the WfR manual argue that, when an individual narrates a traumatic memory that focuses on its sensory aspects, the activation of the original fear-inducing memory becomes inhibited, thus reducing PTSD symptoms (Yule et al., 2005).

The intervention has been used previously with largely promising findings. For instance, when used with 12- to 18-year-old war bereaved Afghani children, it had a significant effect on traumatic grief symptoms post-intervention ( $p < 0.001$ ; Kalantari et al., 2012). In contrast, in a study that evaluated the short-term effect of WfR in Gaza, results at post-test indicated a reduction in PTSD in both the experimental and waitlist groups (Lange-Nielsen et al., 2012). It is unclear whether this finding was related to the ongoing traumatization of children in the region, hence the non-specific effect of the intervention.

The WfR was also considered because of its resource-effectiveness. It is simple and easy to administer (Kalantari et al., 2012), with one-day training required (Lange-Nielsen et al., 2012). This can be used in groups, thus help many children in a short period of time, requires few and affordable materials (pen and paper), and has no known negative effects on participants (Yule et al., 2005). Its cross-cultural implementation in different contexts is another advantage. Many cultures accept writing as a form of expression or communication (Unterhitzberger & Rosner, 2014). This is useful, particularly in non-specialist settings, where writing can be applied to enhance user engagement and reduce stigma (Yang et al., 2013). At the end of the writing exercise, children can develop self-coping mechanisms (Yule et al., 2013), which they can subsequently use to help others in similar situations. The intervention was originally developed for children aged between 12 and 18 years, who had been traumatized by natural or human-induced disasters. This can be flexibly extended to include parents, so that they gain knowledge on how to support their children at home. This was also a recommendation by the WfR authors after lengthy discussions with the researcher, following the phase I finding on the importance of involving parents at some level.

### **6.7.2 Writing for Recovery: Delivery and manual**

In line with the WfR manual, participants completed six sessions of writing over three consecutive days, with two sessions of approximately 15 minutes each day. Participants had a ten-minute break between the two daily sessions. Children were given the opportunity to ask any questions for clarification at the beginning and the end of each session. They were given clear instructions about the writing exercise, as spelled out in the manual. After each session, they were encouraged to leave any painful emotions behind, as they placed their sheet of paper in a sealed box. This ensured that no one else could see their scripts, other than the researcher. Dropping off the scripts into the sealed box also symbolized that children should leave all their painful feelings and memories behind them and move on with life (Kalantari et al., 2012; Lange-Nielsen et al, 2012).

Children were encouraged to construct a complete narrative, which consisted of a beginning, middle and end, as qualities of a good story. The guidelines, which were read by the researcher, prompted the children to focus on the somatic and sensory aspects of their traumatic events that they had experienced such as sights, sounds or smells (Yule et al., 2005). Some specific questions that the participants were asked according to the guidelines manual, included: “How has this event influenced your life? How is this trauma related to your childhood; or your relationship with your parents, with other family members, friends, or teachers? How is it connected to who you would like to become in the future, who you have been in the past, or who you are now? Knowing what helped you most or what you would have liked, what would you say to another person in a similar situation?”

The writing sessions progressively developed from a general unstructured exploration of innermost feelings and thoughts related to the trauma they had experienced (Yule et al., 2005), to more structured writing encouraging insight and shifting of perspective. In the final writing session, the children reflected on what they had learned from their intervention experience; and the advice, given the opportunity, they would offer to children in similar situations (Kalantari et al., 2012). They were reassured that they would not be judged on either giving ‘wrong’ answers or writing incorrect grammar. Instead, the instructor/researcher encouraged them to explore their writing without restrictions or feeling intimidated by other children in the room. They were to concentrate on their own writing style, so long as they expressed their emotional experiences on paper (Taylor et al., 2014).

The researcher communicated with the authors of the WfR manual and was advised on the flexibility of the intervention. In particular, they advised that, since this was an intervention for adolescents rather than for younger children, the methods could easily be applied for parents and teachers too. They suggested to the researcher to offer some sessions to adults on how best they could support their children. In the case of adults being traumatized themselves, the researcher could refer them for professional help. The authors acknowledged that the format and frequency of the sessions was unresolved, and an ongoing empirical question to be studied. They proposed that the pacing of the exercises was flexible, therefore the facilitator/researcher could conduct them either on consecutive days, all in one day or weekly to suit the participants' and the researcher's practical circumstances. Considering the use of the manual, the authors shared that the concepts regarding its use were easy, hence one-day training was sufficient. The researcher was subsequently trained by one of their board members for one day before using it.

## **6.8 Data collection**

### **6.8.1 Procedure**

A randomized controlled trial design with a battery of repeated measures was carried out in this study. Participants, after a baseline assessment (screening), were randomly assigned to either the intervention or the waiting list group. Assessments of symptoms were conducted one day before the intervention, immediately after the intervention, after one week and at two-month follow-up (Figure 6.2). This period was considered suitable in addressing the feasibility and short-term outcomes of this study, as well as completing Phase II within the timescale of the overall PhD study. While the experimental group received the intervention, the waiting list group continued with their normal school work.

Participants completed the questionnaires individually, without anyone sharing or discussing their responses, unless they requested clarification on specific items from the researcher. Completed questionnaires were coded, with identification numbers and letters showing the assigned group, and were collected immediately after the assessment. The researcher, who had been trained by the WfR authors on how to deliver the intervention according to the manual, also administered the questionnaires, after explaining again the rationale and procedures of the study, even if participants' parents had already provided informed consent.

## **6.8.2 Measures**

As discussed in Chapter 1, it is well established that PTSD, depression and anxiety are the most common mental health problems experienced by war-affected children (McMullen et al., 2012), and are associated with exposure to trauma, although through different mechanisms (Thabet et al., 2005; Werner, 2012). Therefore, representative, widely used and psychometrically evaluated measures of these conditions were selected for this study, namely the CRIES-13, RCMAS and DSRS. A measure of quality of life (KIDSCREEN-10) was also included, as trauma often impacts on children's wider psychosocial functioning, beyond mental health symptoms. As already discussed, the trauma checklist SLE was included for screening purposes only.

### **6.8.2.1. Revised Child Impact of Event Scale (Weiss & Marmar, 1997)**

The Revised Child Impact of Event Scale 13 (CRIES-13) was used to measure PTSD symptoms. This instrument was adapted for children aged eight years and older from the adult Impact of Event Scale, which is based on DSM-IV criteria for PTSD (McMullen et al., 2011). It consists of 13 items related to the three core clusters of PTSD symptoms: intrusion (4 items), avoidance (4 items), and arousal (5 items). It allows participants to rate difficulties that they have experienced in the past seven days on a four-point Likert Scale (0=not at all, 1=rarely, 2=sometimes, or 3=often). Symptom severity scores of the scale range from 0 to 65. The instrument has been found to have satisfactory internal consistency in studies with children (Barron et al., 2012). A composite score of 17 or above on the items related to intrusion and avoidance subscales (8 items) has been established as a cut-off score for the likelihood of PTSD (Perrin et al., 2005). In the Gaza WfR evaluation, the scale was found to have a Cronbach's alpha value of .75 (Lange-Nielsen et al., 2012).

### **6.8.2.2. Revised Children's Manifest Anxiety Scale (Reynolds & Richmond, 1978)**

Anxiety symptoms were assessed by the Revised Children's Manifest Anxiety Scale (RCMAS). This is a 37-item, self-report instrument designed to assess the nature and severity of anxiety in children and adolescents, with satisfactory psychometric properties (Varela & Biggs, 2006). Its high reliability and validity has been replicated in a number of countries (Lyse & Chartrand, 2003), e.g. in South Africa, with internal consistency  $\alpha=.81$  (Boyes & Cluver, 2013), and in Gaza with  $\alpha=.89$  (Lange-Nielsen et al., 2012). The instrument has three-factor derived subscales, tapping different areas of anxiety (Varela & Biggs, 2006),



with all items answered as ‘yes’ or ‘no’. First, is the physiological anxiety subscale (10 items about somatic manifestations of anxiety such as sleep difficulties, nausea and fatigue). Second, is the worry/oversensitivity subscale (11 items measuring various obsessive-compulsive symptoms, as well as fears about being hurt or emotionally isolated). Third, is the social concerns subscale (7 items measuring distracting thoughts and fears that have a social or interpersonal nature). A total anxiety score is obtained from the sum of these three subscales. A fourth subscale consists of 9 lie (social desirability) items that measure the desire to present oneself in the absence of negative or presence of positive (Varela & Biggs, 2006). Total symptom severity scores range from 0–28, while the clinical cut-off score, which was also used in this study, was estimated to be 18 or above (Montgomery, 1974).

#### **6.8.2.3 Depression Self-Rating Scale for Children (Birleson et al., 1987)**

The Depression Self-Rating Scale for Children (DSRS) was used to measure depressive symptoms. This is an 18-item self-report instrument designed for children between the ages of 8 and 14 years of age. Children are asked to rate their feelings experienced in the previous seven days. Items are rated on a three-point scale (mostly, sometimes, never), with eight items reversed (Ellis et al., 2008). The sum score of the scale ranges from 0 to 36 (Tol et al., 2014), with the clinical cut-off score, which was also used in this study, for the probability of depression estimated to be 15 or above (Birleson et al., 1987). The instrument has been reported in children to have high internal consistency of 0.90 (Ellis et al., 2008).

#### **6.8.2.4 Stressful Life-Change Events (Holmes & Rahe, 1967)**

Stressful life-change include experiencing or witnessing threatening situations that induce horror, intense fear or stress in children without adaptive coping strategies (Helgeson et al., 2010; Coker et al., 2011). Exposure to these potentially traumatic events is measured by the self-reported Stressful Life Events Checklist (SLEs). The instrument has 13 questions, originally developed for adults. Out of those, the first 12 questions are answered as ‘yes’ or ‘no’, related to experiences of any stressful life events concerning the family, illness, accidents, disasters, war, physical or sexual maltreatment, and other situations where they or any other person they thought was in danger over the last one year. SLE has no formal scoring method or interpretation per se. Its main objective is to collect information about the potentially traumatic experiences that individuals encountered. The checklist therefore, identifies whether the individual experienced one or more of the 12 maximum events on the list (Weathers et al., 2013). The final question is open for the participants to include any

event they found threatening that was not already listed. The checklist which has widely been used in children, in different traumatic situations, has been found to have high test–retest reliability (Helgeson et al., 2010; Michl et al., 2013).

#### **6.8.2.5 KIDSCREEN-10 (KIDSCREEN Group Europe, 2006)**

The KIDSCREEN-10 index is a self-completed measure of the quality of life of children and young people between the ages 8 to 18 years. This is a short version of KIDSCREEN-52 and -27 QoL (Quality of Life) instruments, with is a multidimensional construct of QoL that covers behavioural, emotional, social and physical components of well-being and functioning as perceived by young people (Ravens-Sieberer et al., 2014). The KIDSCREEN-10 contains ten items, which explore the young person’s physical activity, energy and fitness (1 and 2); experiences of depressive moods and stressful feelings (3 and 4); opportunities to structure and enjoy social and leisure time, and participation in social activities (5 and 6); quality of interaction with their parents or carers, and their feelings toward them (7); relationships with others (8); and perceptions of their cognitive capacity and satisfaction with school performance (9 and 10) (Ravens-Sieberer et al., 2010). The ten items are rated on a five-point scale.

Previous studies have shown that the KIDSCREEN-10 exhibits satisfactory reliability and validity across different cultures. For instance, reliability when used with Iranian school students was supported by a high Cronbach’s alpha (0.80) and intra-class correlation coefficient (0.85) (Nik-Azi et al., 2014). The inclusion of this instrument in this study was important in shedding understanding of children’s health behaviours and their social context. It would help to identify children who were either at risk for health problems or those with hidden morbidity and health care needs (Ravens-Sieberer et al., 2010). Although a distinction between primary and secondary outcomes is often not made at feasibility stage, the KIDSCREEN-10 would clearly be a secondary outcome in a substantive trial.

#### **6.8.2.6 Free text feasibility questions**

Free-text comments elicited from open-ended questions have been widely used in research to assess and facilitate quality improvement of intervention programmes (Wright et al., 2012; Asprey et al., 2013). They are particularly useful in complementing information which has not been fully captured from closed or numerical questions in a quantitative study (Richards et al., 2009). To that effect, they allow participants the opportunity to highlight their own issues of importance, without necessarily going into the depth of a qualitative method such as

a semi-structured interview. Their analysis provides insight on the relationship between comments and the rating scale responses, thus prompting further action or investigation (Riiskjær et al., 2012). However, it is also argued that the analysis of such free texts can be time-consuming. Feedback using free texts may also not give the participants sufficient time and flexibility afforded by an interview (Maramba et al., 2015).

In this study participants, together with their parents and teachers, as well as the advisory groups (who were included at this stage only) were invited to evaluate the feasibility of the intervention along different areas, by using a free text. The free text writing covered areas that included, but were not limited to; simplicity of the instructions and procedure of the intervention, sufficiency of information and content, planning and delivery, and easiness of completing the measures. These areas were determined in line with the aims of a feasibility study, as postulated by Orsmond & Cohn (2015).

## **6.9 Ethics procedure**

The same ethics procedures followed in phase I were followed in phase II. Ethics approval was sought from the University of Leicester Research Ethics Committee, and the National Commission for Science, Technology and Innovation of Kenya, which issued a research permit. The Nakuru County Ministry of Education subsequently referred the researcher to the Head teacher of Mwariki secondary school. The head teacher then introduced the researcher to the School Counselling Department, which liaised with the class teachers to reach the children and their parents.

Informed consent was sought from participants before taking part in the study. Selected participants were issued with information letters and consent forms to take to either their parents or guardians. The purpose and procedures of the study were explained in the information letters. Participants who returned signed consent forms by their parents or guardians, were included in the study. In addition, the researcher explained the aims and procedures of the study to the participating children, thus giving them the opportunity to ask questions or withdraw at any time, even if their parents had provided written consent. Participants were not given any financial or other compensation. They had the liberty, without any consequences whatsoever, to withdraw from the study at any time or withhold any information they were uncomfortable to share, without giving any reasons to the researcher.

The study involved writing about any traumatic experiences that the participants had gone through. Children were encouraged to withdraw at any time, in case they became distressed during the intervention. They were assured that assistance was available, including being referred for professional help from the local mental health service. Participants were informed that all information they shared was highly confidential. To that effect, they were given a unique code to avoid any identifiable information. Their privacy, anonymity and confidentiality were maintained throughout the study. Data was kept under lock and key. It was, however, clarified that information could only be shared with other parties in case a child was at risk or placed someone else at risk, i.e. on child protection grounds, threats of violence, or deliberate self-harm. It was acknowledged to participants that there was no guarantee that they would feel immediate benefits from taking part in the study.

## **6.10 Data analysis**

There were three types of data collected, i.e. activity data, free text and standardized measures in phase II, which required different methods of analysis. Activity data are reported through frequencies. Free text was analysed by using content analysis (Shuyler et al., 2003; Richards et al., 2009; Maramba et al., 2015) on the practicability and acceptability of the intervention (Bowen et al., 2009; O’Cathain et al., 2015). Exploratory statistical analysis included effect size calculation and pre-post intervention comparisons to assess the preliminary effects of the intervention on the outcome measures (Bowen et al., 2009; Pallant, 2013).

### **6.10.1 Free text feedback analysis**

Free text data was analysed and quantified by using content analysis (Shuyler et al., 2003; Richards et al., 2009). Steps in content analysis include, preparation, organization, and reporting of the findings. In the preparation step, sense of the data made and the unit of analysis was selected (Elo et al., 2014). During the organization step, open coding led to the creation of categories (Elo & Kyngäs, 2008). The process of creating concepts or categories increases the trustworthiness of the study. Finally, created categories were reported numerically, as frequencies (Elo et al., 2014).

### **6.10.2 Exploratory statistical analysis**

As illustrated earlier in Figure 6.1, a cross-over design is a longitudinal / repeated measurements design. In such a research design subjects are measured over a period of time, on the same experimental unit at different times (two or more) or under different conditions, on the dependent variable (Singh et al., 2013). The same participants are used for each level of treatment, and are measured after each phase of treatment, because each participant serves as their own control (Park et al., 2009). Central in the repeated measures design is the evaluation of treatment effectiveness (Singh et al., 2013). To obtain a valid estimation of the intervention effect, the use of analysis of covariance is recommended (Twisk & de Vente, 2008), where between-subject effects (i.e. group), within-subject effects (i.e. time), and interactions between the two types of effects (i.e. group\*time) are the effects of interest (Park et al., 2009).

An exploratory analysis of the three self-completed questionnaires of emotional problems (CRIES-13, RMCAS and DSRS) was conducted to understand the preliminary participants' outcomes, and the efficacy potential of the intervention. Consistent with the feasibility research literature, this analysis constituted of effect size calculation and pre-post intervention comparisons, with a series of repeated measures between- and within-subjects analysis of variance (ANOVA). This analysis included group status (intervention and waiting list) as the between-subjects factor; and time T1 (pre-intervention), T2 (post-intervention) and T3 (follow-up) as the within-subjects factor, with the repeated measures as the three respective dependent outcome variables (CRIES-13, RCMAS and DSRS) (Pallant, 2013). A pre-post exploratory analysis of KIDSCREEN-10 was conducted to assess changes in HRQoL after treatment.

### **6.10.3 Effect size calculation**

Effect size is calculated to estimate the magnitude effect of the intervention on the target population (Nakagawa & Cuthill, 2007). In this study, effect size calculation was used to compare the difference of magnitude of an effect between groups (intervention and waiting list group) following the implementation of the WfR intervention. The effect size was calculated in two ways, through Cohen's *d*, or Wilk's Lambda and Partial Eta-squared values.

First, Cohen's  $d$  was used to compute the magnitude of the effect of the difference between intervention and waiting list group, by using the formula (McGrath & Meyer, 2006):

$$\text{Cohen's } d = M_1 - M_2 / s_{\text{pooled}}; \text{ Where } s_{\text{pooled}} = \sqrt{(s_1^2 + s_2^2) / 2}$$

Where  $d$ =Cohen's value;  $M_1$ =Mean of the treatment group;  $M_2$ =Mean of the waiting list control group;  $s_{\text{pooled}}$ =pooled standard deviations;  $s_1^2$  = standard deviations squared of treatment group; and  $s_2^2$  = standard deviations squared of waiting list control group. The Cohen's  $d$  values, which by convention, are categorized as 0.14 or more=large effect size, 0.06=moderate effect size and 0.01=small effect size, were used as a benchmark for interpreting the size of these effects (Kelley & Preacher, 2012; Jayanthi et al., 2014)

Second, Wilk's Lambda values and Partial Eta-squared values were obtained from the mixed between-within subjects analysis of variance (ANOVA), with the help of IBM SPSS statistics version 22 to determine the magnitude effect of the intervention. These were also used to calculate the interaction and main effects of the intervention (Pallant, 2013).

#### **6.10.4 Pre-post intervention comparisons**

Cohen's  $d$  values were used to compute the effect size at the pre-post-test to establish and compare the difference between the two groups. The means and standard deviations from both groups were used to calculate the values of Cohen's  $d$ , by using a given standard formula (McGrath & Meyer, 2006).

#### **6.11 Chapter summary**

This chapter provided detailed information and justifications on the choice of the theoretical framework that guided the methodology, design employed and intervention selected and adopted in phase II in this study. The findings of phase I were taken into consideration in the adaptation and implementation of the selected intervention Writing for Recovery. Analytic processes of data collected were elaborated in line with the research objectives and questions of feasibility evaluation. The next Chapter 7 presents the detailed findings of this feasibility study. These findings are structured and presented according to the feasibility criteria recommended by Orsmond and Cohn (2015).

## **CHAPTER SEVEN**

### **PHASE II**

### **FEASIBILITY STUDY RESULTS**

## **7.1 Introduction**

This chapter presents the findings of the phase II feasibility study on the implementation of the Writing for Recovery intervention. As discussed in the previous chapter, the results are based on quantitative methods, i.e. statistical and content analysis (Elo et al., 2014), according to feasibility evaluation criteria (Orsmond & Cohn, 2015). For this reason, descriptive, statistical and content analyses are presented under the criteria headings, and these are combined where appropriate (e.g. on the completion rates and acceptability of the measures). Free text data are treated as quantitative categories through content analysis, with relevant quotes being included to complement the quantitative data rather than being subject to qualitative analysis.

## **7.2 Socio-demographic characteristics**

The socio-demographic characteristics of participants in phase II are presented in Table 7.1. A total of 54 children, n=27 intervention group and n=27 waiting list control group, took part in the study. Their age ranged from 14 years to 17 years, with 41% being male and 59% female. These gender proportions were the same in the two groups. Participants were sampled between Forms 1-3, with two-thirds (61%) coming from Form 3. Most (88.9%) of the intervention participants were in Form 3, while the majority of the waiting list control group participants (n=51.9%) were in Form 2. The majority were of Christian religion (intervention group n=96% and waiting list control group n=100%), and of Kikuyu ethnic background (intervention group n=44.4% and waiting list control group n=56.6%).



**Table 7.1**

**Socio-demographic characteristics of participants (n=54)**

Variables	Intervention group (n=27)		Waiting list control group (n=27)	
	N	%	N	%
<b>Gender</b>				
Male	11	40.7	11	40.7
Female	16	59.3	16	59.3
<b>Form</b>				
F1	0	0.0	3	11.1
F2	0	0.0	14	51.9
F3	24	88.9	9	33.3
F4	3	11.1	1	3.7
<b>Religion</b>				
Christian	26	96.3	27	100
Muslim	1	3.7	0	0
<b>Ethnicity</b>				
Kikuyu	12	44.4	15	55.6
Luo	7	25.9	4	14.8
Luhya	2	7.4	6	22.2
Others	6	22.2	2	7.4
<b>Maternal education</b>				
None	7	25.9	9	33.3
Primary school	8	29.6	13	48.1
Secondary school	9	33.3	3	11.1
Higher education	3	11.1	2	7.4
<b>Paternal education</b>				
None	6	22.2	15	55.6
Primary school	8	29.6	3	11.1
Secondary school	6	22.2	8	29.6
Higher education	4	14.8	1	3.7
<b>Maternal employment</b>				
Employed	4	14.8	2	7.4
Self-employed	19	70.4	13	48.1
Housewife	4	14.8	12	44.4
<b>Paternal employment</b>				
Employed	8	29.6	5	18.5
Self-employed	11	40.7	11	40.7
None	8	29.6	11	40.7
Age	Range	Median	Range	Median
	14-17	17.00	14-17	16.00

Feasibility studies, as explained earlier in Chapter 6, aim to assess the acceptability and suitability of an intervention (Tickle-Degnen, 2013). As the implementation of evidence-based interventions is a fundamental objective of health promotion and disease prevention (Bowen et al., 2009), it is considered necessary to first ascertain whether or not an intervention was empirically and theoretically founded to inform any future implementation with children in similar situations (O’Cathain et al., 2015). This feasibility process should include information on the delivery of the intervention, recruitment and retention rates of participants, necessary resources, effect sizes of outcomes, acceptability and suitability of the intervention (Bowen et al., 2009; O’Cathain et al., 2015).

Therefore, the specific guiding questions in feasibility studies, as highlighted by Orsmond and Cohn (2015), were followed. These questions were:

- i) Was it possible to recruit appropriate participants?
- ii) Did the researcher have the resources and ability to manage the study and intervention?
- iii) How appropriate were the data collection procedures and outcome measures for the intended population and purpose of the study?
- iv) Were the study procedures and intervention suitable for and acceptable to participants?
- v) Did the intervention show promise of being successful with the intended population?

These questions were followed in analysing and presenting the results of phase II below.

### **7.3. Recruitment**

The main question of focus on the objective of recruitment capability and resulting sample characteristics was whether it was possible to recruit the appropriate participants for the study. Eligibility criteria were for children to have experienced at least one traumatic event during the previous year, and to have scored positive on one of the emotional measures during the previous seven days. The frequencies of the exposure to traumatic events witnessed or reported by the children are tabulated in Table 7.2. Children reported on average seven types of traumatic events. The most frequently reported events were experience of war or other armed conflict (87.0%), drastic family changes (85.2%), and fear of being in great danger (81.5%).

**Table 7.2****Frequencies of traumatic events (n=66)**

<b>Traumatic event</b>		<b>Frequency</b>	
	<b>Stressful life events concerning the family</b>	<b>N</b>	<b>%</b>
1	Have there been drastic changes in your family during the last year?	56	85.2
2	Have you ever been separated from your family against your will? (by a stranger, police officer, soldier, fleeing your homeland)	15	22.2
3	Has someone died in your life that you really cared about?	50	75.9
<b>Total</b>		<b>121</b>	<b>25</b>
	<b>Experiences with illness, accidents and disasters</b>		
4	Have you had a life threatening medical problem?	33	50.0
5	Have you been involved in a serious accident? (for example involving a car)	12	18.5
6	Have you ever been involved in a disaster? (for example: flood, hurricane, fire, tornado, avalanche, earthquake, hostage situation, chemical disaster)	26	38.9
<b>Total</b>		<b>71</b>	<b>15</b>
	<b>War</b>		
7	Have you ever experienced war or armed/military conflict going on around you in your country of birth?	57	87.0
<b>Total</b>		<b>57</b>	<b>12</b>
	<b>Physical and sexual mistreatment</b>		
8	Has someone ever hit, kicked, shot at or some other way tried to physically hurt you?	49	74.1
9	Did you ever see it happen to someone else in real life? (not just on television or in a film)	53	79.6
10	Has someone ever tried to touch your private sexual parts against your will or forced you to have sex?	24	37.0
<b>Total</b>		<b>126</b>	<b>26</b>
	<b>Other</b>		
11	Did you experience any other very stressful life events where you thought that you were in great danger?	54	81.5
12	Did you experience any other very stressful life event where you thought that someone else was in great danger?	51	77.8
<b>Total</b>		<b>105</b>	<b>22</b>

Using the established cut-off scores of standardized measures of emotional problems (CRIES-13, RMCAS and DSRS) children also were screened according to these criteria to be eligible for the study. Out of a total 66 children available for screening from one school, 54 (81%) screened positive on at least one of the measures. Consistent with other studies, these prevalence rates of children affected were high, as indicated by the cut-off rates (Table 7.3) for each measure used (Montgomery, 1974; Birlson et al., 1987; Perrin et al., 2005). As illustrated by Table 7.2, most children screened for this study had experienced high depressive (78.8%), anxiety (71.2%) and PTSD symptoms (37.9%).

**Table 7.3**

**Cut-off rates for standardized screening measures (n=66)**

Standardized measure	Cut-off	Frequency	
		N	%
Revised Child Impact of Event Scale	$\geq 17$	25	37.9
Revised Children's Manifest Anxiety Scale	$\geq 18$	47	71.2
Depression Self-Rating Scale for Children	$\geq 15$	52	78.8

The eligibility criteria for recruitment for the intervention were thus both feasible and suitable. Participants also had to fall within the age range between 14 and 17 years, and had to come from a school within an ethnic-conflict affected area. These criteria were neither too inclusive nor too restrictive to the recruitment process. Sampled participants, therefore, portrayed similar characteristics of other disadvantaged children, who had previously been exposed to war trauma and displacement (Thabet et al., 2007).

Overall, 81% of the participants (n=54) out of those sampled (n=66) were easily recruited into the study. This indicated that the recruitment rate was high. Participants were easily randomized into the intervention (n=27) and waiting list control (n=27) groups, without any arising ethical or practical problems. This was achieved by offering the intervention to the control children after they had completed their participation in the research.

#### **7.4 Resources to deliver the intervention and manage the research**

The question on resources and ability to manage the study and intervention provided guidance in assessing the researcher's administrative capacity, expertise, skills and time. The WfR intervention is resource-effective in terms of time and materials needed (Yule et al., 2005). This being a PhD study, the researcher found it particularly suitable and manageable. Running the intervention on three consecutive days was convenient for the researcher, who purposely travelled abroad for the study. Participants were tested a week after the intervention. These time arrangements could be adapted to different circumstances. Apart

from purchasing writing materials (60 pens, paper, one ream of full scarps, and 27 clipboards), other items like chairs, desks, and adequate space (class rooms) were locally and freely available in the school to conduct the intervention. The study did not require more research assistance. The principal researcher was only supported by one assistant researcher, a Master's student at the local Egerton University, who helped in distributing writing materials and questionnaires to participants and in collecting them at the end of every exercise.

The WfR intervention can be carried out by paraprofessionals with minimum one-day training on how to use the manual, and how to refer or support affected participants in seeking mental health and welfare services (Yule et al., 2005). This does, however, require clear protocols in place, and appropriate training and supervision for the researcher. Ethics protocols should ensure that principles are followed such as consenting (recruitment), confidentiality (data management), and free withdrawal (autonomy) throughout the study. These were adhered to in this research, with no untoward incidents observed. There were no identifiable details required from the participants, who were code-numbered in their free text writing and research measures.

Regarding the research resources of phase II, the cost of printing, collecting and carrying questionnaires was manageable. The researcher was trained in data collection, coding and analysis, using computer assisted software (NVivo for phase I and SPSS for phase II). This indicates the importance of supporting research infrastructure, and collaboration between communities, schools, agencies and researchers in future studies of this kind.

## **7.5 Data collection procedures**

The remaining feasibility questions were largely addressed by free text responses. Their overview is presented below, before considering specific responses on each of the feasibility questions. In total, 72 free text questionnaires were completed by: young people  $n=25$ , parents  $n=20$ , teachers  $n=9$ ; and advisory groups which included young people  $n=5$ , professionals  $n=5$ , teachers  $n=5$ , and parents  $n=5$ ). The completion rate of the free texts was 99%. They answered questions well without any significant difficulties or request for assistance from the researcher.

Using content analysis, the issues on the efficacy and effectiveness were raised and reported 982 times. These represented: i) 209 (21.3%) comments about data collection procedures and

outcome measures; ii) 560 (57%) comments about acceptability and suitability of the intervention procedures; and iii) 213 (21.7%) comments about participant responses to the intervention.

**Table 7.4**  
**Efficacy and effectiveness categories**

Category	Code	Frequency		Overall participant response
		N	%	%
<b>Data collection procedures and outcome measures</b>	Understanding of questions and procedures	67	32	93
	Capacity to complete procedures	72	34	100
	Time for overall data collection plan	70	33	97.2
<b>Total</b>		<b>209</b>	<b>21.3</b>	<b>-</b>
<b>Acceptability and suitability of intervention and study procedures</b>	Convenience with daily life activities	71	12.7	98.6
	Capacity to complete the intervention	70	12.5	97.2
	Time to complete the intervention	68	12	94.4
	Acceptable and appealing	70	12.5	97.2
	Easy instructions	69	12.3	95.8
	Content of intervention	71	12.7	98.6
	Culturally appropriate	69	12.3	95.8
	Safety of procedures	72	12.9	100
<b>Total</b>		<b>560</b>	<b>57</b>	<b>-</b>
<b>Potential efficacy of intervention</b>	Likelihood of success	69	32.4	95.8
	Rating of intervention	72	33.8	100
	Intervention recommendation	72	33.8	100
<b>Total</b>		<b>213</b>	<b>21.7</b>	<b>-</b>

In particular relating to collection procedures and outcome measures, there were 209 (21.3%) comments raised in the free text feedback analysis. These comprised of understanding questions and procedures (32%), capacity to complete procedures (32%), and time for data collection (33%). The vast majority (93%) of the participants reported that the procedures and

instructions on data collection were easy to understand. They were also perceived as simple to follow.

*“The questions were simple and easy for me to understand.”* **Child’s comment**

Almost all (97%) of the participants expressed their satisfaction with the time of 10-15 minutes allocated for data collection. Time satisfaction was mentioned 70 times, contributing to 33% of the overall category. They explained that *“the time given”* to fill the questionnaires and free text *“was okay for me”*, therefore, managed to complete them within the allocated time. Such convenience in the procedures and measures used enabled the participants to complete them without any problems, despite their school and other time constraints. All (100%) participants expressed their confidence in young people having the capacity to complete a similar research procedure in future.

Consistent with previous studies, the measures of emotional problems (CRIES-13, RMCAS and DSRS) were found to have satisfactory internal consistency. Using Cronbach’s alpha (CRIES-13=.842, RMCAS=.746, DSRS=.840 and KIDSCREE-10=.795), all values were found to be above 0.70. These findings showed that the reliability indicators of these psychometric instruments were satisfactory and in agreement with the assumptions of the recruited sample (Ellis et al., 2008; Ravens-Sieberer et al., 2010; Deeba et al., 2014).

## **7.6 Acceptability and suitability of the intervention**

Considering the acceptability and suitability of the intervention procedures, 560 (57%) comments of the total free text feedback analysis were raised. This category included comments on compatibility with daily life activities (12.7%), capacity to complete the intervention (12.5%), time to complete the intervention (12%), being acceptable and appealing (12.5%), easiness of instructions (12.3%), quality of the content of the intervention (12.7%), cultural appropriateness (12.3%), and safety of procedures (12.9%).

Almost all (98.6%) of the participants commented that that the intervention was flexible and was facilitated appropriately. They were satisfied that the time was adequate and not conflicting or interfering with other school activities, as it was conducted out of school hours, i.e. in the evenings before the children went home. The programme was described as

*“planned and delivered well”, within three days “in an environment which was good and silent for me to concentrate” throughout the whole process. This gave participants an opportunity to engage in the study until its completion.*

Overall, 95.8% of participants commented that the intervention was well received and accepted. They *“enjoyed the course from the time it started”* and it was *“the best way I could express how I feel”*. Expressions such as *“I would love to have it again”* supported its acceptability. Writing was *“easy to express our feelings”* and able to *“explain without fear”* about traumatic experiences. All (100%) participants commented that the intervention was culturally appropriate and safe.

*I have enjoyed the course from the time it started. I would love to have it again”* **Child’s comment**

*“I feel this is the best way I could express how I feel than talking to anyone”* **Child’s comment**

The content of the intervention (12.7% of comments) was well received too. In total, 98.6% of the participants reported that the structure was clear and commendable. They acknowledged that it gave the children ample opportunity and time to share their traumatic experiences. The writing exercise which started from unstructured to structured writing in the respective sessions, helped the children to develop their story. The six sessions of 15 minutes each, which were conducted daily over three days (i.e. 30 minutes daily duration) were perceived as convenient and *“gave an opportunity to express myself”* comprehensively. It was reported that the instruction procedures were simple to follow. Participants described the structure of the programme to be *“sufficient and effective”* in supporting and helping children with behavioural and emotional problems *“to have a better and normal life like other children”*. However, where clarifications were needed, participants were free to ask. About 5 % of the participants sought clarifications on the areas that they had concerns about.

*“The contents in the intervention were sufficient and effective for those going through emotional problems...can indeed be helped”* **Teacher’s comment**

*“I enjoyed the course from the time it started and it has changed my life”* **Child’s comment**



These factors contributed to the high completion rates of both the intervention and the study across both groups. In particular, 85% of participants from the intervention group and 92% of the participants from the waiting list control group completed the study. The remaining 15% (n=4) of participants in the intervention group, who did not complete the study, were unable to do so because they were absent from school due to family issues. This indicates the importance of considering additional and alternative engagement strategies, or delivering the intervention in the community, in disadvantaged populations.

### **7.7 Potential of the intervention**

Concerning participants' experience of the potential benefit of the intervention, 213 (21.7%) comments were raised. These constituted of the likelihood of success of the intervention (32%) rating of the intervention (33.8%) and recommendation on improving its delivery (33.8%). It was recognized by over 95% of the participants that Writing for Recovery had the potential of being an effective and culturally appropriate approach for similar target populations.

All 72 participants in the free text evaluation gave 33.8% rating of the intervention and thus recommended the intervention program to other children in similar situations. They expressed their satisfaction with sentiments such as *"I had a lot in my heart"* but now *"I feel like I have changed"*; *"now I am free"*; *"I am feeling very good more than happy"*. Comments on the therapeutic process of change were added such as *"the course was helpful, because it makes you to forget the past"* and *"I feel better than before"*.

*"It helped me to know my problems and how to deal with them"* **Child's comment**

*"I am happy to confirm to you that I have seen some changes in my daughter"* **Parent's comment**

Interestingly, positive views were not only expressed by the young recipients of the intervention, but also by teachers, parents and professionals; as well as other young people in the advisory group. These indirect views were formulated after reading the instructions of the manual. They described the procedures and instructions as appropriate and simple respectively, for the young people to understand and follow. They were *"happy with the*

*contents*”, because they felt that the manual was comprehensive. There were also observations on achieved impact *in my house, I have seen changes*”, particularly in social interactions

There were, however, also some concerns raised by a small number of participants. About 4.2% felt that *“writing would challenge the children”*, because *“some children are very poor in writing”* or *“have poor comprehension”*. They argued that the instruction were complex, thus not appropriate in helping children to solve their emotional challenges.

*“Instructions were a bit complex and needed an elaboration, as some children have poor comprehension”* **Professional’s comment**

It was also suggested that for such an intervention to be more culturally acceptable and effective in helping other children in similar contexts, adjustments were needed. For instance, professionals suggested that, if instructions were *“to be more productive”*, they should be *“in point form, not paragraphs”*. There was need for more time *“to be allocated for the intervention”* than the three days, to enable *“the children to share their experiences”*. Teachers stated that other methods or activities *“in addition to writing”* should have been incorporated for the children to be *“given chance to talk out the issues”* clearly and to *“express themselves better”* without being constrained by only accessing writing tools.

*“Oral discussions would have also brought out some hidden ideas”* **Teacher’s comment**

These participants’ and stakeholders’ perspectives were complemented by exploratory calculation of the effect size and by pre-post intervention comparisons with a series of repeated measures mixed between-within subjects’ analysis of variance (ANOVA). Results were tabulated in Tables 7.5 to 7.8 below.

### 7.7.1 Effect size calculation

Table 7.5 shows the interaction effect size values as a reflection of potential changes in scores over time for the four different measures used. The main effect sizes were also calculated to check if the impact of one variable such as time was influenced by the group status (intervention vs control).

Results from the interaction and main effect sizes for the three outcome measures were interpreted (Sawilowsky, 2009; Pallant, 2013) by using the guidelines proposed by Cohen (1988); where 0.01=small effect size, 0.06=moderate effect size and 0.14=large effect size. When the within group effect sizes were calculated by the Partial Eta Squared (Table 7.5), different results for the outcome measures were obtained, i.e. CRIES-13 ( $d=.788$ ), DSRS ( $d=.524$ ) and RCMAS ( $d=.002$ ).

The tabulation of the results of the interaction and main effect size for Time x Group is presented separately below.

**Table 7.5**

#### **Interaction and main effect sizes for the three outcome measures**

<b>Outcome</b>	<b>Effect</b>	<b>Value</b>	<b>F</b>	<b>Hypothesis df</b>	<b>Error df</b>	<b>Sig.</b>	<b>Partial Eta Squared</b>
<b>CRIES-13</b>	Time	.212	87.54	2.00	47.00	.000	.788
	Time x group	.309	52.67	2.00	47.00	.000	.691
<b>RCMAS</b>	Time	.998	.034	2.00	45.00	.967	.002
	Time x group	.646	12.31	2.00	45.00	.000	.354
<b>DSRS</b>	Time	.476	25.37	2.00	46.00	.000	.524
	Time x group	.662	11.74	2.00	46.00	.000	.338
<b>KIDSCREEN-10</b>	Time	.217	56.18	1.00	52.00	.000	.519
	Time x group	.444	29.71	1.00	53.00	.000	.364

#### 7.7.1.1 Effects on PTSD symptoms

The interaction effect values for Time x Group for CRIES-13 (Wilk's Lambda = .31,  $F(2, 47) = 52.67$ ,  $p=.000$ ) in the two groups, intervention and waiting list control groups was statistically significant. The main effect of time on the same outcome (CRIES-13) was also statistically significant across the three time periods of the intervention (Wilk's Lambda

=.212,  $F(2, 47) = 87.54$ ,  $p=.000$ ). The Partial Eta Squared for time main effect (.788) and the time x group interaction (.691) were both more than 0.14, thus indicating that the effects were strong. An interaction effect suggests that the effect of one variable depends on the level of the second variable. A further examination of interaction among the three periods (pre-test (T1) to post-test (T2) and to two-month follow-up (T3) be shown by Figure 7.1.

**Figure7.4**

**Time x group interaction (CRIES)**

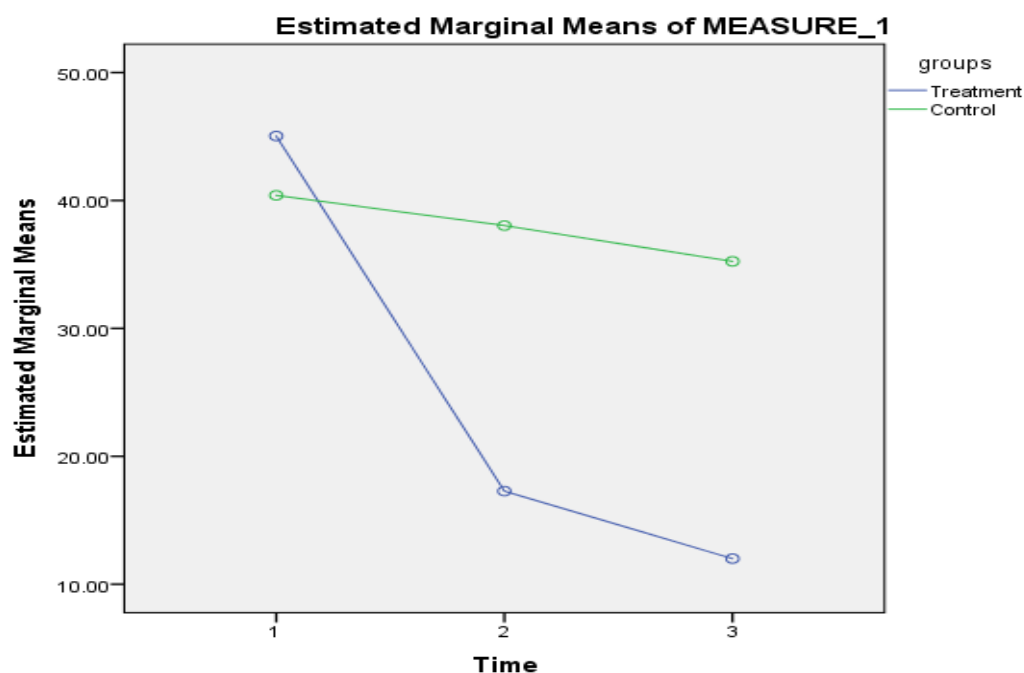


Figure 7.1 presents the interaction between the groups (treatment and control), with time (pre-test (T1) to post-test (T2) and to two-month follow-up (T3). The Figure shows that the effect of the intervention which is represented by the time variable depends on the group (treatment and control). In this study, there was a dramatic increase in the scores for treatment group from T1 to T2 and further decrease to T3. The control group line showed a decline in the scores. However, the decline or improvement was not as large as it was in the treatment group. These results showed that there was an overall decrease in PTSD symptoms among the participants after the intervention was implemented.

### 7.7.1.2 Effects on anxiety symptoms

The interaction effect values for Time x Group for the anxiety scale (RCMAS) (Wilk's Lambda=.65,  $F(2, 45) = 12.31$ ,  $p=.000$ ) for the two groups was also statistically significant. However, the main effect of time on the scale (Wilk's Lambda =.998,  $F(2, 45) = 0.034$ ,  $p=.98$ ) was not statistically significant. The Partial Eta Squared for time main effect (0.002) is an indication of small effect size, while that of the time x group interaction (.354) indicates a stronger effect.

Figure 7.5

Time x group interaction (RCMAS)

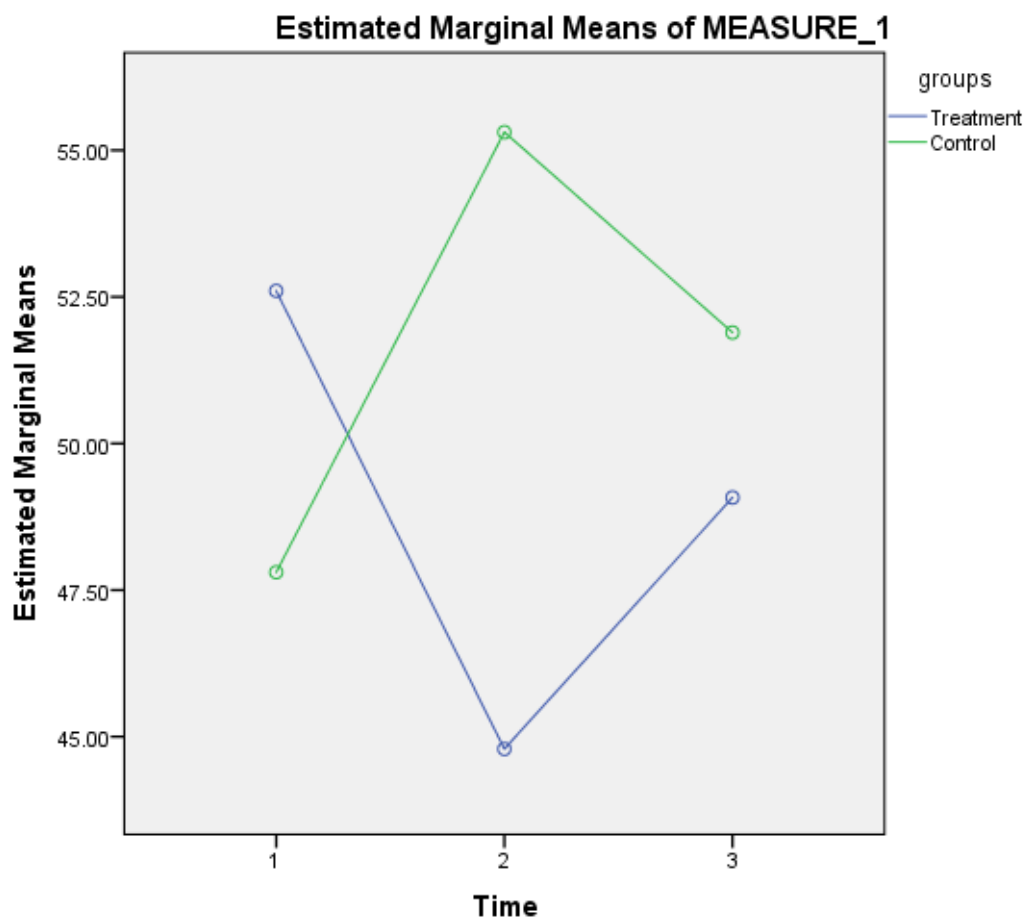


Figure 7.2 shows a graphical representation of the interaction time and group measured using the RCMAS scores. The treatment group results indicated a remarkable decrease in the scores from T1 to T2. However, these increased from period T2 to T3. On the contrary, in the control group, there was a dramatic increase in the scores from T1 to T2, while from period T2 to T3 the scores decreased. These results implied that there was no overall decrease or improvement in anxiety symptoms among the participants after the intervention.

### 7.7.1.3 Effects on Depression Symptoms

The results showed that there was a statically significant interaction effect of Time x Group for DSRS scores (Wilk's Lambda =.66,  $F(2, 46) = 11.74$ ,  $p = .000$ ) in both groups. The main effect of time on DSRS (Wilk's Lambda =.476,  $F(2, 46) = 25.37$ ,  $p = .000$ ) was also statistically significant. The Partial Eta Squared for time main effect (.524) and the time x group interaction (.338) were both more than 0.14, indicating that the effects are strong.

**Figure7.6**

**Time x group interaction (DSRS)**

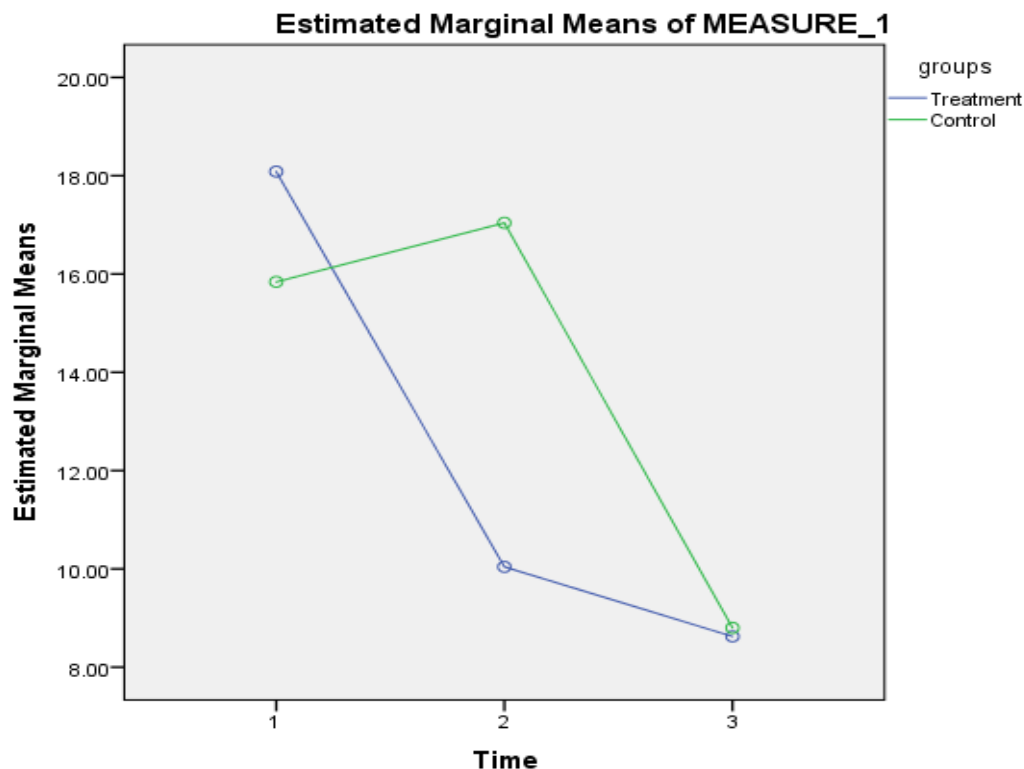


Figure 7.3 shows the graphical presentation of interaction of time and groups using the DSRC scores. Results show that there was a large decline in scores in the treatment group, from time T1 to T2, and a further decline between T2 and T3. On the contrary, there was an increase in scores in the control group between T1 and T2. However, there was a sharp decrease in scores between T2 and T3. Overall, these results showed that participants had an actual decrease in depression symptom levels after the intervention.

#### **7.7.1.4 Effects on KIDSCREEN-10**

The analysis indicated that there was a statically significant interaction effect of Time x Group for KIDSCREEN-10 scores (Wilk's Lambda =.44,  $F(1, 53) = 29.71$ ,  $p = .000$ ) in both groups. The scores had a Wilk's Lambda significance level value of .000. The main effect of time on KIDSCREEN-10 (Wilk's Lambda =.22,  $F(1, 52) = 56.18$ ,  $p = .000$ ) was also statistically significant. The Partial Eta Squared for time main effect (.519) and the time x group interaction were both more than 0.14, thus indicating that the effects were strong. These results showed that overall participants had an improvement in quality of life scores after the intervention.

#### **7.7.2 Effect sizes between and within groups**

Table 7.6 shows the effect size calculation to illustrate the strength of association or the relative magnitude of the difference between the means or proportion of the total variance in the dependent variable that was predicted by the independent variable. When the intervention effects were examined at the participant level, and with both between and within groups, a similar pattern of effect sizes was observed for the four outcome measures (Table 7.6).

**Table 7.6****Effect sizes between and within groups**

<b>Outcome measure</b>	<b>Mean square</b>	<b>F</b>	<b>Sig.</b>	<b>Partial Eta Squared</b>
CRIES13	6455.040	89.130	.000	.650
RCMAS	290.204	2.561	.116	.053
DSRS	99.204	1.543	.220	.032
KIDSCREEN-10	75.852	11.619	.001	.364

Using Cohen's *d* values for interpretation, i.e. 0.14 or more=large effect size, 0.06=moderate effect size and 0.01=small effect size (Cohen, 1988; Jayanthi et al., 2014); the analysis showed that there was a statistically significant moderate effect size for time with CRIES-13 (Wilk's Lambda Partial Eta Squared=.650 with a significance value=.000). This indicated that participants showed significant improvement in PTSD symptoms after being exposed to the intervention. There was also improvement reflecting a small effect size in quality of life (Wilk's Lambda Partial Eta Squared=.364 with a significance value=.001) after the intervention.

However, there was no statistically significant effect size for time for either the anxiety scale RCMAS (Wilk's Lambda Partial Eta Squared=.053 with value=.116) or the depression scale DSRS (Wilk's Lambda Partial Eta Squared=.032 with value=.220). In both cases, the results implied that there was no overall substantial reduction in either anxiety or depressive symptoms after the delivery of the intervention. A different illustration will be presented in the next analysis.

### **7.8 Pre-post intervention comparisons**

Table 7.7 shows the mean scores of outcome measures for CRIES-13, RCMAS and DSRS from pre-test (T1) to post-test (T2) and to two-month follow-up (T3) in the intervention and waiting list control group. General linear models were conducted separately for each outcome measure (CRIES-13, RCMAS or DSRS) and results were tabulated. The descriptive



statistics for the three sets of scores (mean - M, standard deviation - SD and sample size - N) for these outcome measures are illustrated in Table 7.7.

When these mean scores were compared between the baseline (time 1) and post-intervention (time 2) assessments in both groups, these decreased, apart from DSRS scores, which increased in the waiting list group. Looking at changes between post-intervention (time 2) and two-month follow-up scores (time 3) in both groups, the mean scores of outcome measures decreased further for CRIES-13 (17.28 to 12.00 in the intervention group and to a small degree 38.04 to 35.24 in the control group); DSRS (10.04 to 8.63 in the intervention group); and RCMAS (55.31 to 51.89) in the control group. However, RCMAS scores increased in the intervention group (44.79 to 49.08); likewise, DSRS scores increased in the control group (17.04 to 18.80).

**Table 7.7**

**Outcome measures scores across three time periods of the intervention**

Time Period	Intervention group									Waiting list control group								
	CRIES 13			RCMAS			DSRS			CRIES 13			RCMAS			DSRS		
	M	STD	N	M	STD	N	M	STD	N	M	STD	N	M	STD	N	M	STD	N
<b>Pre-intervention (Time 1)</b>	45.04	6.34	25	52.60	10.13	23	18.08	6.67	24	40.40	8.40	25	47.80	9.88	25	15.84	5.30	25
<b>Post-intervention (Time 2)</b>	17.28	11.48	25	44.79	8.01	23	10.04	6.94	24	38.04	10.03	25	55.31	9.15	25	17.04	5.47	25
<b>Two-month follow-up (Time 3)</b>	12.00	6.35	25	49.08	11.72	23	8.63	8.76	24	35.24	9.73	25	51.89	7.65	25	18.80	4.02	25

Similarly, Cohen's  $d$  values were used to compute effect sizes between Time 1 and Time 2 to establish potential differences between the two groups. Mean scores, standard deviations and effect sizes ( $d$ ) from baseline (Time 1) to post-intervention (Time 2) are tabulated in Table 7.8.

**Table 7.8**  
**Effect sizes between Time 1 and Time 2**

Measures	Baseline (Time 1) effect size			Post-intervention (Time 2) effect size		
	M (M1,M2)	STD (S1,S2)	d	M (M1,M2)	STD (S1,S2)	d
<b>CRIES 13</b>	45.04,40.40	6.34, 8.40	.624	17.28, 38.04	11.48, 10.03	1.926
<b>RCMAS</b>	52.60,47.80	10.13, 9.88	.480	44.79, 55.31	8.01, 9.15	1.223
<b>DSRS</b>	18.08, 15.84	6.67, 5.30	.370	10.04, 17.04	6.94, 5.47	1.120
<b>KIDSCRE EN-10</b>	26.11, 30.41	6.82, 8.48	0.55	28.93, 30.85	5.85, 8.23	0.27

Looking at the Cohen's  $d$  values for the outcomes measures across Table 7.8 at baseline (Time 1) of the intervention, the effect size was higher for CRIES-13 ( $d = .624$ ), moderate for RCMAS ( $d = .480$ ), and low for DSRS ( $d = .370$ ). At post-intervention (Time 2), the effect sizes were higher for all outcome measures, with CRIES-13 again showing the highest values: CRIES-13,  $d = 1.926$ , RCMAS,  $d = 1.223$  and DSRS,  $d = 1.120$ . Similar findings were obtained at two-month follow-up (Time 3). The Cohen's  $d$  values were high for CRIES-13 ( $d = 2.829$ ) and DSRS ( $d = 1.492$ ), but not for RCMAS, which had a small effect size ( $d = 0.284$ ). These results are consistent with previous studies in similar populations (Lange-Nielsen et al., 2012) in showing potential for improvement in PTSD symptoms after the implementation of Writing for Recovery, but not for anxiety and depression.

## 7.9 Discussion

The main aims of phase II of this research were, to: i) establish how key community stakeholders' perceptions and recommendations could be incorporated to inform and select a culturally acceptable trauma-focused or other psychosocial intervention; and ii) evaluate the feasibility of the implementation of this intervention. In line with these aims and consistent with the literature on the purpose of conducting a feasibility study (Craig et al., 2008; Bowen et al., 2009; Thabane et al., 2010; Watson et al., 2015; Wuest et al., 2015), the above presented findings on intervention-specific areas as identified by (Orsmond & Cohn, 2015) highlighted how Writing for Recovery was feasible, as discussed in their respective subheadings below.

The phase II study revealed that it was feasible to recruit and retain participants in the intervention. Overall, 81% of the participants (n=54) out of those sampled (n=66) were easily recruited into the study. Consistent with previous research, while using neither too inclusive nor too restrictive criteria in the recruitment process (Thabet et al., 2007), most children screened positive following specified standardised checklist cut off rates (Montgomery, 1974; Birleson et al., 1987; Perrin et al., 2005). The randomization process into the intervention (n=27) and waiting list control (n=27) groups was simple, without any ethical or practical problems experienced. These findings, in line with the existing body of literature, highlight the importance of assessing the recruitment capability of participants and the underpinning eligibility criteria (Arain et al., 2010). Research methodologists argue that such an assessment helps to understand if the sample of interest has been successfully accessed and is representative of the target population (Orsmond & Cohn, 2015). This also provides insight into the practical and financial implications of the research, as well as the therapeutic potential of the intervention which, if established, can inform the subsequent pilot and RCT stages in its evaluation (Tickle-Degnen, 2013).

It was also established that the completion rate of the questionnaires was high. Two-thirds of the total free text comments were related to capacity to complete the procedures (32%) and time for data collection (33%). Almost all (97%) of the participants completed the procedures with ease. They expressed their satisfaction with the time of 10-15 minutes allocated for data collection. These findings indicated that data collection procedures using the selected measures were acceptable within the parameters of the intervention implemented. There are concerns that selecting measures only on the assumption that they have been used before with

similar populations or interventions (Coster, 2013), without understanding how appropriate they are for the new intended population and purpose of the study, may constrain the interpretation of the findings towards a substantive RCT (Orsmond & Cohn, 2015). It was noted that the measures had good internal consistency, all with Cronbach's alpha values above .70. These findings were important, as they showed that reliability indicators of these psychometric instruments were satisfactory and in agreement with the assumptions on the recruited sample, and consistent with previous studies (Ellis et al., 2008; Ravens-Sieberer et al., 2010; Boyes & Cluver, 2013; Deeba et al., 2014).

Therefore, understanding how participants comprehend the intent and meaning of terms applied in research questions; the level of motivation required to complete measures; and how well the participants answer the questions are all supporting the feasibility, suitability and appropriateness of the research design and measures for the target population (Ayala & Elder, 2011).

The findings illustrated that the intervention was accepted and deemed suitable in meeting the needs of the target population. Completion rates of the intervention and the study were reported to be high and satisfactory across both groups. It was illustrated that at least over 85% of participants from the intervention group and 92% of the participants from the control group were able to complete the study. This indicated that the intervention was appealing to participants in the experimental group, although this does not necessarily imply translation to clinical effectiveness; and that the study design was realistic to be replicated in a substantive trial.

The study established that the intervention was well received and accepted. It was reported that planning the intervention was reasonably convenient and appropriate, and thus accepted. Almost all (98.6%) of the participants reported that that the intervention was flexible and well facilitated. While 95.8% of the participants stated that the intervention structure and content were suitable and thus commendable. According to Ayala and Elder (2011), understanding how the target population receive the intervention, can reduce oversight and risks in the implementation, such as mistrust and disengagement. Consistent with other studies, it is important to involve those delivering and receiving the intervention in any healthcare system (Bowen et al., 2009; Wuest et al., 2015). Engaging them at all stages of the research process facilitates decision-making in the selection, planning and implementation of effective and culturally acceptable interventions (Bernal, 2006).

The findings demonstrated that the intervention was resource-effective in constrained settings. According to the researcher's evaluation, running the intervention was affordable. Resources such as writing materials (60 pens, paper, one ream of full scarps, and 27 clipboards), other items like chairs, desks, and adequate space (class rooms) were locally and freely available in the school. Running the intervention was only supported by one assistant researcher (a Master's student), on three consecutive days, which was convenient for the researcher who purposely travelled abroad for the study. Previous studies indicated that Writing for Recovery is resource-effective in terms of resources such as time and materials, skills required to use the manual, and referral pathways of non-respondents to other services (Lange-Nielsen et al., 2012). According to the authors of the manual (Yule et al., 2005), the intervention can be carried out by paraprofessionals with minimum one-day training making it feasible in management. It is, therefore, important to position its potential role within that service and competencies framework, as will be discussed in more detail in the next chapter.

The capacity to handle an intervention administratively, financially and skilfully (Bowen et al., 2009; Orsmond & Cohn, 2015) while utilizing available resources, demonstrates the practicality or degree to which it can be conducted (Wuest et al., 2015). These factors, as argued by other studies, reduce threats to the validity (internal, external, construct, and statistical) of the study and its outcomes (Tickle-Degnen, 2013), thus minimizes or prevents wastage of research funding when conducting pilot studies or larger RCTs (Bird et al., 2014).

The preliminary evaluation of participants' responses (from the free text) regarding the intervention demonstrated that they generally had a positive and satisfactory attitude towards the intervention. For instance, 33.8% of the participants liked the intervention programme and would recommend it to other children in similar situations. Similarly, the complementary exploratory effect size calculation, and pre-post intervention comparisons with a series of repeated measures (PTSD, anxiety, depression symptoms and quality of life), mixed between- and within-subjects' analysis of variance, gave insight on such potential for future effectiveness evaluation (Dobkin, 2009; Orsmond & Cohn, 2015).

Findings showed that there was only an overall decrease of PTSD symptoms, but no impact on anxiety and depressive symptoms, after the intervention was implemented. These results are consistent with previous studies on a similar target population that showed potential improvement in PTSD symptoms (Lange-Nielsen et al., 2012). However, there was inconsistency with anxiety and depression symptom levels. There were some elevated

depression symptom levels in the control group at Time 2, but these symptom levels improved from time 2 to time 3. According to Pachankis and Goldfried (2010), individuals can show different responses after writing therapy. For instance, some studies linked writing with immediate increase in short-term distress and increase of negative mood (Baikie & Wilhelm, 2005). It has been noted that initial psychological distress after writing in some participants, particularly becoming highly disturbed while remaining unsupported, and the content of the writing (i.e. the type of trauma) are some of the causes of the elevation of depression symptoms (Mugerwa & Holden, 2012). It is also argued that individuals who are unable to express their emotions can find writing stressful (Niles et al., 2014). Participants might have found it hard to adjust immediately after the intervention. However, as some of the studies have shown (Baikie & Wilhelm, 2005), positive evidence of health benefits can be experienced after some time. Changes are normally observed after a longer follow-up of participants, during a time when they report feeling better, following a transient effect of trauma writing (Meshberg-Cohen et al., 2014). The lack of impact on depression (immediately after the intervention) and anxiety symptoms (between T1 and T2 in the control group, and between T2 and T3 in the treatment group) could be related to the specific trauma focus of WfR, as well to the potential negative effect of traumatic memories on mood-related symptoms among some children, unless these are targeted with an additional intervention such as CBT or interpersonal therapy (Sloan & Marx, 2004).

These feasibility findings indicate the importance of considering a number of therapeutic and methodological factors when planning the extension of the intervention on a larger scale, by making informed adjustments to make it more efficient and culturally appropriate.

## **7.10 Chapter summary**

This chapter presented the findings from the evaluation of the Writing for Recovery intervention. This evaluation process followed the guiding principles and objectives of feasibility studies as laid down by Orsmond and Cohn (2015). The next chapter will present an overview with an integrated and detailed discussion of the findings from both phase I and phase II studies. The methodological implications, including strengths and limitations, and future research as well as the policy and practice implications of this research will be critically considered.

## **CHAPTER EIGHT**

### **DISCUSSION**

## **8.1 Introduction**

This chapter critically discusses the key integrated findings from both phase I and phase II of this study. These regard stakeholders' views on children's mental health needs in phase I that were used to inform the selection of an appropriate and culturally acceptable intervention, which was subsequently implemented and assessed for its feasibility in phase II. The methodological implications, future research direction, policy and practice implications, final reflections and conclusion of the study are considered in detail in this order. The standalone discussion sections within the two phases of this study focused on more specific arising issues, while the aim of this chapter is to provide an overview across the two phases in the context of the literature. It is, however, acknowledged that there may be some inevitable overlap on certain points discussed in Chapters 5 and 7.

## **8.2 Overview of key findings**

The purpose of this study was to examine the views of community stakeholders on strategies to improve internally displaced children's mental health in Kenya, and which informed the choice and implementation of a psychosocial intervention. The established views, which reflected stakeholders' rich experiences of the challenges that face poor communities in low-income countries and post-conflict settings, were considered important in selecting, planning and delivering a culturally appropriate and acceptable intervention for children exposed to ethnic conflict.

Considering the phase I aim and consistent with the existing literature (e.g. Patel et al., 2007a; Kleintjes et al., 2010), the emerging themes positioned socioeconomic challenges and lack of resources, limited mental health knowledge and stigma, impaired parenting, lack of culturally appropriate intervention models and poor inter-agency collaborations as the major challenges of child mental health and services on the ground. Based on these challenges and consistent with the evidence-base, a psychoeducational and trauma-focused intervention, Writing for Recovery, was selected as a culturally appropriate and acceptable intervention. This intervention was implemented and evaluated for its feasibility in line with the phase II research aims, which included participants' recruitment and retention, data collection, acceptability, practicability and preliminary efficacy (Craig et al., 2008; Bowen et al., 2009; Orsmond & Cohn, 2015). The integration of findings from phase I and phase II was



important in achieving the overall objective of the study, i.e. to establish the feasibility of a psychosocial intervention for children exposed to ethnic violence and who experience mental health problems. These findings are discussed in detail in the respective sections, starting with the identified challenges facing child mental health and services.

### **8.2.1 Socioeconomic challenges and lack of resources**

The findings from this study indicated that socioeconomic challenges and lack of resources were some of the major challenges of child mental health and services. Consistent with other studies, socioeconomic challenges adversely influence child health care in terms of access, utilization and quality in low-income countries (LICs) (Benova et al., 2015). It was identified that many mental health problems that children experienced were related to poverty such as having no food to eat, as well as living in poor houses with single rooms. Well-established barriers include poverty, scarcity and inequities in distribution of mental health resources and facilities (Jenkins et al., 2010). For instance, poverty is associated with most risk factors for child mental health problems affecting families and communities (Saxena et al., 2007). The study noted that poverty forced caregivers to be extremely busy and preoccupied in making a living at the expense of their children's care. Children from these backgrounds fail to access mental health care or receive early help, instead services are more likely to respond to crises when their mental health presentations have become acute and more difficult to resolve (Benova et al., 2015a). Poverty and ill mental health affect each other in a negative cycle (Patel et al., 2007b; Lund et al., 2011). Ehiemua (2014) argued that that people who live in poverty are more likely to experience mental health problems; while those who have already developed mental disorders are vulnerable to be pushed into poverty and the margins of society, because of stigma, lacking appropriate supports and not being able to function independently.

Patel et al. (2007a) highlighted the complex underpinning mechanisms through which poverty increases the risk of exposure to adversities such as shortage of food, malnutrition, disrupted social networks, poor housing, inadequate education and violent communities. Such adversities are associated with social isolation and loss of protective factors, which in turn compound the development and continuation of mental health problems, particularly among vulnerable groups such as children without parents (Amuyunzu-Nyamongo, 2013). Funk et al. (2012) and Reiss (2013) established that children who come from disadvantaged

backgrounds are approximately three times more likely to develop mental health problems than their peers in the general population. Vice versa, children and young people with mental health problems are more likely to be trapped in poverty (Lund et al., 2011), because they lack capacity to work, are stigmatised and discriminated at school or work, have reduced social productivity, and face disproportionate health costs to their families' income (Gureje & Jenkins, 2007; Saxena et al., 2007).

Lack of resources, which included policy and infrastructure, mental health and related services (within welfare, physical health and education), economic costs, and workforce in terms of staff numbers and competencies (Saxena et al., 2007), were positioned in the study as adversely affecting both children's mental health and their access to services. These resources are both important and inter-linked for children with emerging mental health problems to access adequate and effective treatment. Unfortunately, due to the low prioritisation and the resulting limited budget allocated to mental health, these resources are often scarce or fragmented, particularly in LICs (Prince et al., 2007; Kakuma et al., 2011). Many of these countries spend less than 1% of their allocated health budget on mental health (Saxena et al., 2007).

The scarcity of motivated, trained and qualified mental health professionals was identified as a challenge. It was noted that services without such professionals failed to identify affected children, and were more likely to offer poor quality support and interventions. In line with the existing body of literature, limited personnel (human resources) affect all disciplines such as social workers, psychologists, psychiatric nurses and psychiatrists. This is an overwhelming worldwide problem, which is obviously more prominent in low-income countries (Kakuma et al., 2011). In addition, non-specialist frontline professionals have limited opportunities to develop basic mental health skills relevant to their role. These groups include teachers, health professionals, humanitarian and other NGO staff, and community volunteers. These quantitative and qualitative deficits are due to several reasons, like low remuneration, lack of training and career development, consequently poor staff retention and migration to high-income countries (Williams et al., 2007; Killackey et al., 2008). In contrast, unequal distribution of resources, either between regions and/or within local communities was found to be a challenge in this study. For instance, poor decisions were realised to influence distribution of facilities and resources, particularly in urban centres as opposed to rural environments. It is argued that unsuitable or not child-centred environments and equipment pose as additional constraints to child mental health services. All these resource factors

compound the high rates of child mental health problems, hence increase the likelihood of lasting effects during young life and indeed adulthood (Williams et al., 2007; Killackey et al., 2008). In contrast, governments need to address issues of inequality in distribution of resources, funding, infrastructure and capacity-building (Prince et al., 2007; Saxena et al., 2007). All these factors can lead to improved and more equitable access and to early response to children's needs (Brooke-Sumner et al., 2015).

### **8.2.2 Limited mental health knowledge and stigma**

The study findings established that poor mental health knowledge and awareness can act as barriers to seeking and using mental health services. Limited information about mental health and services available resulted to children using dysfunctional coping strategies such as taking drugs. Lack of adaptive coping strategies was argued to lead children to making such wrong choices, taking risks and leading unhealthy life style, thus perpetuating their cycle of adversity. These findings were consistent with previous studies (Eaton et al., 2011). Care pathways and service provision become inevitably affected when communities are poorly informed about the concepts, causes and implications of ill mental health (Lauber et al., 2005; Patel et al., 2007a; Rickwood et al., 2007). Mental health knowledge is thus a fundamental contributor to children's mental well-being, by improving access to early detection, treatment and required supports. In particular, this enhances children's and parents' ability to understand the role of risk and resilience factors, recognition of emerging symptoms, self-help strategies, and external help-seeking (Lam, 2014).

The study found that children with mental health problems and their families or caregivers, were reluctant or even scared to seek help openly, because they were not sure how they would be viewed. The findings illustrated that stigma can decrease children's self-esteem and confidence, thus altering their help-seeking behaviours and affecting their access to mental health services. It has been acknowledged that lack of knowledge across communities can result in stigma and discrimination for affected children and their families (Knifton, 2012). Stigma of mental illness can be described as the negative attitude (through beliefs and behaviours) towards individuals with mental health problems (Bjorkman et al., 2008). Stigmatised children are often perceived to be unpredictable, difficult to communicate with, violent and dangerous; and these perceptions can lead to exploitation and victimisation (Lauber & Rössler, 2007). Stigma and discrimination can in turn affect community and health

decision-makers in their own perceptions of children with mental health problems and their families, mental health workers and institutions, thus resulting in further reluctance to invest in mental health care (Lauber & Rössler, 2007; Sartorius, 2007). Social exclusion causes additional suffering, thus compounding access to and utilization of mental health services (Ehiemua, 2014).

Considering LICs, especially in Africa, where mental illness is a taboo subject (Amuyunzu-Nyamongo, 2013), children with mental health problems may be excluded from education, or be maltreated through harsh physical punishment such as physical restraint, being chained to trees or locked in the house (Killion & Cayetano, 2009; Klasen & Crombag, 2013; Ehiemua, 2014). The findings of this study demonstrated that stigma can arise from culturally perceived stereotypes in regard to children with mental health problems. However, evidence from the literature is also encouraging in that stigmatizing beliefs can change through awareness such as psychoeducational interventions (Killion & Cayetano, 2009; Kiima & Jenkins, 2010), and such changes improve help-seeking and utilization of mental health services (Rickwood et al., 2007).

The availability of culturally appropriate and acceptable mental health interventions can motivate children to seek the help that they need without fears of being ridiculed (Balaji et al., 2012). Instead children need to be treated with dignity, by using engaging approaches to ensure uptake of treatment and prevention of drop-out (Hegde et al., 2012).

### **8.2.3 Impaired parenting capacity**

The study identified impaired parenting as a major barrier to accessing child mental health services in LICs. It was realised that mental health problems not only affected children's functioning, but also the quality of life of parents or caregivers. In turn, it was noted that the existence of mental health problems in parents or caregivers directly or indirectly affected children's seeking and receiving quality mental health care. According to the existing literature, impaired parenting capacity is both a risk factor for child mental health problems and a barrier to seeking help (Betancourt & Khan, 2008). Parents' own mental well-being, emotional sensitivity and provision of safety all act as predictors of their children's mental health (Betancourt et al., 2010; Jordans et al., 2010; Werner, 2012). Parents' mental health often mediates the primary attachment relationships, nurturing and social supports that children require (Betancourt & Khan, 2008; Abera et al., 2015). When parental mental health

is affected, this interacts with negative child rearing, with both risk factors leading to child psychopathology (Vostanis et al., 2006). Other confounders in this relationship include family conflict, domestic violence and parental drug or alcohol abuse (Wieling et al., 2015). Different pathways such as through parental non-responsiveness to children's needs, disengagement or hostility may lead to behavioural and/or emotional problems among their children (Bayer et al., 2011; Sriskandarajah et al., 2015; Panday & Fatima, 2016).

In contrast, parents' mental well-being is vital in maximizing their care functions, both physically and emotionally, in order to protect their children during and after conflict and war. Therefore, interventions addressing both parents' and children's mental health problems should be essential components of multi-modal programmes (Panter-Brick et al., 2014).

#### **8.2.4 Lack of culturally appropriate interventions**

The lack of culturally appropriate interventions, was positioned as one of the challenges that child mental health services face in LICs. It was noted that interventions used were not conforming to and reflecting the reality of children's communities and living environments. The underlying causes of these problems were not assessed carefully, therefore not managed appropriately, thus making interventions to be perceived as ineffective and/or culturally inappropriate. These findings recognised that the use of culturally insensitive methods or approaches adversely impacted on the quality of support and interventions children received. In line with the existing body of literature, it is argued that cultural beliefs and practices influence the way individuals understand and conceptualize mental health (Bolton et al., 2007; Park et al., 2011), thus affect the delivery of mental health care services (Coast et al., 2016). For instance, culture plays a significant role in the way individuals identify mental health symptoms, how they experience, express, self-manage, and seek support and treatment (Ingraham & Oka, 2006; Kirmayer et al., 2012; Chalmers et al., 2014). Henderson et al. (2011) argued that lack of cultural identity can cause insecurity that leads to misconceptions and challenges in the delivery of and access to mental health services. Patel et al. (2007b) also highlighted that understanding the cultural context in which children and families live is crucial in determining the way policies, plans, and specific interventions are formulated and implemented.

The study indicated that the automatic transfer of western mental health ideology and treatment were perceived as ineffective and/or culturally inappropriate. Such uncritical implementation could cause confusion of its failure to account for values, beliefs and culture of the national and local context. Most of the evidence-based mental health interventions available were developed in high-income countries (Bolton et al., 2007). However, for these interventions to be relevant, appropriate and culturally sensitive in other sociocultural settings, such as in low-income countries, they must be adapted to culturally specific needs (Bernal, 2006; Wiley-Exley, 2007). A growing body of literature indicates that lack of culturally sensitive approaches may lead to poor quality of care, miscommunication, misdiagnosis and inappropriate treatment choices (Bhui et al., 2007). For these reasons, Jordans et al. (2011) argue that evidence-based interventions developed in high-income settings are not automatically transferrable to LICs. Consequently, cultural preferences should be taken into account in adjusting, co-developing and refining available interventions. In particular, such an adaptation process should consider factors such as language, religion and local context (Persson & Rousseau, 2009; Henderson et al., 2011; Heo & Braun, 2014). Interventions should also be culturally acceptable to be clinically effective (Chadzynska & Charzynska, 2011). In particular, they need to be tailored to the nature of the trauma that children have been exposed to (Cartwright et al., 2015). Otherwise, (Asmal et al., 2013) children are not likely to engage or to benefit (Zimmer et al., 2006).

### **8.2.5 Poor inter-agency collaboration**

Poor communication among carers, professional and agencies were reported in the study to cause significant frustrations and delays in early recognition, decision-making and early intervention. Lack of community readiness and engagement, and children being left to create their own coping alternatives were some of the key gaps identified. These factors are often caused and compounded by fragmentation of care pathways. Consistent with the literature, lack of inter-agency collaboration affects the supports and interventions that children with mental health problems receive, especially those with complex needs such as living in care or areas of disadvantage (Rothi & Leavey, 2006; Patel et al., 2007b; Andvig et al., 2014). Absence of community involvement can enhance service fragmentation (Lebowitz, 2015). Particularly in Africa, lack of political will is associated with parallel lack of mental health policies and poor funding (Eaton et al., 2011).

In contrast, community togetherness as well as collective responsibility would enhance supports for children with mental health problems. These children, for example, need close supervision and stimulation. It is well established that inter-agency collaboration across the health, education and welfare sectors based on good communication, shared decision-making, and clarity on agency and professional roles and responsibilities, can enhance the quality of care that children and young people receive (Michener et al., 2008; Andvig et al., 2014). Such collaboration helps to capitalize on complementary knowledge and expertise, which are especially important for vulnerable and disadvantaged groups with multiple and complex needs (Lamb et al., 2014). These principles apply to all societies and systems, but in LICs should particularly involve community, religious and spiritual leads to maximize local strengths and resources.

After having taken these factors into consideration, consistent with the phase II research aims, the selected and implemented intervention, Writing for recovery, a psychoeducational and trauma-focused intervention was evaluated for its feasibility. The following section discusses the implications of the feasibility findings in more detail.

#### **8.2.6 Participants' recruitment**

The study indicated that the recruitment and retention of participants were feasible. Out of the total 66 children who were available for screening from one school, 54 (81%) screened positive on at least one of the measures. The findings showed that most of these children experienced high depressive (78.8%), anxiety (71.2%) and PTSD symptoms (37.9%); with many of them reporting experiencing war or other armed conflict (87.0%), drastic family changes (85.2%), and fear of being in great danger (81.5%). According to Thabet et al. (2007) using appropriate criteria, which were neither too inclusive nor restrictive, makes it was possible to screen a large number of children. Adopting standardised questionnaire cut-off scores (Montgomery, 1974; Birleson et al., 1987; Perrin et al., 2005), these children were randomly assigned into the intervention (n=27) or waiting list control groups (n=27) without facing any ethical or practical challenges. Only four participants did not complete the intervention. However, their reason was not intervention-related, but this was rather due to their parents not affording tuition fees. Similar observations in other studies have also reported that participants fail to take part or to complete a study because of several reasons (Brooke-Sumner et al., 2015), including their education level, i.e. not being able to read or

write (Zimmer et al., 2006), logistic issues such as being able to afford to travel locally, and availability because of other commitments (Paranthaman et al., 2010).

Assessment of recruitment capability and the feasibility of their eligibility criteria in a study are important factors in implementing and evaluating interventions in substantive trials (Arain et al., 2010). This initially helps the researchers to understand if the population of interest has been successfully accessed and whether it is representative of the target study population (Orsmond & Cohn, 2015). Such knowledge will then determine the practical and financial impact, and future efficacy of the intervention (Tickle-Degnen, 2013).

### **8.2.7 Procedures and data collection**

The study revealed that the research procedure and data collections were feasible. Out of the 982 items raised on efficacy and effectiveness raised, there were 209 (21.3%) comments about data collection procedures and outcome measures in the free text feedback. About one third (32%) of these issues related to understanding questions and procedures, 32% on capacity to complete procedures, and 33% on time for data collection. Most (93%) of the reported comments on procedures, instructions and data collection indicated that they were easy to understand, while 97% comments expressed satisfaction with the time allocated for data collection. These findings illustrated that completion rate of questionnaires was high, which suggests that young people found them easy to understand and rate. Likewise, the exploratory analysis offered complementary findings, which also indicated that measures had good internal consistency (CRIES-13=.842, RMCAS=.746, DSRS=.840), with all of them demonstrating Cronbach's alpha values above .70. Both these findings were significant in supporting their reliability. These indicators, consistent with the literature, indicated that these widely used instruments had satisfactory psychometric properties, in relation to the recruited sample (Ellis et al., 2008; Boyes & Cluver, 2013; Deeba et al., 2014). The success of procedures and data collection in this study might be attributed to the fact that the researcher was present to clarify and assist with any of the participants' questions or concerns in completing the questionnaires. This was in line with other studies, where a high return rate was achieved through active researcher involvement (Cartwright et al., 2014).

Ayala and Elder (2011) argue that, understanding how participants comprehend and answer the questions is very important. Giving acceptable responses as per the intent of the study



makes the intervention feasible, suitable and appropriate for the target population. This explains why it is not advisable to select measures merely on the assumption of having been used before with similar populations or interventions (Coster, 2013), without further testing them to understand their appropriateness with the intended target population (Orsmond & Cohn, 2015).

### **8.2.8 Acceptability**

This study found out the intervention was perceived to be acceptable and suitable to the target population. Almost all (98.6%) of the participants were satisfied with the flexibility of the intervention. The findings demonstrated that the same number (98.6%) of participants accepted that the structure was commendable to give the children ample opportunity to share their traumatic experiences. The completion rates of the intervention were high, with many young participants reporting satisfaction in relation to its appropriateness, planning, delivery and implementation. This was illustrated by the results showing over 85% of participants from the intervention group and 92% of the participants from the control group to have completed the study. This insight is also essential in designing a future RCT trial on its effectiveness (Tarrier et al., 2005; Asmal et al., 2013; Cabral et al., 2010).

Consistent with the previous body of literature, the acceptability and suitability of this intervention could be due to several reasons (Hommel et al., 2013; Sekhon et al., 2017). First, the personal attributes of the researcher delivering the intervention and those receiving it (Diepeveen et al., 2013). The researcher in this study had good knowledge of the topic under study, and good communication skills, both in English and Swahili, the local dialect. In line with the literature, researchers who are well-trained and knowledgeable on mental health issues (Balaji et al., 2012), as well who can communicate fluently in local dialects and are familiar with the participants' cultural context are fundamental factors to the success of an intervention study (Brooke-Sumner et al., 2015). Chadzyska and Charzyska (2011), in their psychoeducational intervention evaluation, noted that empathic listening, appropriate communication skills and extensive knowledge attracted and motivated the participants to complete the study.

Second, participant information documents and intervention instructions were made available to the participants before and during their intervention. In their assessment of the feasibility

and acceptability of an intervention to enhance relapse prevention for bipolar disorders, Lobban et al. (2017) noted that participants' understanding of the opportunity to improve their own resilience and help others encouraged them to take part in the study. Consistent with other studies, involving those delivering and receiving the intervention in any healthcare system is important (Bowen et al., 2009; Wuest et al., 2015). Making sure that participants are engaged at all stages of the research process promotes good decision-making on the selection, planning and implementation of effective and culturally acceptable interventions (Bartholomew et al., 2006; Bernal, 2006). The involvement of an advisory group that included children also contributed by anticipating and resolving engagement difficulties.

Finally, the structure and content of the intervention was experienced and observed to be suitable. These observations are likely to imply that a writing exercise was less stigmatizing, compared to personal discussions with professionals, particularly in school-based groups. This is consistent with other research that suggested that some interventions can make individuals uncomfortable in seeking help directly from mental health professionals (Lobban et al., 2017). Instead, when an intervention is regarded to be acceptable and suitable, there is a higher likelihood for the target group to adhere to treatment and improve mental health outcomes, hence the importance of establishing this understanding at an early stage (Ayala & Elder, 2011; Hommel et al., 2013; Sekhon et al., 2017).

### **8.2.9 Practicability**

The study suggested that it was feasible to implement the WfR intervention in a resource-constrained setting. Based on the researcher's experience, running the intervention on three consecutive days was convenient, as he purposely travelled abroad for the study. However, this format may need to be re-considered in a substantive trial. Materials needed for the intervention; writing materials (60 pens, paper, one ream of full scarps, and 27 clipboards) were cheap to purchase. Other items like chairs, desks, and adequate space (class rooms) were locally and freely available in the school to conduct the intervention. The cost of printing, collecting and carrying questionnaires was manageable for the principal researcher, with the help of one assistant (Masters Student). The affordability and availability of the materials locally demonstrated the practicability of the resources to implement the intervention.

Previous studies have also indicated that this intervention is resource-effective. The materials (paper, pens and clipboard), space (classroom) and required skills to administer it are cheap and accessible (Lange-Nielsen et al., 2012). Classes and paraprofessionals such as teachers with a minimum one-day training are easily available in local schools (Yule et al., 2005). These are important factors in establishing capacity to handle an intervention (administratively, financially and skilfully), by maximizing readily available resources (Bowen et al., 2009; Orsmond & Cohn, 2015; Wuest et al., 2015). For instance, in India a study that evaluated the impact of a structured psychoeducational intervention for schizophrenia reduced the costs of the intervention when they used non-medical personnel with appropriate training and supervision (Kulhara et al., 2009). This made it possible to generate and sustain its use in real settings (Brooke-Sumner et al., 2015).

Implementing and evaluating feasibility interventions in LICs settings, with resource constraints and different cultural contexts, has always been a challenge for providers and researchers (Brooke-Sumner et al., 2015). A combination of therapeutic, methodological and resource considerations can help overcome such barriers. With culturally appropriate interventions like WfR, it is possible to address fidelity, validity (internal, external, construct, and statistical validity of the design), measurement and delivery issues (Tickle-Degnen, 2013). These will prevent researchers from repeating similar errors, thus wasting grant resources while conducting pilot studies or larger RCTs without a priori access to feasibility findings (Bird et al., 2014).

#### **8.2.10 Preliminary efficacy**

Findings from this study showed that the intervention was promising in achieving the most anticipated symptomatic benefits to participating children. Out of the 982 comments raised about a range of issues on efficacy and effectiveness, 213(21.7%) comments represented the experience of the potential benefit of the intervention, while 33.8% recommended the intervention program to other children in similar situations, even though they could not specify the therapeutic process of their perceived effect.

These findings were supported by the exploratory analyses of effect size calculation and pre-post intervention comparisons (Dobkin, 2009; Orsmond & Cohn, 2015). Evaluation of the preliminary participant response to the intervention helps to understand whether this is

promising to be successful with the intended population under study. This assessment helps to determine whether to proceed with a more controlled, larger study or not (Bowen et al., 2009).

A series of repeated measures (PTSD, anxiety, depression symptoms and health-related quality of life) that were subjected to both between- and within-subjects' analysis of variance subsequently illustrated mixed results. First, there was an overall decrease in PTSD symptoms. This finding is consistent with previous studies on similar target populations when using psychoeducational and trauma-focused interventions such as WfR (Lange-Nielsen et al., 2012). This was the primary outcome of the intervention, with its trauma-focused framework.

Second, there was a rather unexpected improvement in children's health-related quality of life. This is usually a secondary outcome that does not necessarily respond to an individual trauma-focused intervention. Health-related quality of life (HRQoL) is a multi-faceted concept of domains related to an individual's physical, mental and social functioning. Children's HRQoL has been previously found to inversely correlate to exposure to traumatic events (Massad et al., 2011). Such effects on HRQoL can continue for a long period, even after the conflict or war is over (Matanov et al., 2013). The treatment of PTSD symptoms in maltreated children, by using trauma-focused cognitive behavioural therapy, was previously shown to lead to HRQoL improvement too. In addition to PTSD, other emotional and behavioural symptoms have also been found to predict lower HRQoL in children (Weber et al., 2017).

Third, findings from the depressive symptoms analysis showed mixed results. Not only there was no consistent improvement in symptoms, but at some point an actual increase in depressive symptoms was detected. These findings were not a surprise, because other studies have reported different responses to writing therapy (Pachankis & Goldfried, 2010; Lange-Nielsen et al., 2012). It is argued that time of evaluation after writing, ability to express the emotions and type of trauma can all influence participants' responses to the intervention (Baikie & Wilhelm, 2005; Lu & Stanton, 2009; Mugerwa & Holden, 2012; Meshberg-Cohen et al., 2014; Niles et al., 2014). For instance, writing has been linked with immediate increase in short-term distress and negative effect such as increases in negative mood and physical symptoms (Baikie & Wilhelm, 2005; Meshberg-Cohen et al., 2014). This observation has been associated with initial psychological distress resulting from too much

writing in some participants (especially those who are unsupported, more distressed and lack the capacity to reflect), lack of emotional expression as well as the content of the writing that is dictated by the type of trauma (Mugerwa & Holden, 2012). Individuals, particularly those who are not able to express their emotions, have higher symptom levels after writing.

On the contrary, other studies have observed the opposite pattern (Niles et al., 2014). Lu and Stanton (2009) reported that individuals who have difficulty expressing emotions may find writing to be more effective for them. On the other hand, according to other studies, a longer-term follow-up of writing interventions has indicated delayed positive responses in self-reported physical and emotional health outcomes (Baikie & Wilhelm, 2005). Meshberg-Cohen et al. (2014) argue that the reason for such findings is the latent effect that is not evident immediately after writing activities, as participants require more time to re-process their traumatic experiences and to generate improvement in dealing with symptoms such as of PTSD.

The elevation in depression symptoms could be attributed to the short period of time between the implementation of the intervention and the post-test (one week). The short period may have created a temporary negative effect in children, when they were processing traumatic memories, thus showing the Writing for Recovery intervention to have no substantial psychological effect (Sloan & Marx, 2004). As WfR was not designed to target depressive symptoms by not including any of the established interpersonal or cognitive-behavioural strategies, this is clearly not an indicated first-step intervention for depression, although other self-help packages have been developed in high-income countries (NICE, 2017).

Finally, there were mixed results too for anxiety symptoms levels. For instance, the control group participants showed no significant improvement in anxiety symptom levels between T1 and T2, but reported significant improvement between T2 and T3. However, these results were inconsistent with the treatment group, who reported improvement between T1 and T2, followed by increase in anxiety levels after T2. Similar lack of positive response of anxiety symptoms to WfR has been reported by Lange-Nielsen et al. (2012) in contrast with positive effects through different interventions with children from war-affected areas (Bolton et al., 2007). Studies using trauma-focused interventions have reported a decline in anxiety symptoms in children (Berger & Gelkopf, 2007). This may be related to the modalities used and their supporting techniques, i.e. whether they targeted comorbid anxiety or primarily PTSD symptoms such as was the case for WfR.

## **8.3 Methodological implications**

### **8.3.1 Limitations**

The findings of this research need to be interpreted by acknowledging certain methodological limitations. First, the sample of stakeholders (children, parents, teachers and professionals who worked with children) was purposely selected from a particular ethnic, cultural and socio-economic context, was thus not necessarily representative of the target population. Purposive sampling is a non-random technique that depends on researcher's judgment on recruiting participants. The researcher may be biased in the selection, a factor that may affect representation of the target population (Palinkas et al., 2015).

Second, it is possible that the findings in this study may have been influenced by social desirability bias. There is a likelihood that participants may have attempted to come across as more positive about their community. The sample may have presented with self-selection characteristics, with more motivated participants expressing positive views towards mental health, and yet their honesty about some of the challenges and endemic problems were refreshing.

Third, even if the questions aimed to explore both strengths and challenges, there was an over-representation of negative perspectives and identified barriers or gaps in the findings. Participants did not sufficiently explore the potential strengths of child mental health supports and services available such as family and social support networks. This could be reflective of the reality, or of the participants' desperate need to be heard and improve services on the ground. Similarly, in the light of the experience of ethnic conflict which had caused severe disruptions (lack of care, limited resources and personnel) in the existing settings, challenges such as participants balancing between the interests of resource prioritization for care versus research may have been encountered. These, together with a adhering to research protocols, may have affected the impact of the intervention and its detected outcomes (House et al., 2015).

Fourth, it is likely that there could have been potential limitations in relation to the implementation of the intervention. The researcher only attended one-day training on how to use the WfR manual. More extensive and an in depth training could possibly have given the researcher more confidence and better strategies on how to conduct the writing exercise. Time could also have possibly influenced the results. The writing exercise was condensed to

three days, with many short sessions of 15 minutes each within a day, which may not have given the children sufficient time to process their experiences and developing coping strategies. Similarly, the post-intervention assessment which was completed after one week and the follow-up assessment at two months may have not been enough for the children to practice and generate improvement in daily life. Both these factors may have thus ‘rushed’ the children during the intervention. Pacing the days and allocating more time for writing sessions could have possibly allowed enough time for children to reflect and practice what they learnt from the intervention. Writing instructions were only read to the children. It is likely that some children may have struggled while listening to the researcher reading the instructions. Providing the manual instructions to the children during the sessions may have helped them to understand those better. This could have particularly encouraged the more introverted ones, who were guarded in seeking clarification from the researcher. Finally, the intervention predominantly targeted PTSD symptoms, but not other comorbid emotional problems. The further development of WfR and other first-stage psychoeducational approaches could consider theory-driven techniques for anxiety and mild depressive presentations.

Fifth, understanding the theory of change could help explain the effectiveness of using WfR. Theory of change forms a cornerstone for the evaluation of the impact of an intervention. This helps the researcher to understand the planning, implementation and impact of the intervention better (Rogers, 2014). A clearly understood and formulated theory of change on how the WfR intervention works is likely to explain the therapeutic process of the intervention in future research. For example, it could explain how writing stories about traumatic experiences seek meaning to help the affected individuals (Taylor et al., 2014).

These limitations should be taken into consideration in the light of the contributions and innovation of this research. While the generalizability of the findings from this study may require further evaluation, it is important to acknowledge the contribution of stakeholders representing the key voices of people in LICs such as Kenya, and which has been limited in the body of literature. It should also be noted that the exploratory findings from this study are consistent with other LIC research (Jordans et al., 2010), which supports their transferability. The integration of different stakeholders’ views, especially those of young people and their parents, demonstrates the importance of community and user involvement in the development of interventions and services, thus promotes their implementation and sustainability. The use of an experimental design, even if this was not a randomized controlled trial, to evaluate the

feasibility of Writing for Recovery was rigorous, consequently provided reliable findings to inform future pilot and RCT studies (Odgaard-Jensen et al., 2011). Finally, the effect size, which is the magnitude of the effect of the treatment, indicated that the intervention led to the reduction of PTSD symptoms in participants, which supported its potential for further development, implementation and evaluation in similar post-conflict settings.

### **8.3.2 Future research**

Future research will need to link similar stakeholders' perspectives to mental health awareness, resilience-building and culturally adapted psychosocial interventions for the purpose of improving child mental health and services. It will be important to incorporate stakeholders from rural areas too, in order to account for different views about the concepts of mental health problems and interventions such as traditional healing. This would help to obtain a wider scope of ideas from a variety of participants, since displacement also takes place in rural areas. In order to inform policy and service planning, future studies should recruit larger samples to understand help-seeking patterns through quantitative methods, in relation to existing informal supports and formal services across health, welfare and education.

Future research should understand better the therapeutic process that underpins WfR and its relationship with trauma reduction. The intervention exercise should be adapted by spreading the days and allocating longer writing sessions to give the children time to be more reflective during and after writing. The instruction manual should be simplified and made easy for children with lower levels of education to understand it (Pooe et al., 2010). The manual should be distributed to the children before each writing session in addition to offering to clarify any questions. If possible, the intervention should be integrated or incorporated with other strategies such as arts or music, instead of using it as standalone, to enhance its engagement, rather than solely relying on expression and communication through writing (Chadzynska & Charzynska, 2011).

Active parental involvement in the intervention should be considered in future studies. Parents play a critical role in protecting children and therefore, their involvement will enhance the effectiveness of the interventions (El-khani et al., 2018). Finally, to evaluate the



effectiveness of WfR intervention other measures i.e. for physical health should be included during implementation of the intervention (Frattaroli, 2006).

### **8.3.3 Policy, service and practice implications**

These findings will be useful for policy makers and other stakeholders, both at national and international level, in planning services to help children in communities that face similar challenges. They will also assist policy makers when assessing the suitability of evidence-based interventions and developing guidelines. The study demonstrated how community stakeholders' engagement and service user involvement serves as a cornerstone in improving child mental health services. These are essential in identifying, mobilizing and addressing mental health concerns based on local needs and socio-cultural context, thus facilitating the implementation and sustainability of interventions (Michener et al., 2008). Such involvement is especially pertinent in LICs, with few intervention programmes and lack of extensive specialist resources, in order to gain maximum benefit from utilizing existing community strengths (Loza & Effat, 2017).

The study had training implications for non-specialist staff and community volunteers in applying WfR and similar psychoeducational approaches. The manual is simple to administer, as it only requires a minimum one-day training for paraprofessionals before implementing it (Yule et al., 2005). Such training should be linked to broader child development and mental health education programmes, so that non-specialists develop a broad understanding of children's needs, other modalities, risks involved and boundaries between different modalities, for example in not attempting interpretative techniques while administering the WfR intervention.

Service development, choice of interventions and capacity-building should adhere to a comprehensive overarching framework. It is widely acknowledged among international organizations that a stepped model and scaling-up of interventions is the way forward in meeting children's mental health needs in LIC (WHO, 2010). The ecological systems framework also offers a guide on how interventions for children, families and communities can be integrated in multi-modal programmes. The evaluated WfR psychoeducational intervention could contribute at the first step for children with common and less complex mental health presentations, and delivered to children and young people in school and

community settings by trained paraprofessionals and community volunteers. This first tier should be closely linked to other support systems for direct access and referrals of children who do not respond to this first-line intervention, as well as for supervision, consultation and training to the community workers.

## **8.4 Final reflections**

The whole journey of this research, from beginning to end, was a learning experience. Being inspired by founding and volunteering in a small charity supporting children displaced by ethnic conflict, most of them being orphaned and living with single parents or extended families, the researcher needed further knowledge on how to support these children better. It was a challenge where to begin from! Subsequent challenges were selecting a research topic and research question, and deciding the scope of the study. Due the nature of the research questions, a sequentially linked mixed methods approach was selected, which faced the researcher with further philosophical and practical challenges. For example, it was initially hard to reconcile the different philosophical stances of qualitative and quantitative research methodologies. Searching the diverse literature was time-consuming and testing, because of the dearth of relevant evidence, variety of sources, and heterogeneous populations under study.

The researcher, in addition to being a part-time student at the University of Leicester, was in full-time employment in Reading. Being a self-sponsored student and coming from a poor background in Kenya, the researcher had no option other than to work and raise tuition fees. This made balancing work and studying so demanding, especially travelling from Reading to Leicester to attend supervision and research meetings, and training workshops. This research was based in Kenya, where data was collected from, even though the researcher resides in the UK. It was costly to travel to Kenya (tickets and subsistence) and to buy study materials (paper and pens) alongside other miscellaneous costs (printing, refreshments for the focus group in local the restaurants, and transport within Kenya).

However, with continuous reading, attending training events such as workshops and the PhD peer group, and delivering conference presentations, the researcher managed to broaden the knowledge and to complete the study. Permission to pay University tuition fees in

instalments, to work flexible shifts at full-time employment, and commendable support from the supervisor, family and friends made the researcher feel motivated.

That being said, it was a unique experience to understand how children exposed to ethnic violence were faced with various challenges. Surprisingly, it was also positive to realise that, despite the adversities that these children encountered, most of them built resilience strategies, and used resources from their own, families' and communities' valuable perspectives. The current research adopted a 'what works' approach by engaging stakeholders from the outset. Stakeholders' views on how best to improve awareness of and respond to child mental health problems and services, was thus a central thread in this research.

This study also highlighted the value of using mixed methods techniques in soliciting stakeholders' views on children's mental health and services, and in evaluating the feasibility of a culturally acceptable psychosocial intervention for children exposed to ethnic violence. The researcher learnt that qualitative methods are best suited to understand the context of an intervention programme, while quantitative methods measure aspects of the content of the intervention and its outcomes. The researcher gained insight into different epistemological positions in mixed methods and the way they can influence the research design, data collection, analysis, interpretation and dissemination of the findings. Having managed to conduct this mixed method study successfully, the researcher feels well equipped with the methodological skills to face similar challenges in future in undertaking such research, and in integrating this to service development such as through international or LIC-based non-governmental organizations.

## **8.5 Conclusion**

This study provides new insight into 'what works' in psychosocial interventions for children exposed to ethnic violence in LICs. It highlights which factors are perceived as important, but also as challenging, by stakeholders in selecting, adapting, implementing and evaluating interventions in similar contexts. These findings are important in informing researchers, policy makers, service providers and stakeholders involved in child mental health care provision. The findings indicate that, when integrating mental health interventions into a new context, especially when translating research from one setting to another, adequate evidence-

based formative research of the intervention must be conducted before full-scale implementation.

Findings from this study also suggest that the WfR intervention was feasible to implement, as it showed promise in reducing PTSD symptoms among children. It was also appropriate for use in resource-constrained settings. Consequently, taking into account the factors that impact on feasibility and acceptability promotes the robust evaluation through pilot and RCT designs. Notably, a clear therapeutic framework, evidence-base and socio-cultural adaptation are important factors in ensuring the sustainability of such interventions.

## **APPENDICES**

## **Appendix 1: PARTICIPANT INFORMATION LETTER (PHASE I)**

### **Invitation**

My name is Mr Elijah Mironga Getanda. I am a student on the PhD Psychology course at the University of Leicester. I would very much like to invite you to take part in this research study which I am doing. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take as much time as you need to read the following information carefully. You can discuss it with others if you wish. Please feel free to contact me if there is anything that is not clear, or if you would need more information on the study before deciding to participate. Please decide whether or not you wish to take part.

### **The purpose of this research study**

The aim of this research is to understand what prevents children and young people with wellbeing of the mind (mental health) problems not to receive the help that they need, and how these can be improved. The findings of this study will be used to form ideas and inform the professionals who work with children, on the best way possible to help them in future.

### **Why you have been chosen**

I would like to invite and request you to participate in this research study. You are invited to take part in this study because you as a parent you bring up children and live with them at home. You know and understand their problems. It is important that you are involved in identifying and designing solutions for their mental health problems.

### **Do you have to take part?**

No. It is your decision to take part or not in this study. However, if you agree to participate, then could you please sign the permission letter. In any case, if you decide to participate but would prefer to withdraw after you have begun the interview, you may do so at any time without providing a reason. A decision to withdraw will not affect you or your child's care and education in any way. Once you withdraw, your data will not be used. You will only withdraw your data until when it will be used to inform the intervention development. You will be offered the chance to have a brief report of the findings, so that you can see how the data has been used. However, you can no longer withdraw once the thesis is written, as it gets published through the library.

### **What you have to do**

Please I would like to invite you to participate in a group interview (focus group). During the interview I will be the facilitator. You will only need to follow the instructions of each question very carefully, which will guide you through. The most important thing that I would request from you is to answer all of the questions truthfully. You should also be aware that there will be no right or wrong answers, as this interview is not a test.

**Will your taking part in this study be kept confidential?**

Yes. All of the information collected during this research study will be kept strictly confidential. No names or identifiable information will be collected and all collected data will be securely stored.

**What will happen to the results of the study?**

The information collected will be used and written up in professional journals for staff working with children. The findings may also be presented at relevant national and international meetings to educate the health communities and policy makers, so as to bring about positive changes that can support and improve the mental health of children. Finally, the findings will hopefully help us develop a programme to help children in this community.

If you have any questions please feel free to contact me or my supervisor at any time. I will be delighted to answer and explain them in more detail. The contact information is as follows:

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**My supervisor's contact information:**

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**Thank you for your time!**

## **Appendix 2 PARTICIPANT CONSENT STATEMENT**

1. I understand that my participation is voluntary and that I may withdraw from the research at any time without giving any reason.
2. I am aware of what my participation will involve.
3. My information is to be held confidentially, and only Mr Elijah Mironga Getanda and Prof Panos Vostanis will have access to it.
4. My information will be kept in a locked in a cupboard for a period of at least five years after written in professional journals working with children, a time when it will be removed completely.
5. My processed information may be shared with other competent researchers, and may also be used in other related studies. However, my name and other identifying details will not be shared with anyone.
6. The overall findings may be submitted for publication in a scientific journal, or presented at scientific conferences.
7. I am giving permission for my information to be used for the explained purposes of the present study. All questions that I have about the research have been answered fully. I therefore agree to participate.
8. I would like to receive a summary of the results when the study is complete please through my email address provided: Y/N\_\_\_\_\_

Participant's signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Thank you for your time!**



### Appendix 3: INTERVIEW GUIDE (PHASE I)

1. Could you tell me what you know about mental health?

**Probe:** happy feelings / positive feelings/ relaxed feelings/ good feelings?

2. What are some of the mental health problems that young people have?

**Probe:** unwanted, ignored, sad, discomfort, poor or no personal relations, exclusion, rejection, abuse, isolation, loneliness, vulnerability, fear, insecurity, helpless, frustrated, angry, powerless, grief, humiliated, ashamed, anxiety, worry, stress.

3. What are your views concerning mental health problems of young people in the community?

**Probe:** Not taken seriously or neglected?

4. What kind of mental health interventions are there for young people?

**Probe:** Counselling? Advice? Telling stories about their feelings? Writing down the stories on how they are feeling? Other?

5. Where are these interventions available/ carried out?

**Probe:** School? Church? Clinics? Hospital? Home? Camps? Other?

6. Who is responsible for carrying out these interventions?

**Probe:** Teachers? Pastors? Counsellors? Parents? Local leaders?

7. Whether and why do you think these interventions are not working or are not sufficient?

**Probe:** the type of intervention? The way interventions are carried out? Approach? Lack of personnel? Untrained personnel? Time factor?

8. Now imagine that you are part of a committee of people designing the modification of such an intervention. What are the factors that you will make sure your committee considers in designing these modifications?

**Probe:** Remember, these can be in many areas such as:

a) ***Context:*** Format, setting, personnel, population

b) ***Content:*** Refining language, repeating elements, substituting elements, adding or removing elements, shortening or condensing, integrating another approach into the intervention or the intervention into another approach

c) ***Training and evaluation processes:*** Enough training /workshop sessions

9. Is there anything else that we have not discussed yet which you think is important for modifications of a mental health intervention for young people?

#### **Appendix 4: PARTICIPANT INFORMATION LETTER (PHASE II)**

My name is Mr Elijah Mirona Getanda. I am a student on the PhD Psychology course at the University of Leicester. I would very much like to invite you to take part in this study which I am doing. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take as much time as you need to read the following information carefully. You can discuss it with others if you wish. Please feel free to contact me if there is anything that is not clear, or if you would need more information on the study before deciding to participate. Please decide whether or not you wish to take part.

##### **The purpose of this study and course**

The aim of this study is to help young people deal with the thoughts, nightmares, and powerful feelings that result from their emotional problems such as worries, sadness or anger, through a writing exercise course; and to find out what young people think of participating in this course.

##### **Why you have been chosen**

Many young people in your school will be invited to participate, first to find out if they have concerns such as sadness and worries that might benefit from this course. For those young people who fulfil these criteria, we will then invite them and request to participate in this course. If you are within this group of young people and decide to be in the course, your experiences and views of the course will be essential in understanding how similar programmes can help other young people in the future. If you do not express any such concerns, there is no need to be involved any further in the study, although we would still like to compare your questionnaires scores with those of other young people.

##### **Is it a must you have to take part?**

No. It is your decision to take part or not in this course and study. However, if you agree to participate then please you must sign the permission letter. If you initially decide to participate but would prefer to withdraw after you have begun the course, you may do so at any time without providing a reason. A decision to withdraw will not affect other types of help you receive in any way. Once you withdraw, your data will not be used. You will only withdraw your data until when the course has been implemented. You will be offered the chance to have a brief report of the findings so that you can see how the data has been used. However, you cannot withdraw once the findings have been published.

##### **What you have to do**

Please I would like to invite you to participate in the study. You will first complete four brief questionnaires on how you feel. If you score below a certain point, you would not normally require any help on emotional issues and there is nothing else you will need to do. If you score above a certain point, it does not mean that you have a mental health problem but that you might benefit from some additional help in dealing with your feelings. To that effect we will be providing this course.

During the course I will be the instructor. You will either attend the course straightaway with others or with another group after two weeks, to help us understand how it best helps. The course, which includes six short writing sessions over three consecutive days, with each day consisting of two 15-minute sessions, will be administered in school. It will be delivered in the morning before classes and in the evening after classes to give you enough time for your normal school learning. After two weeks you will complete the same questionnaires, and also give feedback on the course. Your parents and teachers will take part in this study as well by receiving information and advice on how to best help you, and will also give us feedback on what they have found useful. If during the course or the period of the study you ask for additional help, I will advise you and your family who would be the best person to talk to.

**Will your taking part in this course and study be kept confidential?**

Yes. All of the information collected during this course and study will be kept strictly confidential. No names or identifiable information will be collected and all collected information will be securely stored.

**What will happen to the results of the course and this study?**

The information collected will be used and written up in professional journals for staff who work with children and young people. The findings may also be presented at relevant national and international meetings of the same professional groups in order to influence and improve the future help and supports that young people receive. A brief report will be presented to your school and the Educational Authorities, although no names will be mentioned. I will be delighted to send you a copy of this report too.

If you have any questions please feel free to contact me or my supervisor at any time. The contact information is as follows:

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## Appendix 5: Baseline Characteristics of the Participants

1. How old are you?
2. What is your gender?
3. In which class are you?
4. What is your religion
5. What is your ethnic background?
6. What is your mother's occupation?
7. What is your father's occupation?
8. What level of education does your mother have?
9. What level of education does your mother have?

## Appendix 6: Revised Child impact of Event Scale (13) CRIES-13

Below is a list of comments made by people after stressful life Event. Please tick each item showing how frequently these comments were true for you during the past seven days. If they did not occur during that time please tick the 'not at all' box.

		<b>Not at all</b>	<b>Rarely</b>	<b>Sometimes</b>	<b>Often</b>
1	Do you think about it even when you don't mean to?				
2	Do you try to remove it from your memory				
3	Do you have difficulties paying attention or concentrating				
4	Do you have waves of strong feelings about it				
5	Do you startle more easily or feel more nervous than you did before it happened?				
6	Do you stay away from reminders of it (e.g. places or situations)				
7	Do you try not talk about it				
8	Do pictures about it pop into your mind?				
9	Do other things keep making you think about it?				
10	Do you try not to think about it?				
11	Do you get easily irritable				
12	Are you alert and watchful even when there is no obvious need to be?				
13	Do you have sleep problems?				

## Appendix 7: Revised Children's Manifest Anxiety Scale (RCMAS)

### “What I think and Feel”

Read each question carefully. Put a circle around the word **YES** if you think it is true about you. Put a circle around the word **NO** if you think it is not true about you

1	I have trouble making up my mind.	Yes	No
2	I get nervous when things do not go the right way for me.	Yes	No
3	Others seem to do things easier than I can.	Yes	No
4	I like everyone I know	Yes	No
5	Often I have trouble getting my breath	Yes	No
6	I worry a lot of the time	Yes	No
7	I am afraid of a lot of things	Yes	No
8	I am always kind	Yes	No
9	I get mad easily	Yes	No
10	I worry about what my parents will say to me	Yes	No
11	I feel that others do not like the way I do things	Yes	No
12	I always have good manners	Yes	No
13	It is hard for me to get to sleep at night	Yes	No
14	I worry about what other people think about me	Yes	No
15	I feel alone even when there are people with me	Yes	No
16	I am always good	Yes	No
17	Often I feel sick in the stomach	Yes	No
18	My feelings get hurt easily	Yes	No
19	My hands feel sweaty	Yes	No
20	I am always nice to everyone	Yes	No
21	I am tired a lot	Yes	No
22	I worry about what is going to happen	Yes	No
23	Other children are happier than I am	Yes	No
24	I tell the truth every single time	Yes	No
25	I have bad dreams	Yes	No
26	My feelings get hurt easily when I am fussed at	Yes	No
27	I feel someone will tell me I do things the wrong way	Yes	No

28	I never get angry	Yes	No
29	I wake up scared some of the time	Yes	No
30	I worry when I go to bed at night	Yes	No
31	It is hard for me to keep my mind on my schoolwork	Yes	No
32	I never say things that I shouldn't	Yes	No
33	I wriggle in my seat a lot	Yes	No
34	I am nervous	Yes	No
35	A lot of people are against me	Yes	No
36	I never lie	Yes	No
37	I often worry about something bad happening to me	Yes	No

### **Appendix 8: DEPRESSION SELF-RATING SCALE FOR CHILDREN (DSRC)**

Please read these statements and tick the answer that best describes how you have felt in the past week. Answer as honestly as you can. The correct answer is to say how you really have felt.

		<b>Mostly</b>	<b>Sometimes</b>	<b>Never</b>
1	I look forward to things as much as I used to			
2	I sleep very well			
3	I feel like crying			
4	I like to go out to play			
5	I feel like running away			
6	I get tummy aches			
7	I have lots of energy			
8	I enjoy my food			
9	I can stick up for myself			
10	I think life isn't worth living			
11	I am good at the things I do			
12	I enjoy the things I do as much as I used to			
13	I like talking with my family			
14	I have bad dreams			
15	I feel very lonely			
16	I am easily cheered up			
17	I feel so sad I can hardly stand it			
18	I feel very bored			

## Appendix 9: KIDSCREEN-10

### Health Questionnaire for Children and Young People

Date: \_\_\_\_\_ (Month) \_\_\_\_\_ (Year) \_\_\_\_\_

Hello,

How are you? How do you feel? This is what I would like you to tell me. Please read every question carefully. What answer comes to your mind first? Choose the box that fits your answer best and cross it. Remember: This is not a test so there are no wrong answers. It is important that you answer all the questions and also that we can see your marks clearly. When you think of your answer please try to remember the last week. You do not have to show your answers to anybody. Also, nobody who knows you will look at your questionnaire once you have finished it.

#### About Your Health

<b>Thinking about the last week.....</b>	<b>not at all</b>	<b>slightly</b>	<b>moderately</b>	<b>very</b>	<b>extremely</b>
i. Have you felt fit and well?					
<b>Thinking about the last week...</b>	<b>never</b>	<b>seldom</b>	<b>quite often</b>	<b>very often</b>	<b>always</b>
ii. Have you felt full of energy?					
<b>Thinking about the last week...</b>	<b>never</b>	<b>seldom</b>	<b>quite often</b>	<b>very often</b>	<b>always</b>
iii). Have you felt sad?					
iv). Have you felt lonely?					
v). Have you had enough time for yourself?					
vi). Have you been able to do the things that you want to do in your free time?					
vii). Have your parent(s) treated you fairly?					
viii). Have you had fun with your friends?					
<b>Thinking about the last week.....</b>	<b>not at all</b>	<b>slightly</b>	<b>moderately</b>	<b>very</b>	<b>extremely</b>
ix). Have you got on well in school?					
<b>Thinking about the last week...</b>	<b>never</b>	<b>seldom</b>	<b>quite often</b>	<b>very often</b>	<b>always</b>
X) Have you been able to pay attention?					

In general, how would you say your health is?

☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

## Appendix 10: Stressful Life Events Checklist

Something bad happens to people sometimes. Below, there are questions about these things. Please read them and tick up the “yes” if you have experienced this event before. If you want to add something else, please write down after completing the questions.

Thank you

	<b>Stressful Life Events concerning the family</b>		
1	Have there been drastic changes in your family during the last year?	Yes	No
2	Have you ever been separated from your family against your will? (By a stranger, police officer, soldier, fleeing your homeland)	Yes	No
3	Has someone died in your life that you really cared about?	Yes	No
	<b>Experiences with illness, accidents and disasters</b>		
4	Have you had a life threatening medical problem?	Yes	No
5	Have you been involved in a serious accident? (for example involving a car)	Yes	No
6	Have you ever been involved in a disaster? (For example: flood, hurricane, fire, tornado, avalanche, earthquake, hostage situation, chemical disaster?)	Yes	No
	<b>War</b>	Yes	No
7	Have you ever experienced a war or an armed military conflict going on around you in your country of birth?	Yes	No
	<b>Physical and sexual mistreatment</b>		
8	Has someone ever hit, kicked, shot at or some other way tried to physically hurt you?	Yes	No
9	Did you ever see it happen to someone else in real life? (Not just on television or in a film?)	Yes	No
10	Has someone ever tried to touch your private sexual parts against your will or forced you to have sex	Yes	No
	<b>Other</b>		
11	Did you experience any other very stressful life events where you thought that you were in great danger?	Yes	No
12	Did you experience any other very stressful life event where you thought that someone else was in great danger?	yes	No



## **Appendix 11: INTERVENTION IMPLEMENTATION GUIDE**

Traumatic experiences have the ability to touch every part of our lives. The purpose of this project is to help young people deal with the thoughts, nightmares, and powerful feelings that result from traumatic events. In this project, you will be asked to write six times about issues surrounding your experience(s) or the trauma(s). There is good evidence to suggest that this writing exercise can be helpful. The entire procedure will take less than two hours. It may be hard to start, but it may make a big difference in your life. Please try it. You will be asked to put your writings in the box but what you have written will be read by people who work to better the situation for young people who experience major upheavals in their life.

### **Day One**

I would like you write about your deepest emotions and thoughts about the trauma/traumas. How has this event (s) touched your life? You might describe what happened, what you saw and felt, and what you remember. Also, you might tie this event (s) to other parts of your life. For example, how is this trauma or series of critical events related to your childhood, your relation with your parents, other family members, friends, or teachers? How might it be related to people you love? How is it connected to who you would like to become in the future, who you have been in the past, or who you are now? You might even write about how this trauma or these traumatic events are related to the dreams you may be having or some of the thoughts that may be have been haunting you.

Whatever you choose to write about, however, it is very important that you are completely honest with yourself. Really let go and explore your very deepest emotions and thoughts. Some other issues you might want to write about are to do with what you saw, heard, felt, smelled, what you thought about at the time. You may have found it difficult to share these with other people. If you want to, you have this opportunity to write about all or any of these.

### **After the break:**

Now that you have got the idea of writing it all down, this time I want you really to let go and write about all the ways you remember this or these experiences – sights, sounds, smells, memories, thoughts, feelings. You may link it up to other important things in your life. You may want to write about the same thing or about another aspect or event -- it is up to you.

### **Day Two**

I'd like you explore your thoughts and feelings about whatever emotional upheaval is bothering you the most. I want you to focus on some of the emotions that have come up after such an event(s).

After an event (s) like the one you lived through, people often report that they thought they were going to die or that they were responsible for what happened. Many people think this way and we want you to write about what you now know – that you did not die; that you were not to blame.

You can write about the exact same things you wrote about yesterday, or you can write about something different – your family or other powerful emotions or experiences you have not told others about.

**After the break:**

Write down the story about what happened to you and maybe include what you did that helped you to survive. A good story has a beginning, middle and an end. Most of you did something active to survive. Try to tell your story about what you did then. Even though no one else will see your story, you will remember better what you did to survive.

Now that you have got the idea of writing it all down, this time I want you really to let go and write about all the ways you remember it – sights, sounds, smells, memories, thoughts, feelings. You may link it up to other important things in your life. You may want to write about the same thing or about another aspect or event -- it is up to you.

**Day Three**

You are free to choose to write again the way you did the first two days. This event has affected not just you, but everyone else around you. The way you think and talk to people about it may have changed. However painful your experiences have been, you will have learned from them. Think of another person who has gone through a similar event (s). Knowing what helped you most or what you would have liked, what would you say to that other person?

**After the break:**

Imagine that it is ten years on from now and you are looking back on what happened. How will you want to think about the event/events? What does it mean to you now and what do you think you will see as the most important part when you look back on it in ten years' time.

**Thanks for your time!**

**Appendix 12: FEASIBILITY FORM**

Please we would like to have your views and experiences about the course. It is important you keep in mind that there is no “right” or “wrong” answers to any of the views you will give. What really matters in this case is your experience about the course.

In order for us to understand your views and thoughts about this course, please could you comment on the following;

**i). Instructions and procedure of the course**

Please tell us if the instructions were easy or simple to follow and understand before and during the course.

**ii). Information of the course**

Please tell us if you think the information in the course is sufficient to help young people with concerns.

**iii). Planning and delivery of the course**

Please tell how well you think the course was planned and delivered. We would like to know what you think about the environment that the course was delivered.

**iv). Questionnaires used in the course**

We would like to know if you think the questionnaires completed before the course gave you enough opportunity to express how you felt. Were they easy to understand? Were they appropriate for your culture? Please tell us also if you think the questionnaires completed after the course gave you a good opportunity to tell if the help from the course was helpful.

**v). Rating of the course.**

Please let us know in your own opinion if you think the course was helpful and if you can recommend it for other young people in similar situations.

**vi).** Please comment on any other points we may not have thought about.

**Thank you!**

## Appendix 13: ETHICS APPROVAL LETTER



University Ethics Sub-Committee for Psychology

11/11/2015

**Ethics Reference:** 3267-emg15-neuroscience,psychologyandbehaviour

TO:

Name of Researcher Applicant: Elijah Getanda

Department: Psychology

Research Project Title: Feasibility of psychosocial intervention for children exposed to ethnic conflict in Kenya (Phase two)

Dear Elijah Getanda,

**RE: Ethics review of Research Study application**

The University Ethics Sub-Committee for Psychology has reviewed and discussed the above application.

1. Ethical opinion

The Sub-Committee grants ethical approval to the above research project on the basis described in the application form and supporting documentation, subject to the conditions specified below.

2. Summary of ethics review discussion

The Committee noted the following issues:

The application was discussed by the ethics committee on 11th November 2015, who were satisfied following the reviewer's recommendation.

3. General conditions of the ethical approval

The ethics approval is subject to the following general conditions being met prior to the start of the project:


As the Principal Investigator, you are expected to deliver the research project in accordance with the University's policies and procedures, which includes the University's Research Code of Conduct and the University's Research Ethics Policy.

If relevant, management permission or approval (gate keeper role) must be obtained from host organisation prior to the start of the study at the site concerned.

## Appendix 14: RESEARCH PERMIT

**THIS IS TO CERTIFY THAT:**  
**MR. ELIJAH MIRONGA GETANDA**  
**of LEICESTER UNIVERSITY UK,**  
**13828-20100 Nakuru, has been**  
**permitted to conduct research in**  
**Nakuru County**  
**on the topic: FEASIBILITY OF**  
**PSYCHOSOCIAL INTERVENTION FOR**  
**CHILDREN EXPOSED TO ETHNIC**  
**CONFLICT IN KENYA**  
**for the period ending:**  
**31st October, 2017**

**Permit No : NACOSTI/P/16/6180/5838**  
**Date Of issue : 3rd November, 2016**  
**Fee Received : Ksh 2,000**




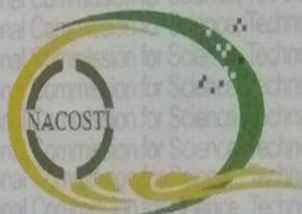
**Applicant's Signature**

*[Signature]*  
**Director General**  
**National Commission for Science,**  
**Technology & Innovation**

**CONDITIONS**

1. You must report to the County Commissioner and the County Education Officer of the area before embarking on your research. Failure to do that may lead to the cancellation of your permit.
2. Government Officer will not be interviewed without prior appointment.
3. No questionnaire will be used unless it has been approved.
4. Excavation, filming and collection of biological specimens are subject to further permission from the relevant Government Ministries.
5. You are required to submit at least two(2) hard copies and one (1) soft copy of your final report.
6. The Government of Kenya reserves the right to modify the conditions of this permit including its cancellation without notice

  
**REPUBLIC OF KENYA**

  
**National Commission for Science,**  
**Technology and Innovation**  
**RESEACH CLEARANCE**  
**PERMIT**

**Serial No.A** **11610**  
**CONDITIONS: see back page**

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