EARLY CHILDHOOD TRAUMA'S PSYCHOLOGICAL EFFECTS ON CHILDREN FROM SINGLE-PARENT HOUSEHOLDS IN KENYA: A CASE OF SELECTED PRIMARY SCHOOLS IN KANDUYI SUB-COUNTY, BUNGOMA COUNTY, KENYA

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A Thesis submitted in partial fulfillment of the requirements for the award of the degree of Master of Arts in Counseling Psychology in the Department of Counseling Psychology and the School of Humanities and Social Sciences of Africa Nazarene University

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DECLARATION

I declare that this document and the research that it describes are my original work and have not been presented in any other Institution/University for academic work.

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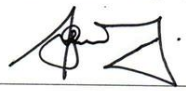

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This research was conducted under our supervision and is submitted with our approval as university supervisors.

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DEDICATION

I dedicate this Thesis to all the children of single parents in Kenya, who have encountered traumatic experiences that have shaped their lives. I also dedicate this study to my family members who have also gone through traumatic experiences, for their continued financial and moral support as I pursue my Postgraduate Education.

ACKNOWLEDGEMENTS

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ABSTRACT

The study investigated the psychological impact of early childhood trauma on children from single-parent families in Bungoma County, Kenya. This study investigated the effects of early childhood trauma on the psychological well-being of children from single-parent families, seeking to uncover nuanced insights into the specific psychological indicators affected by trauma exposure. The study drew upon Erikson's psychosocial development theory to understand how early trauma may disrupt normal progression through psychosocial stages and influence psychological outcomes. The target population comprised 28,000 children from parents single-parent families, while 379 participants were sampled for the study. Quantitative data were collected using structured questionnaires and surveys to assess psychological symptoms, resilience factors, and demographic information. Two standardized tests were used: Eisen, "Children's Posttraumatic Symptom Inventory (PT-SIC)," and, "Revisions to the Traumatic Events Screening Inventory-Parent Report (TESI-PRR)".Other tools that bridged the generation gap: CPSS (Child PTSD Symptom Scale): The CPSS is a self-report questionnaire used to measure the symptoms of Posttraumatic Stress Disorder (PTSD) in children between the ages of 6 and 17. Qualitative data were gathered through in-depth interviews and focus group discussions with children, teachers, and single parents. The research interviews were conducted with 15 children from a sample of 379, 10 teachers and 10 single parents, who were selected through snowball sampling. Both data types were analyzed separately and integrated to understand the research questions, using the Statistical Package for Social Sciences (SPSS) version 24. Findings indicated a significant relationship between the type and severity of early childhood trauma and various psychological symptoms. The study revealed that early childhood trauma has lasting effects on children's psychological well-being, mediated by cultural, socioeconomic, and resilience factors. The impact of trauma was 12.9% among children aged 4 to 6 years, 31.7% among those aged 7-12, and 55.4% among 13 to 17 years old children. The study recommends the development and implementation of early intervention programs to address the psychological needs of children who have experienced trauma. Further, increasing access to mental health services for both children and their caregivers is crucial, while engaging communities and local support networks are essential to creating safe and nurturing environments for the children while remaining mindful of cultural considerations.

DEFINITION OF TERMS

Acute Stress Disorder (ASD): After a traumatic event, one encounters a mental health condition that appears within the first month. The symptoms of ASD are analogous to those of PTSD, however, in PTSD, the symptoms must persist for more than a month. The term is used in the study as defined.

Adjustment Disorders (AD): As is used operationally in this study**,** AD refers to a condition that affects people who overreact to stressful or upsetting situations. Stressors might be a single occurrence (like a difficult breakup) or a string of events (like work problems, struggles at school, or financial issues).

Child: "Child" means any human being under the age of eighteen years; For this study, the term is used to refer to a boy or girl between the ages of 3 and 17, per the Children Act of 2010 Kenyan law.

Post-Traumatic Stress Disorder (PTSD): According to the American Psychiatric Association (2022), Post Traumatic Stress Disorder (PTSD) is a psychiatric disorder that may occur in people who have experienced or witnessed a traumatic event, series of events, or set of circumstances. An individual may experience this as emotionally or physically harmful or life-threatening, affecting mental, physical, social, and spiritual well-being. The term is used in this study as defined.

Reactive Attachment Disorder (RAD): This is a condition where children who have experienced emotional abuse or neglect as infants or young children fail to form emotionally healthy bonds with their caregivers (parental figures). Children with RAD struggle to control their emotions. In this study, the term is used as defined.

Trauma: According to the American Psychiatric Association (2022), trauma is an emotional response to a terrible event like an accident, crime, or natural disaster. Reactions such as shock and denial are typical. Longer-term reactions include unpredictable emotions, flashbacks, strained relationships, and physical symptoms. In this study, the term is used as defined.

ABBREVIATIONS AND ACRONYMS

ASD	Acute Stress Disorder
AD	Adjustment Disorders
DSED	Disinhibited Social Engagement Disorder
FGD	Focus Group Discussion
IQ	Intelligent Quotient
PTSD	Post Traumatic Stress Disorder
PT-SIC	Post Traumatic Symptom Inventory for Children
RAD	Reactive Attachment Disorder
TESI-PRR	Traumatic Events Screening Inventory Parents Report

CHAPTER ONE

INTRODUCTION AND BACKGROUND

1.1 Introduction

In contemporary society, the structure of the family unit has undergone significant transformations, leading to an increased prevalence of single-parent households. Like many other regions, Kenya has witnessed a notable rise in families where one parent assumes primary caregiving responsibilities. This shift in family dynamics raises critical questions about the potential impact on the psychological well-being of children raised in such households, particularly in the context of early childhood trauma, Dye (2018).

According to Cross, Powers & Bradley (2017), the psychological well-being of children is profoundly shaped by various factors, among which early childhood experiences play a pivotal role. Research has extensively documented the profound impact of childhood trauma on the psychological development of individuals, McLaughlin, K. A., et al. (2020). However, the intricate relationship between early childhood trauma and the psychological well-being of children from single-parent families remains a significant area of exploration. This study aims to investigate the effects of early childhood trauma on the psychological well-being of children raised in single-parent households, considering various variables that might influence and mediate these effects, Bernardi & Radl (2014). In contemporary society, the structure of the family unit has undergone significant transformations, leading to an increased prevalence of single-parent households, Erola & Jalovaara (2016). Like many other regions, Kenya has witnessed a notable rise in families where one parent assumes primary caregiving responsibilities. This shift in family dynamics raises critical questions about the potential

impact on the psychological well-being of children raised in such households, particularly in the context of early childhood trauma, Amato & Boyd (2014).

The psychological well-being of children is profoundly shaped by various factors, among which early childhood experiences play a pivotal role. Research has extensively documented the profound impact of childhood trauma on the psychological development of individuals, (Rothschild, 2000; Siegel, 2012; Walker, 2013). However, the intricate relationship between early childhood trauma and the psychological well-being of children from single-parent families remains a significant area of exploration. This study aims to investigate the effects of early childhood trauma on the psychological well-being of children raised in single-parent households, considering various variables that might influence and mediate these effects, (Copley, 2023).

1.2 Background of the Study

The family is widely recognized as a fundamental unit in shaping individuals' development, providing a foundation for emotional and psychological well-being. However, the evolving socio-cultural landscape has brought about a significant increase in single-parent households, where a solitary caregiver navigates the challenges of parenting. In Kenya, the reasons behind the rise of single-parent households are multifaceted, ranging from economic pressures to sociocultural shifts, Mbithi, J. N. (2019).

Children in single-parent households may encounter distinctive circumstances that contribute to their vulnerability to early childhood trauma. According to Bernstein & Foote (1994), Early childhood trauma, encompassing experiences such as neglect, abuse, or witnessing violence, has been linked to long-lasting psychological consequences. According to Kahongeh, J.

(2022), understanding the intricate interplay between single-parent household structures and the psychological well-being of children necessitates a comprehensive examination of the prevalence, nature, and impact of early childhood trauma within this context.

The Study sheds light on the nuanced aspects of children's experiences in single-parent households in Kenya, unraveling the complexities of their psychological development in the face of early adversity, Grasso, D. J. (2022). By doing so, the researcher aspired to inform interventions and support systems that enhance the resilience of these children, ultimately fostering their holistic well-being.

Early childhood is a critical period in a child's life, marked by rapid development and impressionable moments that can shape their future. In Kenya, as in many parts of the world, there is a growing concern surrounding the psychological effects of early childhood trauma, particularly among children from single-parent families, Murphy & Dube, S. R. (2016). This issue is particularly salient in the rural region of Bungoma's Kanduyi Sub County, as the dynamics of family structure and the challenges associated with single-parent households intersect with the vulnerabilities of early childhood.

Early childhood trauma can have negative effects that last into adulthood and manifest as personality disorders. Examples of early childhood trauma include physical, psychological, or sexual abuse, life-threatening illnesses, neglect, being kidnapped, and the death of a loved one. Murray (2019) claims that trauma-induced brain changes can cause varying degrees of emotional instability and cognitive impairment, which can cause issues including difficulty in focusing and paying attention. Additional repercussions of trauma include difficulty learning, feeling inadequate, employing poor judgment, having poor social skills, and having sleep issues (Nemeroff, 2016).

According to Kolk (1991), a variety of attacks or traumatic event presentations among children, include complex Post Traumatic Stress Disorders (PTSD) and ongoing difficulties with daily living. Other complex presentations include difficulty building relationships, trusting others, and developing relationships.

Behavioral and mental health problems may have an early childhood origin, according to Bowlby (1990), who also suggested that children are biologically predisposed to form social bonds from birth. According to Bowlby (1990), a child would initially create just one attachment and use that person as a safe basis for exploring the outside world. Since it serves as the basis for all subsequent social relationships, upsetting the attachment bond can have profoundly detrimental effects. The behaviorist idea, which holds that every action is learned through exposure to the outside world, is examined in the study. This learning theory contends that environmental factors, as opposed to innate or inherited features, have a significantly higher influence on behavior.

According to Erikson (1963), personality changes in a predetermined order as it progresses through eight stages of psychosocial development from infancy to adulthood. While Erikson did not explicitly link his stages to childhood trauma, his theory does offer insights into how early experiences, including trauma, can influence personality development within these stages. Childhood trauma can affect the successful resolution of these conflicts, leading to difficulties in forming healthy relationships, establishing a sense of identity, and managing emotions in later life. Individuals who have experienced trauma may grapple with ongoing issues related to trust, autonomy, initiative, and competence, impacting their overall personality development. A child's development is also influenced by their relationships with

friends and neighbors and their access to playgrounds, parks, stores, and neighborhood amenities like child care, playgroups, kindergartens, schools, health clinics, and libraries.

Shaffer (2009) and subsequent research have indicated that early childhood experiences, particularly traumatic events, can significantly impact personality development. Early experiences, especially traumatic ones, can shape how a child perceives themselves and the world. Such experiences may influence the development of certain personality traits, coping mechanisms, and behavioral patterns that persist into adulthood. Trauma during childhood can disrupt the formation of secure attachments with caregivers. This can lead to insecure attachment styles, such as anxious, avoidant, or disorganized attachment, influencing how individuals relate to others and handle relationships later in their lives.

According to Grossman (2001), experiences with single parenting and one's traumatic events that are connected to the impacts of childhood trauma through generations, PTSD in parents, and cortisol excretion raise the likelihood of PTSD and childhood trauma. In general, single parents may focus on earning and providing their children with the necessities of life and tend to ignore their children's undesirable behavior, which can cause issues for them in their future life journey.

Understanding the psychological effects of early childhood trauma on children from single-parent families in this specific context is vital for the well-being and prospects of these children. To foster a more supportive environment for these children, educators, legislators, and the larger society must recognize the difficulties faced by parents and other caregivers in single-parent households. Through this research, the study aims to highlight the importance of addressing these issues and promoting the well-being of young individuals who are among the most vulnerable members of our society.

Early childhood is a critical period in a child's life, marked by rapid development and impressionable moments that can shape their future. In Kenya, as in many parts of the world, there is a growing concern surrounding the psychological effects of early childhood trauma, particularly among children from single-parent families. This issue is particularly salient in the rural region of Bungoma's Kanduyi Sub-County, as the dynamics of family structure and the challenges associated with single-parent households intersect with the vulnerabilities of early childhood.

This study focused on selected primary schools in Bungoma's Kanduyi Sub-County. It aimed to explore the intricate relationship between early childhood trauma and its psychological effects on children in single-parent families. The study sought to shed light on the unique challenges faced by these children, offering insights that can inform policies, interventions, and support systems to help mitigate the potential long-term consequences of early trauma.

According to Vos (2012), neglect has long-term health effects on children, including poor growth, excess weight, and untreated medical conditions. Inadequate clothing or materials to suit a child's needs as well as poor personal cleanliness, physical abuse, or neglect, affects a child's health. A child is more likely to experience trauma if there is a sudden and serious medical emergency, there is a war in the country, or if there are violent actions committed at school, at home, or in the neighborhood. Early experiences shape a child's connections, with what they see, hear, touch, smell, and taste.

According to Otieno& Gichohi (2019), Single-parent families have become increasingly common in Kenya due to a variety of factors, including divorce, separation, and the loss of a spouse. The absence of one parent can place additional stressors on the family

unit, often affecting the child's emotional well-being and overall development, Mwoma & Pillay (2016). The impact of early childhood trauma in these circumstances is a matter of growing concern, as it may manifest in various ways, affecting children's cognitive, emotional, and social development, Shonkoff & Garner (2012). In Kanduyi Sub-County, the impact of early childhood trauma on children from single-parent families can be exacerbated by socio-economic challenges. These families often struggle to meet basic needs, limited access to healthcare, education, and emotional support. Consequently, the children's exposure to adverse experiences and their capacity to cope with trauma can be compromised, making them more vulnerable to long-lasting psychological effects, Van der Kolk (2005).

1.3 Statement of The Problem

Despite growing awareness of the profound impact of early childhood trauma on children's psychological well-being, there exists a significant gap in understanding the specific ramifications of such trauma within the unique context of single-parent families. While research has extensively documented the effects of adverse childhood experiences on children's mental health, the exploration of these effects within the framework of single-parent households remains relatively underexplored and requires meticulous examination, Crosnoe & Cavanagh (2010). The problem at hand revolves around the need to broadly comprehend how early childhood trauma influences the psychological well-being of children within single-parent families. Limited empirical studies focusing on this intersection fail to provide a detailed understanding of the diverse facets and complexities that might exacerbate or alleviate the impact of trauma on the psychological development of children in these family structures O'Connor & Scott (2007).

This research gap is a crucial one to address due to the increasing prevalence of single-parent households globally. Factors such as parental stress, financial constraints, limited social support networks, and disrupted family dynamics within these settings may significantly interact with the effects of childhood trauma, potentially intensifying its adverse consequences on children's mental health. Hence, the central problem addressed by this study is the lack of a comprehensive understanding of how early childhood trauma specifically manifests within the psychological well-being of children from single-parent families, more so amongst the study population. Unraveling the intricacies of this relationship is pivotal for devising targeted interventions, support strategies, and policies tailored to alleviate the psychological burdens faced by these vulnerable children and families.

This study aimed to investigate the nuanced effects of early childhood trauma on the psychological well-being of children raised in single-parent households within this region, identifying prevalent forms of trauma and exploring their implications on the emotional, cognitive, and social development of these children. The lack of empirical data and an in-depth understanding of how early trauma manifests and influences psychological well-being among children in single-parent families in this specific geographic area underscores the urgency and necessity of this research inquiry.

Despite the global acknowledgment of the profound impact of early childhood trauma on mental health, there exists a noticeable gap in empirical research, specifically within the context of single-parent households in Kenya, Gavurova, Ivankova, Rigelsky, M., et al. (2022). Limited comprehensive studies have been conducted to scrutinize the unique challenges children in these families do face, particularly in the region of Bungoma's Kanduyi Sub-County.

There is a growing recognition of the prevalence of single-parent families in Kenya, yet there's a lack of in-depth research examining how children within these households navigate and cope with early traumatic experiences, Murry & Stephens (2001). Understanding the nuances of trauma within this family structure is crucial for developing targeted interventions and support systems, O'Connor & Scott (2007). The study sought to focus on Bungoma's Kanduyi Sub-County, recognizing the importance of understanding localized influences and experiences that might differ from broader national or global trends. This region might have its own social, cultural, and economic factors that play a role in shaping the nature and extent of childhood trauma and its impact on psychological well-being.

This study further aimed to identify the types and prevalence of traumatic experiences encountered by children in single-parent households. These could range from parental separation or loss, exposure to violence, neglect, economic hardships, or other adverse childhood experiences that significantly impact a child's mental and emotional well-being Anda & Brown (2010). The research sought to delve into the multifaceted effects of early childhood trauma on the psychological well-being of these children. This includes exploring how trauma influences emotional regulation, cognitive development, social interactions, academic performance, and overall mental health within the school environment. The urgency of this research stems from the critical need to understand, identify, and address the psychological challenges faced by children in single-parent families within this specific geographic area. The lack of empirical data in this context underscores the necessity of this study to inform policies, interventions, and support systems tailored to the needs of these children.

1.4 Purpose of The Study

This study's purpose was to investigate the specific psychological impact of early trauma on children growing up in single-parent households within the Kenyan context. The study sought to explore and identify the various psychological effects experienced by children who have encountered trauma in their early years.

1.5 Objective of the Study

This study aimed to investigate the effects of early childhood trauma on the psychological well-being of children from single-parent households within the Kanduyi sub-county, Bungoma, County, Kenya.

1.5.1 Specific Objectives

The specific objectives of the study were:

i. To examine the prevalence of different types of early childhood trauma experienced by children in single-parent households in Kanduyi sub-county, Bungoma County of Kenya.

ii. To investigate the psychological impact of early childhood trauma on the cognitive and emotional development of children raised in single-parent households in Kanduyi sub-county, Bungoma County of Kenya.

iii. To identify coping mechanisms employed by children in single-parent households in Kanduyi sub-county, Bungoma County of Kenya, to mitigate the psychological effects of early childhood trauma.

iv. To assess the role of support systems in buffering the psychological impact of early childhood trauma on children from single-parent households in Kenya.

1.6 Research Questions

The study was guided by the following research questions:

i. What is the prevalence of different types of early childhood trauma among children in single-parent households in Kanduyi sub-county, Bungoma County of Kenya?
ii. How does early childhood trauma affect the cognitive and emotional development of children raised in single-parent households in Kanduyi sub-county, Bungoma County of Kenya?
iii. What coping mechanisms do children from single-parent households in Kanduyi sub-county, Bungoma County of Kenya employ to mitigate the psychological effects of early childhood trauma?
iv. To what extent do support systems contribute to buffering the psychological impact of early childhood trauma on children from single-parent households in Kanduyi sub-county, Bungoma County of Kenya?

1.7 Hypotheses (Null)

i. There is no significant difference in the prevalence and types of early childhood trauma experienced by children across various family structures within single-parent households.
ii. There is no significant association between early childhood trauma and specific psychological indicators such as emotional regulation, behavior, mental health, and cognitive development, among children from single-parent families.

1.8 Significance of the Study

The study's significance encompasses its potential contributions and importance within the field of psychology, child development, and social interventions, its potential to generate

knowledge that is both academically enriching and practically impactful. It aims to contribute to the understanding of childhood trauma within the specific context of single-parent households in Kenya, with the ultimate goal of informing interventions, policies, and practices aimed at supporting the psychological well-being of affected children. Positive nurture in a child's growth and development determines their future psychological development, which includes personality, cognition, behavior, and moral accomplishments. The single parents will be informed of the consequences of their negligence while handling or neglecting children's needs in their early growth stages.

The study will enable children to learn to cope with early traumatic effects in their lives. The community will benefit from the studies' outcome by knowing how to handle and assist children who experience trauma in their early lives to overcome the transfer effects of trauma to their adult lives. The significance of understanding early childhood trauma among single parents lies in its potential to drive evidence-based policymaking, allocate resources effectively, promote trauma-informed care, and enhance the well-being of single-parent families. Through research, advocacy, and informed policy decisions, we can create a society that provides the necessary support and resources for these families to thrive despite the challenges they face.

The study holds significance in shedding light on the specific psychological challenges faced by children growing up in single-parent households in Kenya after experiencing early trauma. This understanding is crucial for developing targeted interventions and support systems. There might be a scarcity of research focusing on the intersection of childhood trauma and the single-parent household context in Kenya.

This study fills this gap by providing empirical data and insights into the psychological effects, potentially guiding future research endeavors in similar contexts. By identifying and understanding the psychological impact of trauma within single-parent households in a specific region in Kenya, the study can inform the development of tailored interventions and support programs that cater to the specific needs of these children from beyond. This can potentially enhance mental health outcomes and resilience in this population. Findings from the study may have implications for policies related to child welfare, mental health services, and family support programs in Kenya. Understanding the needs of children in single-parent households who have experienced trauma can influence policy decisions aimed at providing adequate resources and support structures.

Given Kenya's unique cultural, social, and economic aspects, the study's findings can provide insights into how these factors interact with childhood trauma and family structure. This understanding is valuable for culturally sensitive interventions and strategies. The study's findings may benefit mental health practitioners, counselors, and psychologists working with children exposed to trauma. Insights gained from this research can inform therapeutic approaches and strategies to address the psychological effects of trauma in single-parent household settings.

1.9 Scope of the Study

The scope of this study outlined the specific parameters and objectives that guided the research on the psychological effects of childhood trauma within the context of single-parent households in Bungoma County, Kenya. It delineated the boundaries and considerations necessary for conducting a comprehensive investigation while aiming to provide meaningful insights into the identified research area. The researcher focused on children who have single

parents, or separated parents. The age set for this study was the preschoolers/ primary and junior secondary aged 4-17. This is the age set where the behaviors of a child can be modeled and nurtured easily as part of the growth process as affirmed by Psychology theorists, other participants are teachers and single parents. The study considered socioeconomic status, cultural diversity, and geographical locations for diverse representation.

The study focused on specific psychological effects resulting from childhood trauma, such as behavioral changes, emotional regulation, cognitive functioning, and social interactions. Considered how these effects manifested and differed within single-parent households compared to two-parent households. The study identified and categorized different types of early childhood trauma, including abuse (physical, emotional, sexual), neglect, exposure to violence, loss of a parent, or other adverse experiences. Considered both the frequency and severity of traumatic events.

1.10 Delimitations

The study focused on specific regions or districts within Kenya due to logistical constraints, accessibility, or resource limitations. This could limit the generalizability of findings to other areas within the country. The study focused on a specific age group of children, mainly 4-17-year-olds due to developmental considerations or the relevance of trauma experiences within this age range. Excluding other age groups could limit the applicability of findings to younger or older children. The study might define single-parent households in a particular way about households with only one biological parent, excluding those with guardians or extended family members as primary caregivers. This delimitation helps maintain clarity but might exclude certain family structures.

The study focused on specific types of childhood trauma such as abuse, and neglect, and excluded other traumatic experiences related to community violence, and natural disasters, due to the specificity of the research question. This delimitation could restrict the comprehensiveness of the trauma experiences studied. By focusing solely on single-parent households, the study deliberately excludes comparisons with two-parent households. While this might allow for a more targeted analysis, it limits direct comparisons between different family structures.

The study was limited to a specific timeframe or historical context due to practical reasons or changes in societal factors. This delimitation may affect the relevance of findings beyond the specified timeframe. The study was also conducted within a specific language or cultural context, potentially limiting the generalizability of findings to other cultural or linguistic groups within Kenya. The study also had constraints related to sample size limitations or specific sampling techniques used, potentially impacting the representation of the population and the generalizability of results. Delimitations related to the chosen research methodology, such as constraints in data collection methods by reliance on self-reporting or data analysis techniques, might impact the depth or breadth of the study findings.

1.11 Limitations

The study may have suffered from sampling bias since the sample selection process did not represent the entire population of children from single-parent households in Kenya. Factors like limited access to certain communities or low participant response rates could contribute to bias. Findings from a specific region or a particular age group might not be universally applicable to all children from single-parent households in Kenya. Limited generalizability could arise due to regional differences, cultural variations, or the exclusion of certain age

groups. Reliance on self-reported data from children or caregivers could introduce recall or social desirability bias.

Additionally, participants may under-report or over-report traumatic experiences, affecting the accuracy of the data, while establishing a direct cause-and-effect relationship between childhood trauma and psychological effects could have posed challenges due to the complexity of factors influencing psychological well-being. Other variables, such as social support, resilience, or additional stressors, could also impact outcomes. Uncontrolled variables, such as socioeconomic status, cultural differences, access to resources, or prior psychological history, could confound the relationship between childhood trauma and psychological effects.

Ethical considerations regarding the sensitive nature of discussing traumatic experiences with children and ensuring their well-being might limit the depth or scope of data collection. Cultural differences and language barriers could impact the interpretation of psychological effects; as certain expressions or experiences might vary across different cultural contexts within Kenya. Limitations in time, funding, or resources could affect the scope of the study, sample size, or data collection methods, potentially impacting the thoroughness and comprehensiveness of the research. The study might focus on immediate or short-term psychological effects of childhood trauma, resulting in long-term effects on psychological well-being or development not being fully captured due to the study's timeframe. Qualitative data analysis methods might be subjective to interpretation, potentially leading to bias in identifying themes or patterns within qualitative data.

The study focused on Bungoma County as the selected schools' locational proximity would allow easier study and data collection, yet samples from this county may represent the

other 46 counties in Kenya. The amount of time allotted for the longitudinal research component which takes years had been limited. While a longitudinal study which is correlational by design would have been preferable in looking at variables over an extended period, this study was limited since its time frame fell within one year. For good data analysis, more than one year of research may not be possible, though necessary to acquire a sufficient sample and selection. There is a protocol approach to obtain data, particularly from schools of sampled children with various parental backgrounds, although in most cases the protocol is denied due to client/child confidentiality. Conflicts can also arise from parental background acceptance of research on their children who can be less engaged because of cultural bias and other personal difficulties.

1.12 Assumptions of the Study

It is important to note that while these assumptions are often based on observations or prevalent theories, individual experiences and circumstances can significantly vary, and not all children from single-parent households will have the same outcomes or responses to early childhood trauma. Additionally, various protective factors and interventions can mitigate the potential negative effects of trauma on children's psychological well-being. Children in single-parent households may be assumed to face increased vulnerability to psychological trauma due to the potential lack of emotional, financial, or social support compared to those in two-parent households.

The study also worked with the assumption that children raised in single-parent households might face challenges in forming secure attachments and healthy relationships due to potential disruptions in caregiving or family dynamics. It may be assumed that single-parent households, which often experience economic strains and time constraints, could create

stressors that impact a child's emotional and psychological well-being. Further, there were assumptions about children from single-parent households facing social stigma or identity issues in a society where traditional family structures are prevalent, potentially leading to feelings of isolation or self-esteem challenges. While recognizing the challenges, assumptions exist about the resilience and adaptability of children from single-parent households, suggesting that they might develop unique coping mechanisms and strengths to navigate adversity.

There would also be assumptions about a higher likelihood of academic struggles or behavioral challenges due to the stressors and potential lack of supervision or guidance in single-parent households. Likewise, assumptions might exist about increased risks of mental health issues, such as anxiety, depression, or behavioral disorders, due to the experience of early childhood trauma within single-parent households. Others might vary based on the cultural context and available community support systems, suggesting that the impact of early childhood trauma on children in single-parent households could differ based on these factors.

Seeking parental, guardians or school management consent was paramount to this study. The study targeted children at the age set of 4-17 years, who require an adult’s consent, also necessary for collection of concrete data via questionnaires or oral interviews. The importance and benefits of the study have to be explained to both the parents, school management, and the children targeted in the cohort. The ethical principle of no harm needed to be explained and complied with by a researcher to get confidence from the research cohorts. The characteristic of confidentiality of information collected has to be assured to the Participants involved in the study. Therefore, it was assumed that the respondents, both the

children, instructors, and parents or guardians were honest, and responded to the interviewers' questions appropriately.

1.13 Theoretical Framework

Two theorists whose work is correlated with the objectives of this research topic are included in this study.

1.13.1 Erikson's Stages of Psychosocial Development

One prominent psychological theorist who extensively explored the impact of early childhood trauma is Erik Erikson, a developmental psychologist and psychoanalyst. Erikson's psychosocial development theory emphasizes the critical role of early experiences and the social environment in shaping human development across the lifespan. Erikson's theory includes a stage known as "Trust versus Mistrust," (Infancy, 0-18 months) which occurs during the first year of life. In this stage, infants develop a sense of trust and security when their needs are consistently met by responsive and nurturing caregivers. Conversely, inadequate care or inconsistent responses may lead to mistrust and insecurity. Initiative vs. Guilt (Preschool, 3-5 years); Children begin to assert control over their environment and develop a sense of purpose.

In Kenya, where communal living and extended family support are common, the development of trust and autonomy in children might be influenced by the support and guidance from not only parents but also other family members and the broader community. Children's growth makes the stages of "Industry versus Inferiority" relevant. In Kenya, the emphasis on education and communal responsibilities may affect how children perceive their competence and capabilities within their cultural and educational systems. The way children navigate these challenges influences their self-esteem and sense of accomplishment.

1.13.2 Attachment Theory

John Bowlby's attachment theory is another significant framework that delves into early childhood trauma, Bowlby (1980), Bowlby emphasized the importance of a secure and affectionate attachment between infants and their primary caregivers. The theory highlighted how disruptions in this attachment, often due to trauma or neglect, can have profound and lasting effects on a child's emotional regulation, relationships, and mental health throughout their life. The long-term impacts of maternal neglect on a child or having limited time of attachment or motherly love impact children's attitudes and behavior. According to the Mother Deprivation Hypothesis, a child's intellectual, social, and emotional development is significantly impacted when a mother's relationship with her child is severed during infancy.

In the Kenyan context, where family and community bonds hold significant value, Bowlby's theory aligns with the emphasis on caregiving practices and the importance of close relationships. The traditional Kenyan family structure often involves extended families, where multiple caregivers, including grandparents, aunts, uncles, and older siblings, contribute to a child's upbringing. This communal approach to caregiving may influence the formation of multiple secure attachment figures for the child, contributing to their emotional security. Additionally, the cultural practices and values surrounding childcare, such as baby weaning, breastfeeding, and close physical contact between caregivers and infants, align with the principles of attachment theory. These practices foster a nurturing environment that supports the development of secure attachments between children and caregivers.

Both Erikson's psychosocial development theory and Bowlby's attachment theory can be related to the Kenyan context by considering the cultural, familial, and societal influences on the development of children. Understanding these theories within the framework of Kenyan

culture allows for a more nuanced perspective on how cultural practices and social contexts shape the psychosocial development and attachment experiences of children in Kenya. Both Erikson and Bowlby, among other theorists, have contributed foundational insights into understanding the effects of early childhood trauma and the critical role of early experiences in shaping an individual's psychological and emotional development.

1.14 Conceptual Framework

The conceptual framework laid out these theoretical foundations, explaining how these theories and perspectives would guide the examination of the psychological effects of early childhood trauma on children from single-parent households in Kenya. It also highlighted the significance of considering cultural nuances and contextual factors in understanding and addressing the complexities of this issue within the specific societal and familial structures present in Kenya. The conceptual framework for this study involved integrating various psychological and sociological theories, considering cultural, familial, and contextual factors specific to Kenya

The framework incorporated Attachment Theory to understand how early trauma within single-parent households could impact a child's ability to form secure attachments, affecting their emotional development and relationships in the long term. The conceptual framework emphasized the importance of considering Kenya's diverse cultural landscape. It would account for indigenous or culturally specific frameworks to understand how cultural norms, community support systems, and traditional beliefs influence the experiences and coping mechanisms of children facing early childhood trauma in single-parent households. By integrating the concept of resilience, the framework examined the strengths, resources, and coping mechanisms developed by these children within the context of single-parent

households, focusing on how these factors mitigated or exacerbated the psychological effects of early trauma.

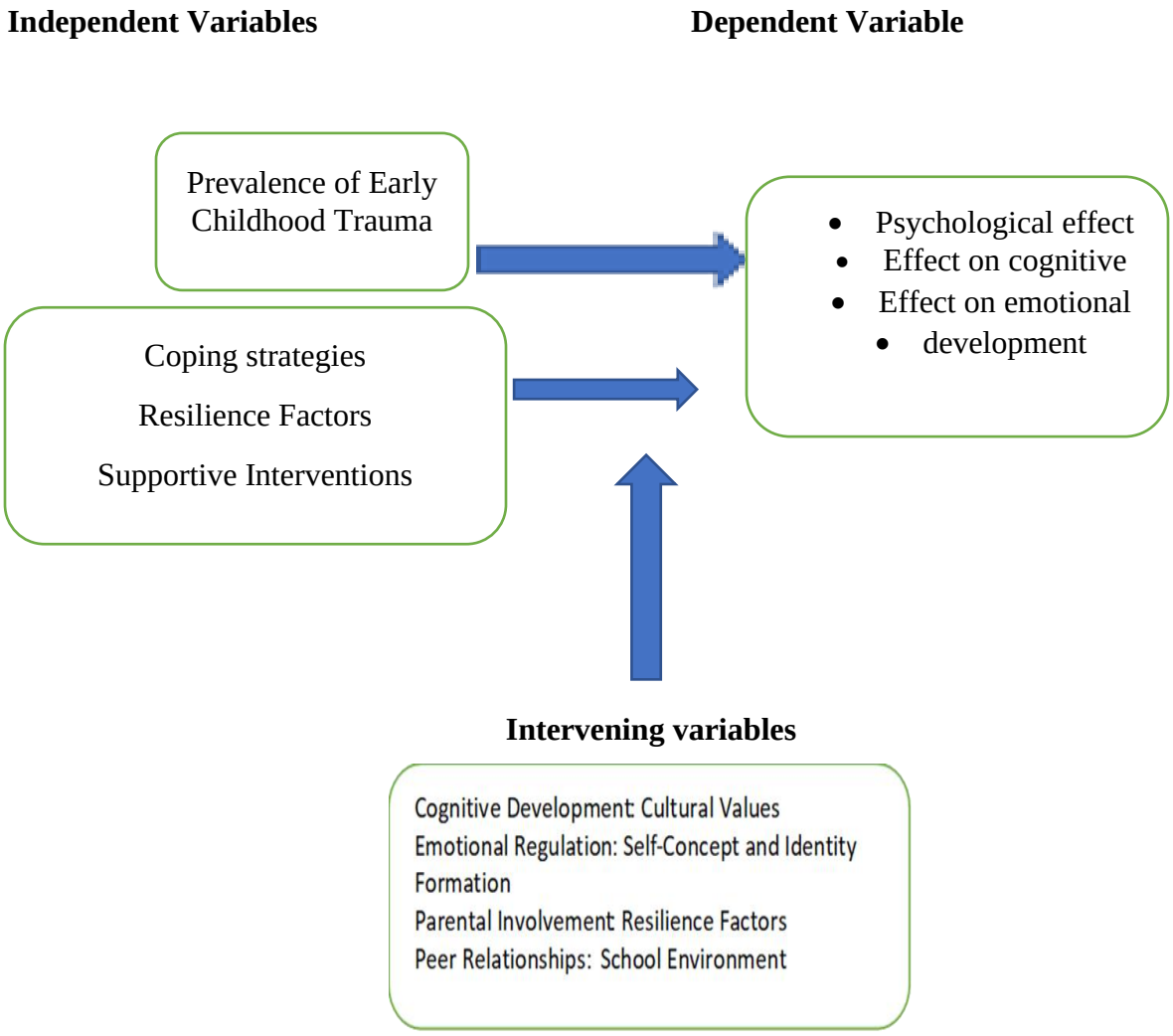

Figure 1: Conceptual Framework

Source: Researcher (2023)

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter gives an introduction before outlining a relevant review of the literature regarding early childhood trauma's psychological effects on children from single-parent households, in line with the study objectives. The literature is presented under both theoretical and empirical review, which is aligned to the objectives of the study. Lastly, a summary of the literature review is provided. Is provided.

The psychological well-being of children is significantly influenced by their early experiences, particularly when exposed to traumatic events during their formative years. In the context of Kenya, where single-parent households are prevalent due to various socio-economic and cultural factors, understanding the impact of early childhood trauma on children raised in such environments becomes imperative. This literature review aimed to explore and synthesize existing research and scholarly works about the psychological effects of early childhood trauma specifically within the context of single-parent households in a specified region of Kenya.

Theoretical frameworks, such as attachment theory and Erikson's Trust systems theory, have provided valuable lenses through which the study analyzed the intricate relationships between family structures, parenting styles, and the manifestation of early childhood trauma. Empirical studies explored the coping mechanisms employed by children in single-parent households, shedding light on their resilience and adaptability in the face of adversity. The study navigated through the literature, which discerned the contextual relevance of existing findings to the Kenyan socio-cultural landscape. This review set the basis for the subsequent

chapters, guiding the formulation of research questions and objectives that addressed the gaps in our current understanding. Ultimately, this endeavor sought to contribute to the development of targeted interventions and policies aimed at promoting the well-being of children in single-parent households in Kenya who had faced early childhood trauma.

Central to this review is an exploration of culturally relevant frameworks and contextual factors intrinsic to Kenyan society. Recognizing the diverse cultural tapestry of Kenya, this review investigated how cultural norms, traditions, and communal support systems intersect with the psychological impact of early trauma on children in single-parent households. Understanding these cultural dynamics was fundamental in comprehending the coping mechanisms, resilience, and potential vulnerabilities that children exhibited in response to early childhood trauma.

This literature review consolidated and critically analyzed empirical studies, scholarly articles, and theoretical frameworks that delved into the psychological effects of trauma on children in single-parent households within the Kenyan setting, as well as other regions. The focus was on elucidating the varied manifestations of trauma, including its effects on emotional development, behavioral patterns, cognitive functioning, and the overall psychological well-being of these children.

By synthesizing existing knowledge, this review sought to highlight gaps in current research, offered insights into effective interventions, and provided recommendations for policymakers, mental health professionals, educators, and community stakeholders. Ultimately, the aim was to contribute to the development of culturally sensitive and contextually relevant strategies that supported the psychological resilience and well-being of children facing early trauma in single-parent households in Kenya.

The exploration of early childhood trauma and its psychological effects on children within single-parent households in Kenya was grounded in the recognition of the intricate interplay between family structures and individual development. The study delved into the existing body of literature, with this chapter aiming to provide a comprehensive review of relevant studies, theoretical frameworks, and empirical findings that contributed to our understanding of the complex dynamics at play in this context. The literature review served as a critical foundation for identifying gaps, synthesizing knowledge, and contextualizing the current research within the broader field of child psychology and family studies.

Understanding the psychological implications of early childhood trauma requires a nuanced examination of the factors that shape children's experiences within the family unit. Single-parent households, characterized by the absence of one parent due to various circumstances, have become a focal point of scholarly inquiry. Researchers have explored the different challenges and benefits that diverse family arrangements have, recognizing the need for tailored interventions and support systems.

Studies have investigated the prevalence of single-parent households in Kenya, unveiling the socio-economic, cultural, and demographic factors contributing to their rise. Concurrently, an expanding body of literature has sought to unravel the multifaceted nature of early childhood trauma, recognizing its potential to exert a profound impact on children's cognitive, emotional, and social development.

The phrase "childhood trauma" is used to characterize the impact of traumatic experiences, such as sexual or physical abuse, neglect, domestic violence, or natural disasters, on a child's physical, cognitive, social, or emotional development. Childhood trauma has been linked to a wide range of detrimental impacts on people's mental and social welfare. Kenyan

single-parent households have several challenges, such as poverty, a lack of social support, and limited access to healthcare and education, which could make them more vulnerable to the negative effects of childhood trauma. A thorough understanding of childhood trauma, single-parent families, the psycho-social repercussions of childhood trauma, coping mechanisms, and interventions to lessen the negative effects of childhood trauma among single-parent families in Kenya are the goals of this research review. According to Thomsen & Wadsworth (2001), coping with stress during childhood and adolescence presents problems, progress, and opportunity.

Childhood trauma is a serious incident that can negatively affect children's psychological and emotional health for a very long time. Neglect, domestic dysfunction, and physical, emotional, or sexual abuse are examples of traumatic events. A variety of psychological and behavioral effects, including depression, anxiety, PTSD, substance abuse, and self-harm, may result from such encounters. The trauma inflicted during early life is particularly harmful since it may affect the developing brain, which may have adverse impacts on the child as they grow. Early-life traumatized children are more likely to struggle with emotional control, which can have negative effects on social skills, career security, and self-esteem, Turner, Shattuck, & Hamby (2015).

Single-parent families in Kenya are often more vulnerable to childhood trauma due to various factors, including financial insecurity, limited social support, and the stress associated with parenting alone. The financial stressors associated with single parenting can lead to neglect and abuse, which can further exacerbate the traumatic experiences of children. Lack of social support is another significant factor that can affect the psychosocial well-being of single parents and their children. Single-parent families often lack the necessary resources, including

time, to create a supportive network. Post-traumatic stress disorder (PTSD), anxiety, and depression are some of the negative psychological effects of parenting stress. Children and families who have experienced trauma require trauma-focused cognitive behavioral therapy, according to Cohen & Mannarino (2017).

2.2 Theoretical Literature Review

Early childhood trauma theorists have considerably advanced the field of psychology by exploring how early trauma affects a person's development, mental health, and general well-being. To design effective interventions and treatment strategies, professionals who work with children who have experienced trauma need to be aware of these beliefs. The two theorists whose work is relevant to the objectives of this research topic are included in this study. One prominent psychological theorist who extensively explored the impact of early childhood trauma is Erik Erikson, a developmental psychologist and psychoanalyst. Erikson's psychosocial development theory emphasizes the critical role of early experiences and the social environment in shaping human development across the lifespan.

According to Erikson's hypothesis, the first year of life is characterized by a stage known as "Trust versus Mistrust," or Infancy (0–18 months). When their needs are consistently satisfied by attentive and compassionate caretakers, newborns in this period grow a sense of trust and security. On the other hand, insufficient attention or uneven reactions can breed uneasiness and mistrust. Confusion about identity vs. roles in adolescence (ages 12 to 18) Early Childhood, 18 months; Autonomy vs. Shame and Doubt; This phase focuses on gaining independence and autonomy while learning to manage one's actions. When a child's attempts at independence are rewarded with support and encouragement, they gain confidence. In the Initiative vs. Guilt (Preschool, 3-5 years) stage, children start to take charge of their

surroundings and find their purpose. Encouragement from caregivers fosters initiative, while excessive criticism may lead to guilt.

Industry vs. Inferiority (ages 6 to 11); The focus is on mastering activities and skills; competency is built via education and interpersonal interactions. Lack of support or recognition may cause feelings of inferiority. Confusion about identity vs. roles in adolescence (ages 12 to 18) To find their identity and direction in life, adolescents investigate their identities, values, and beliefs. A good resolution leads to a distinct sense of self, whereas misunderstanding may result in a murky view of oneself. The fundamental premise of Erikson's theory is that each stage of life presents a unique psychosocial crisis or conflict that an individual must successfully navigate. These crises emerge as a result of the interplay between a person's biological development, social interactions, and cultural influences.

In Kenya, where communal living and extended family support are common, the development of trust and autonomy in children might be influenced by the support and guidance from not only parents but also other family members and the broader community. As children grow, the stage of "Industry versus Inferiority" becomes pertinent. In Kenya, the emphasis on education and communal responsibilities may affect how children perceive their competence and capabilities within their cultural and educational systems. The way children navigate these challenges influences their self-esteem and sense of accomplishment.

Early childhood trauma, such as neglect, abuse, or disrupted attachment, can significantly impact a child's ability to develop trust and form secure attachments. This disrupted trust can have far-reaching effects on the child's emotional, social, and psychological well-being as they grow and navigate subsequent stages of development.

John Bowlby's attachment theory is yet another significant method for examining childhood trauma. Bowlby emphasized the importance of young children and their primary caregivers developing a secure and caring relationship. He stressed how interruptions in this connection, which are usually brought on by trauma or neglect, can have a dramatic and long-lasting influence on a child's emotional control, relationships, and mental health throughout their lives. The attitudes and behavior of a child are affected over time by maternal neglect, lack of maternal affection, or lack of bonding time. According to the Mother Deprivation Hypothesis, a child's intellectual, social, and emotional development is significantly impacted when a mother's relationship with her child is severed during infancy.

In the Kenyan context, where family and community bonds hold significant value, Bowlby's theory aligns with the emphasis on caregiving practices and the importance of close relationships. The traditional Kenyan family structure often involves extended families, where multiple caregivers, including grandparents, aunts, uncles, and older siblings, contribute to a child's upbringing. This communal approach to caregiving may influence the formation of multiple secure attachment figures for the child, contributing to their emotional security.

Additionally, the cultural practices and values surrounding childcare, such as baby weaning, breastfeeding, and close physical contact between caregivers and infants, align with the principles of attachment theory. These practices foster a nurturing environment that supports the development of secure attachments between children and caregivers.

Among other theories, Erikson and Bowlby have made fundamental contributions to understanding the impacts of early childhood trauma and the crucial role that early experiences play in influencing a person's psychological and emotional development. However, there are weaknesses in these theories; Erikson's theory is more descriptive than explanatory, and some

stages lack robust empirical evidence to support their universality or sequential nature across all cultures or individuals. The theory's stages were initially developed based on observations within Western societies, which might limit its applicability and relevance to individuals from diverse cultural backgrounds. The theory's rigid age-related stages might not adequately represent the experiences or developmental trajectories of individuals who do not conform to the expected timelines or experiences described in each stage.

Attachment Theory heavily focuses on the impact of early caregiver-child relationships on later development, potentially underestimating the influence of later experiences and relationships in shaping an individual's behavior and attachments. The theory was primarily developed based on studies in Western cultures, which might limit its applicability across diverse cultural contexts. The theory may not fully account for cultural variations in parenting styles and societal norms. Historically, Attachment Theory primarily concentrated on the mother-child relationship, potentially overlooking the significance of other caregivers or family dynamics in shaping attachment patterns. These theorists and their contributions have greatly influenced our understanding of how early childhood trauma can shape an individual's psychological, emotional, and social development. Their research has helped inform therapeutic approaches and interventions to support individuals who have experienced early trauma.

Both Erikson's psychosocial theory and Bowlby's attachment theory can be related to the Kenyan context by considering the cultural, familial, and societal influences on the development of children. Understanding these theories within the framework of Kenyan culture allows for a more nuanced perspective on how cultural practices and social contexts shape the psychosocial development and attachment experiences of children in Kenya. Both

Erikson and Bowlby, among other theorists, have contributed foundational insights into understanding the effects of early childhood trauma and the critical role of early experiences in shaping an individual's psychological and emotional development.

2.3 Empirical Review

2.3.1 The Prevalence and Types of Early Childhood Trauma

This relates to the first objective of the study, which seeks to examine the prevalence of different types of early childhood trauma experienced by children in single-parent households in the Kanduyi sub-county, Bungoma County of Kenya. Generally, trauma is an abnormal emotional response to an experience in an event that is deeply distressing or disturbing, such as rape, tragedy, or natural disaster. Children often experience shock and denial after an occurrence. Unpredictable emotions, flashbacks, strained relationships, and even medical problems are longer-term effects (Leavey & Gerard, 2018).

Additionally, emotional abuse and neglect are the most frequent causes of childhood trauma, (Churchill & Gillian, 2015). The long-term health repercussions of neglect on children also include stunted growth, extra weight, and untreated medical disorders (Vos, 2012). If childhood trauma is not identified and handled properly, there could be serious repercussions. Children who have experienced trauma or who have been abused exhibit an intensified stress response. Young children who suffer trauma are more likely to engage in undesirable behavior that will later affect their personalities, especially those who are raised by a single parent (Kail & Robert, 2011).

Childhood trauma has been related to several negative effects on children's physical, cognitive, social, and emotional development. Studies show that traumatized children are more likely to grow up with mental health problems like depression, anxiety, and post-traumatic

stress disorder (PTSD). Children's social and emotional development may be negatively impacted by childhood trauma, which can result in poor social skills, low self-esteem, and relationship issues. Children between the ages of 4 and 17 are affected by seeing or hearing, Harmer and Sanderson (1999). Home, school, or community violence; terrorism, war, or other forms of extreme adversity; emotional abuse; poverty; the untimely death of a loved one; the sudden and serious medical condition can have negative effects on a child and result in personality problems.

According to Pearce et al. (2019), traumatic reactions can manifest in a variety of ways, such as intense and persistent emotional upset, anxiety or depressive symptoms, behavioral changes, problems with self-control, difficulty connecting with others or forming attachments, regression, loss of previously acquired skills, or attention on academics. Pearce et al. (2019) completed a comprehensive review of the literature on trauma-informed therapy for children and teens who have experienced severe trauma in 2019. The study's goals were to identify effective interventions and highlight areas that required further investigation.

The psycho-social effects of childhood trauma may manifest in children's mental health, social relationships, and academic performance. According to studies, children who suffer trauma are more prone to face mental health issues like PTSD, sadness, and anxiety. Additionally, childhood trauma has been connected to interpersonal problems, a lack of social skills, and low self-esteem. Children who have gone through childhood trauma may also struggle in school since they find it difficult to concentrate, recall, and pick things up.

According to Clark and Hamplová (2013), a Kenyan woman has a 59.5% probability of becoming a single mother by the time she is 45, either as a result of premarital birth or the breakdown of a partnership, according to the Pan African poll conducted in 2012. The study

referenced by Clark and Hamplová (2013) was conducted in Kenya. The Pan African poll they refer to was a survey conducted in several African countries, including Kenya, by the Gallup World Poll 2012. The survey was designed to gather data on a range of social and economic issues, including family structure and dynamics. The study also found that roughly 30% of Kenyan women give birth before marriage. Indeed, teenage pregnancies persisted during the period of the coronavirus pandemic.

Kenya had one of the highest rates of children born to unmarried mothers between the ages of 15 and 49 in the region when compared to her African nations. By the time they are 45, 60% of women will have had children outside of marriage. Divorce, breakups, desertion, widowhood, domestic violence, rape, single-person births, and single-person adoption are a few of the scenarios that could lead to single parenthood. A longitudinal investigation is required to fill in the gaps in the aforementioned data before reaching this conclusion. The effects of Corona were broad, so it is possible that the poll's findings and analyses do not correctly represent single parenthood in Kenya. A single-parent family is one with only one parent in charge and children.

The work-life challenges that sum up to being unable to provide for the children's fundamental requirements are the issues single mothers encounter in society that contribute to or precipitate child trauma. Parenting has never been more difficult, yet the shame associated with single parenting makes children more likely to rebel. The single parent's way of life may include drug use and open dating before having children with different partners. The majority of single mothers, especially working single mothers, are completely beyond parenthood, which accounts for the discourse of shame, blame, and responsibility.

There are emotional difficulties, financial pressures, time constraints, and fatigue for single parents. In the book "McGraw-Hill Higher Education," Brooks (2012) makes the case that the stressors associated with parenting that single-parent families must deal with vary based on social contact, financial capacity, and lifestyle. The most frequent issues are finances, time commitments, and issues related to raising children. Having less money, spending less time with loved ones, being overworked and multitasking, having bad sentiments, disciplining children, and having behavioral issues are the challenges faced by single-parent families.

Abuse, which can take the form of physical abuse, sexual abuse, emotional or psychological abuse, and neglect are common types of early childhood traumatic events. The purposeful injury or mistreatment of a child by a parent, caregiver, or another person in a position of trust and authority is referred to as abuse in the context of early life. The child's physical, emotional, and psychological well-being is significantly and permanently harmed by this form of abuse, which can be physical, emotional, sexual, or neglectful.

Physical abuse is the intentional act that harms or injures a child physically. This includes harming the child physically, whether through beating, punching, kicking, slapping, burning, or other methods. Physical abuse can leave scars or bruises on the body as well as psychological effects that last a lifetime. Sexual abuse on the other hand entails performing sexual acts on a child or exposing them to sexual material that is unsuitable for their stage of development. This can include both non-contact behaviors such as indecent exposure or exposing the youngster to graphic literature and contact behaviors such as molestation, rape, or other types of sexual assault.

A child's emotional development and mental health can be seriously harmed by acts or behaviors that are considered emotional or psychological abuse. Constant criticism,

denigration, humiliation, rejection, or manipulation are examples of this. The ability of a youngster to develop healthy connections and feel confident in themselves can all be negatively impacted by emotional abuse. Also affecting the child's emotional and psychological would be neglect. This occurs when a parent or other adult does not meet a child's fundamental requirements, such as enough food, shelter, clothes, supervision, medical attention, and emotional support. The child may experience delays in their physical, emotional, and cognitive growth as a result of persistent or severe neglect.

Loss or separation in the context of early childhood refers to experiences where a child is separated from or loses a significant attachment figure, such as a parent, guardian, sibling, or caregiver. These separations can occur due to various circumstances, including death, divorce, parental incarceration, foster care placement, migration, or other life events that disrupt the child's sense of stability and connection with a primary caregiver.

Natural disasters and accidents are events that can also have a profound impact on young children during their early development. These events are unpredictable and can cause physical, emotional, and psychological harm to children and their families. Understanding how natural disasters and accidents affect young children is crucial for providing appropriate support and assistance to help them cope and recover. Similarly, community violence, which is a form of violence that occurs within a community or neighborhood, affecting its residents, institutions, and overall social fabric can also result in trauma. This type of violence can manifest in different forms, including physical, psychological, or structural, and is often associated with factors such as poverty, social inequality, gang activity, drug trafficking, and a lack of social support and resources. Communal violence trauma impacts on child's development.

Another source of trauma would be medical trauma. This is the psychological and emotional distress experienced by a child as a result of their interactions with the healthcare system, medical procedures, diagnoses, treatment, or hospitalization. This trauma can occur due to a range of experiences, from receiving distressing medical news to undergoing invasive procedures, and it can have lasting effects on a child's mental and emotional well-being.

War or conflict between nations, groups, or individuals, often involving force, violence, and military operations can also be traumatic to children. These conflicts can range from localized disputes to large-scale wars involving multiple nations and have significant social, economic, political, and humanitarian consequences, particularly for children. Wars and conflicts have shaped the course of history and continue to impact societies and individuals in various ways. A Case of Israel's war versus Hamas from 0ctober 2023 to date has seriously impacted negatively and caused trauma to children, and thousands of these children killed in this region.

Pearce and Murray (2019) assert that trauma alters the brain to varying degrees, leading to cognitive decline and emotional dysregulation. A few of these problems include difficulty focusing and paying attention, learning disabilities, low self-esteem, inadequate social skills, and sleep disturbances. When children aged 4–17 years old are exposed to a horrific, dangerous, violent, or life-threatening circumstance, trauma occurs. If a child sees the other person being harmed or injured or learns about it from others, they could also be affected by this type of incident. According to a basic study, infants as young as five months old can recall being startled by a stranger three weeks prior. The infants later recall upsetting events despite not being able to talk at the time.

According to Halligan and Grossman (2001), "Single parenting related to adverse experiences and own traumatic events, such as own poor personal relationship; parental PTSD, and cortisol excretion, raises the likelihood of PTSD and childhood trauma in children under such guardianship." Normally, single parents prioritize their careers, rather than meeting their children's fundamental requirements at the expense of their children's emotional needs. Compared to their counterparts who grew up in married-couple families, children of single mothers are at the following well-known risks: fewer high school graduates, poorer college attendance and graduation, more criminality, and greater incarceration rates are the results of decreased academic achievement, increased behavioral problems, and school suspension, (Murray & Larkin, 2019).

In Kenya, the prevalence of single-parent families, particularly those headed by women, has been a subject, and the prevalence of single-parent families, particularly those headed by women, has been a subject of academic inquiry. A study by Nyambedha et al. (2013) examined the experiences of single mothers in Western Kenya and found that they faced significant economic hardships, often struggling to provide for their children's basic needs. The study highlighted the impact of poverty on these families, with implications for the children's nutrition, health, and overall well-being. In Kenya, a typical problem single-parent households face is a dearth of social support. A study by Atwoli et al. (2015) explored the mental health implications of single parenthood in a Kenyan urban setting and identified social isolation as a key factor contributing to psychological distress among single mothers. The study emphasized the need for targeted interventions to address the social support needs of single-parent families, particularly those headed by women.t of academic inquiry. A study by Nyambedha et al. (2013) examined the experiences of single mothers in Western Kenya and

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2.3.2 The Psychological Impact of Early Childhood Trauma

Under this objective, the researcher sought to investigate the psychological impact of early childhood trauma on the cognitive and emotional development of children raised in single-parent households in Kanduyi sub-county, Bungoma County of Kenya. Copeland et al. (2007) state that traumatic experiences cause intense emotions and physical reactions that might last for a long time after the occurrence. Emotional trauma experienced throughout childhood commonly externalizes or internalizes stress responses, which can result in extreme depressive, anxious, or aggressive behavior. Children may experience panic, helplessness, or horror in addition to physiological reactions such as heart palpitations, vomiting, or a lack of bowel or bladder control. Their emotional reactions could be abrupt or erratic.

When a child experiences a distressing situation again, they may exhibit avoidance, anger, grief, or shaking. Critical developmental processes that take place in children before the age of three might be severely hampered by trauma. Child traumatic stress hurts learning, which results in worse grades and more suspensions and expulsions. Other detrimental impacts

include the early development of language, mobility, physical and social skills, and emotion management, as well as relationships and attachments with parents.

Being raised in an unstable home, by an emotionally absent parent or guardian can lead to a life of unstable connections, a string of failed relationships, emotional neediness, an inability to self-regulate and provide for oneself, and identity instability. The child may reside in an unsanitary or unsafe physical environment without access to heat, electricity, running water, or sewage disposal. The house might need routine maintenance. The second body instability is caused by the physical interactions that occur between family members.

According to Harmer et al. (1999), a child who has been neglected by either parents or guardians will exhibit signs and symptoms like slow growth, excess weight, medical conditions that are not being adequately treated, poor personal hygiene, a lack of clothing or supplies to meet physical needs, participation in hoarding or food stealing, and a poor attendance record at school. The child may also feel empty and think, "Since I don't know who I am or what my mission is, I won't be loved or disappointed if I put my trust in someone." There may be worries about dependence and a lack of ability to properly define oneself. Adults who experienced emotional maltreatment as children display such traits.

A Marulli (2021) study suggests that a child who lacks parental love or affection shows signs of self-isolation and cannot establish a strong bond with others if they are around people who don't provide them with the usual care and attention. This could result in attachment disorder, a condition that manifests in isolation. For whatever reason, babies and young toddlers in foster care who have endured abuse or neglect have been taken away from their parents and frequently suffer as a result. Szellner (2022) asserts that behavior is communication, and it is not uncommon for children to use behavior to communicate.

Sometimes, children act in ways that feel like a rejection of their parents. In these moments, it is important to remember that children need love, assurance, and validation. Understanding the root of the child's behavior can make it easier for parents to help them.

Glass (2019) contends in writings under the title "ReachOutRecovery" that children who do not grow up in secure, loving, polite, and consistent environments end up feeling very uncomfortable and untrusting. As a result, they frequently struggle to trust themselves and others throughout their lives. With a hostile or overly critical mother or one who lacks emotional stability, the child learns that trust is transitory and cannot be relied upon in relationships. Unloved children struggle to trust in any connection, but friendships are particularly difficult for them. A child of an unloving mother will be emotionally aloof, reserved, unreliable, or even harsh, and will learn various lessons about the outside world and self. Likewise, children without loving parents usually feel more aggressive, violent, and antisocial and have poorer self-esteem. There is a connection between parental love and children's success and happiness.

Natasha (2020), in an article on “Parenting Family, Therapy” explains emotionally unavailable parents as those who often display emotional instability, psychological rigidity, self-centeredness, the driven parent type, passivity, and emotional distance toward their children. They are also unable or unwilling to show empathy or emotional awareness toward them. Inner child wounds, also known as attachment wounds, appear in a child raised by an emotionally unavailable parent and are brought on by either a catastrophic event or a chronic rupture that goes unrepaired. A rupture that cannot be repaired can appear to children as their cries for assistance being ignored by an emotionally unavailable mother or caregiver.

Children who spend time with stressed-out, irate parents find it difficult to concentrate, play well with other children, and develop shy, fearful, rude, or violent behavior. They may also have difficulties falling asleep. Mothers who are emotionally cold or distant may not recognize their children's needs. They could act indifferent and disengaged when interacting with the child or flatly reject the child's advances. Children who do not feel connected to their parents are more aggressive, violent, and antisocial.

According to Vasundhara (2022), to start the tie and attachment, there must be a relationship between parental love and children's success and contentment. This study shows that adolescents with absent parents typically have lower self-perceptions of their behavior and campus life, including being more likely to be tardy for class, less likely to receive praise from the principal, and having difficulties with class integration and socializing with other students. These repercussions of parental absence in childhood.

"When a child experiences trauma from a parent, they stop loving themselves, not the parent," (Maisie, 2011). Childhood trauma affects a child's behavior: Children who experience high-stress symptoms typically have difficulty managing their emotions and conduct. They can be extremely sentimental, cautious in strange environments, easily scared, hard to console, or violently impulsive. In addition, they could find it difficult to build lasting connections and deal with intense anxiety, hopelessness, or dread of terrifying dreams, flashbacks, or recollections, and gradually avoid objects that bring up recollections of the interaction.

According to Nater (2010), trauma can still affect an adult and result in remorse and humiliation, a feeling of being cut off from others and a lack of empathy, problems with emotion regulation, increased anxiety and despair, and fury. Depression, substance use disorder, anxiety, eating disorders, and other adult-onset mental health issues have all been

substantially connected to childhood trauma. Adults who have traumatic experiences as children may also struggle with relationships, have a variety of health issues, suffer from low self-esteem, or lack direction. Unresolved childhood trauma increases an adult's likelihood of developing PTSD, committing suicide, and other adverse effects.

In a book, Harris (2021) elaborates on the consequences of unresolved childhood trauma. A child's personality is altered by trauma: A person's mood may change after experiencing a stressful scenario or witnessing an upsetting incident. These behavioral alterations could be the result of a mental health disorder like anxiety, a feeling of worry, or trepidation about a situation.

Single-parent families in Kenya are characterized by a single parent, typically a mother, who is responsible for raising children. This family structure is associated with various challenges, including poverty, lack of social support, and limited access to healthcare and education. Research indicates that single-parent families are more likely to experience financial difficulties, emotional stress, and social isolation, which can have implications for the well-being of the children in these families.

Access to healthcare and education is another concern for single-parent families in Kenya. Research by Mbagaya and Odhiambo (2017) highlighted the barriers faced by single mothers in accessing healthcare services for themselves and their children, often due to financial constraints and lack of social support. Similarly, limited access to education for the children of single-parent families has been documented in studies by Omondi and Oloo (2018), underscoring the need for policies and programs to address educational disparities and promote equal opportunities for all children, regardless of family structure.

In conclusion generally, Brooks (2012), in the article "McGraw-Hill Higher Education, the Process of Parenting," argues that stressors faced by single-parent families vary depending on social interaction, financial capabilities, and lifestyle. The most common problems are related to finances, time commitments, and issues with raising children; there is never enough of the first two problems and too much of the third; single parents tend to have poor emotions and struggle to establish discipline in their children, which results in a child or children developing negative behavioral disorders.

Single parents also tend to have less money, less time with loved ones, work overload, and multitasking; and they tend to have bad emotions and issues with discipline in their children. Relationship issues in single-parent families, difficulties in holding on to the children, the effects of parental conflict that has persisted, fewer opportunities for family time, effects of divorce on children's academic performance, disruptions in interactions with extended family, and peer connections all contribute to the child becoming distant and failing to form attachments.

In Kenya, single-parent families in Kenya, particularly those headed by women, encounter a range of challenges, including poverty, lack of social support, and limited access to healthcare and education. These challenges have implications for the well-being of both the single parents and their children, highlighting the need for targeted interventions and supportive policies to address the unique needs of single-parent families in the Kenyan context.

2.3.3 Coping Mechanisms

The researcher further sought to identify coping mechanisms employed by children in single-parent households in the Kanduyi sub-county, Bungoma County of Kenya, to mitigate the psychological effects of early childhood trauma. Children of single parents who have experienced early trauma may employ a variety of coping strategies to navigate their

circumstances and mitigate the impact of their early traumatic experiences, Luthar & Becker (2000). It is important to recognize that each child is unique, and coping strategies may vary based on the child's personality, age, the nature of the trauma, and the support systems available to them, Werner & Smith (1982). Children may seek support from friends, teachers, extended family, or counselors. Building a strong support network can help them express their feelings and find emotional comfort as would be developing resilience which involves adapting and bouncing back from challenges. Children may develop resilience by cultivating a positive outlook, setting achievable goals, and maintaining hope despite adversity, Luthar & Becker (2000).

Expression of their emotions by encouraging children to express their emotions through art, writing, or talking can help them process and cope with their traumatic experiences. Creative expression provides an outlet for their emotions and allows for healing. Educational pursuits, such as focusing on education and academic achievements can serve as a distraction and a source of hope for the future. Children may find solace and purpose in excelling academically and setting and achieving goals related to their education, Masten, (2001).

According to Masten (2001), engaging in physical activities and participating in sports, exercise, or outdoor activities can be a healthy coping mechanism. Physical activities can help reduce stress, anxiety, and depression while promoting overall well-being. Practicing mindfulness and relaxation techniques: teaching children mindfulness, deep breathing, meditation, or yoga techniques can help them manage stress and anxiety, allowing them to stay present and calm in challenging situations. Connecting with siblings and peers who build strong bonds or forming friendships with peers who have experienced similar challenges can provide emotional support and understanding, reducing feelings of isolation. Therapeutic

interventions offered by professional counselors who provide therapy sessions can provide a safe space for children to explore and process their traumatic experiences, learn coping strategies, and develop resilience, Werner & Smith (1982).

A regular daily schedule helps give children stability and predictability, which helps them feel secure and normal for the rest of their lives. Allowing the children to engage in hobbies and interests, by pursuing hobbies and interests that bring joy and fulfillment can provide an outlet for creativity and passion, enhancing the child's overall sense of well-being. Advocating for themselves through or by teaching children self-advocacy skills, assertiveness, and effective communication can empower them to express their needs, seek help, and protect themselves.

According to Werner & Smith (1982), encouraging children to reach out to mental health professionals for specialized support and guidance is crucial. Professional help can aid in processing trauma and developing healthy coping mechanisms. Supportive, loving, and nurturing environments, along with access to appropriate resources and professional assistance, are fundamental in helping children of single parents who have experienced early trauma develop effective coping strategies and thrive despite their past experiences.

2.3.4 The Role of Support Systems

The study also aimed to assess the role of support systems in buffering the psychological impact of early childhood trauma, Lang & Vanderploeg (2015), Child Health and Development Institute of Connecticut, Inc. (2017, March).

Interventional models for addressing children's traumatic experiences provide appropriate support, therapy, and healing to help them recover from trauma, Scheeringa & Zeanah (2001). These models vary based on the type and severity of the trauma, the child's age and

developmental stage, and the resources available. Here are several commonly used interventional models:

According to Clarkson Freeman (2014), Trauma-informed care is an approach that recognizes the widespread impact of trauma and emphasizes creating a safe and supportive environment for children. It involves understanding the effects of trauma on behavior and implementing strategies to promote healing, resilience, and empowerment, (Perry,2002).

According to Fletcher (2003), Cognitive-behavioral therapy (CBT) is widely used to help children cope with trauma. It focuses on identifying and challenging negative thought patterns and behaviors associated with trauma, providing coping strategies, and promoting emotional regulation and resilience.

Play therapy allows children to express themselves through play, it helps them process traumatic experiences and emotions. Various play techniques used by Therapists help children communicate and work through their trauma in a safe and supportive environment, Chu & Lieberman (2010).

Eye Movement Desensitization and Reprocessing (EMDR) is effective in treating trauma by helping children process distressing memories and emotions associated with the trauma. It involves guided eye movements while recalling the traumatic experience, facilitating the brain's natural healing process, Shonkoff & McEwen (2009).

Narrative therapy helps children reframe and reconstruct their traumatic experiences into a coherent narrative, empowering them to create a more positive and empowering interpretation of their lives, Rothschild (2000).

Art therapy utilizes creative expression through art to help children communicate and process their traumatic experiences. It provides a non-verbal outlet for emotional expression and healing, Rothschild (2000).

The attachment-based Therapy approach focuses on strengthening the child's attachment with caregivers and helping them develop secure relationships, which is crucial for healing from trauma and building resilience Rothschild (2000).

Mindfulness-based Intervention practices, including mindfulness meditation and mindful breathing, can help children manage stress, anxiety, and trauma symptoms by promoting self-awareness and emotional regulation.

Parent-Child Interaction Therapy (PCIT) involves coaching parents to improve their relationship with their child, enhance parenting skills, and provide a nurturing and secure environment, which is vital for children recovering from trauma Rothschild (2000).

School-based interventions involve creating trauma-sensitive schools, training educators to recognize signs of trauma, and implementing supportive programs and practices within the school environment.

Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT) is specifically designed for children who have experienced trauma. It combines cognitive-behavioral techniques with components addressing trauma and the child's emotional well-being, Gaensbauer (2002).

Sensory integration therapy helps children who have experienced trauma regulate their sensory responses, which can be disrupted due to trauma, by using sensory activities to promote self-regulation and coping skills. Tailoring interventions to the unique needs and experiences of each child is essential for effective trauma recovery. Multidisciplinary approaches,

collaboration between professionals, and involvement of caregivers and the community are critical elements of successful intervention models for children who have experienced trauma.

2.4 Summary

Research has shown that early childhood trauma can lead to significant changes in brain function, resulting in a range of emotional and cognitive challenges. Pearce and Murray (2019) highlight that trauma can cause emotional dysregulation and cognitive impairments, leading to issues such as difficulties with focus and attention, learning disabilities, low self-esteem, poor social skills, and sleep disturbances. These effects can extend into longer-term impacts, including unpredictable emotions, flashbacks, strained relationships, and health problems, as discussed by Gerard and Leavey (2018).

Churchill and Gillian (2015) identify emotional abuse and neglect as primary causes of childhood trauma. Vos (2012) adds that neglected children may experience stunted growth, excessive weight, and untreated medical conditions. Brooks (2012), in "The Process of Parenting," argues that single-parent households face various stressors due to social interactions, financial constraints, and lifestyle challenges, which can exacerbate the impact of trauma on children in these households.

Single parents commonly face issues related to financial constraints, spending less quality time with their children, and persistent worries about child-rearing. They often deal with overwork, multitasking suppressed negative emotions, difficulties in disciplining children, and behavioral problems in both children and themselves. Children’s academic performance can suffer due to parental conflicts, lack of quality time together, and the effects of divorce or separation. Additionally, single parents may struggle with maintaining relationships, accepting new partnerships, and dealing with extended family relationships.

Maisie (2011) highlights the psychological impact of parental trauma on children, noting that children may stop loving themselves instead of their parents, a phenomenon linked to the lack of a father figure. Childhood trauma can lead to difficulties in self-control, heightened sensitivity, fearfulness, and aggressive tendencies. It also contributes to anxiety issues, such as phobias, and makes it challenging for children to form lasting bonds due to intense fear, worry, or despair.

Childhood trauma is most commonly caused by emotional and physical abuse or neglect. Additional factors include separation from a parent or caregiver, sexual abuse, and other stressful situations. The delayed effects of trauma can include chronic fatigue, sleep disturbances, nightmares, fear of recurrence, anxiety from flashbacks, depression, and avoidance of anything associated with the traumatic event. Unresolved childhood trauma can have long-lasting effects on adulthood. According to Harris (2021), adults with unresolved childhood trauma may struggle with relationships, suffer from various health issues, have low self-esteem, and lack direction. They are also at increased risk of developing PTSD, committing suicide, or self-harming. Traumatic experiences in childhood can significantly alter a person's personality, leading to changes in attitude following distressing events. Unresolved trauma caused by a parent or guardian heightens the likelihood of developing mental health issues such as PTSD, anxiety, and depression. Physical symptoms, such as cardiovascular problems including high blood pressure, strokes, or heart attacks, may also manifest later in life. Children experiencing cognitive symptoms of unresolved trauma might have dreams or flashbacks of the traumatic event. They may also suffer from mood swings, confusion, and disorientation, making it difficult to perform everyday tasks.

2.5 Research Gap

In exploring the psychological effects of early childhood trauma on children from single-parent households in Kenya, several research gaps existed within the body of literature. Limited research might address the nuanced cultural factors unique to Kenya that influence the experience of childhood trauma within single-parent households. Understanding how cultural practices, beliefs, and community support systems impact the psychological effects of trauma on children in this specific context is essential. There might be a scarcity of longitudinal studies tracking the long-term psychological outcomes of children from single-parent households who have experienced early trauma. Such research could provide insights into how these experiences manifest in different developmental stages and adulthood.

Research might not adequately address the intersectionality of factors such as gender, socioeconomic status, rural-urban divide, and ethnic diversity within single-parent households in Kenya. Exploring how these intersecting identities influence the psychological effects of trauma on children is crucial. There may be a lack of comprehensive studies evaluating the effectiveness of interventions or support systems aimed at mitigating the psychological impact of early childhood trauma within single-parent households in Kenya. Understanding which interventions are culturally appropriate and effective in this context is essential for informing policy and practice.

Limited research might explore the coping mechanisms and support networks available to single parents in Kenya and how these resources influence children's resilience and recovery from trauma. The impact of early trauma on children's educational attainment, school performance, and behavioral issues within the specific context of single-parent households in Kenya may be an underexplored area. There might be a gap in understanding the accessibility

and utilization of mental health services for children in single-parent households who have experienced trauma. Investigating barriers to accessing mental health support and strategies to improve access is crucial.

Addressing these research gaps provided a more comprehensive understanding of the psychological effects of early childhood trauma on children from single-parent households in Kenya and informed targeted interventions and support systems tailored to the specific needs of this population.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter describes the research methodology used in the study. It outlines the research design, analysis, target population, study location, sample size, and sampling methods applied. The chapter also describes the research instruments, as well as the reliability and validity of the instruments. It further details the data collection methods and procedures, data management, and data analysis in line with the variables described in the previous chapter. Ethical considerations taken during the study are also discussed in this chapter.

3.2 Research Design

This research was guided by the mixed methods approach, combining quantitative and qualitative data collection and analysis so as to achieve a detailed understanding of the research questions, as well as to explore each variable while establishing their interactions where present. The researcher opted to use the mixed method approach as it would enable them to enables the researcher to benefit from having the strengths of both approaches, while at the same time having each compensate for the weakness of the other. Towards achieving this end, the study used questionnaires and standardized psychological assessment tools to address the quantitative part of the research, and in-depth interviews for the qualitative data.

The study survey was conducted using a cross-sectional design. This was suitable because the targeted respondents were residents of close neighborhoods and common schools and therefore largely known to each other. This enabled the researcher to administer the survey instruments and carry out the interviews within the location of the study in a quick, efficient, and cost-effective manner as extended periods of study were not necessary. The design also

allowed for a non-random selection of study participants who would then be processed to ensure they met the set criteria for inclusion before being recruited into the study.

3.3 Research Site

The study was conducted in 10 public primary schools in Kanduyi Constituency, Bungoma County in, the western region of Kenya. The 10 schools were selected based on geographical spread, with 5 being situated in an urban area and the other 5 were schools in rural areas. The spread was intended to give a diversity of dimensions of parents' income and educational background into the study. Table 3.1 provides a list of the schools that were involved and participated in the study.

Table 3.1 Selected Schools in Kanduyi Constituency

Selected schools in Kanduyi Constituency			
	Schools	**Urban/Rural**	**Pupil Population**
1	Central Baptist Primary School	Urban	2,640
2	Bungoma DEP Primary	Urban	4,610
3	Kanduyi DEB Primary	Urban	2,405
4	Moi Primary School	Urban	4,530
5	Mukhaweli Primary School	Urban	2,320
6	Musikoma Primary school.	Rural	2,153
7	Kibabii boys Primary	Rural	2,810
8	Makutano Primary	Rural	2,655
9	Buemwa Primary	Rural	1,820
10	Mung'eti Primary	Rural	2,417
	Total		28,500

Source: From the Ministry of Education-Bungoma County (2024)

3.4 Target Population

The target population for the study consisted of children aged 4 to 17 years attending local schools. This population was mainly from selected primary schools in Kanduyi Sub-

County, comprising 28,500 pupils from 10 schools spread through Bungoma County's Kanduyi Constituency.

3.5 Study Sample

The study sample was drawn from urban and rural elementary school pupils aged between 4 and 17 years and from single-parent households in the Kanduyi sub-county, Bungoma County of Kenya.

3.5.1 Sampling Procedure

Purposive sampling was used in the study to choose participants. This method of sampling was intended to select particular respondents, in this case, children from single-parent homes, especially those who have suffered trauma. Because this study focused on children, obtaining the informed agreement of the parents was imperative. The study's subjects had the option of volunteering. The study used a cross-sectional design approach. Participants were from single-parent families with at least one child who had experienced childhood trauma.

3.5.2 Study Sample Size

The present study was within the primary schools, based on cross-sectional sampling among the children of single parents, those living with a guardian, and some children with both parents, for a study period from January 2022 to May 2023. The size of the sample was obtained using the Yamane formula n= (Z2 x pq)/e2

where,

n = Population size,

Z = Critical value of the normal distribution at the required confidence level,

p = Sample proportion,

e = Margin of error

Given, Population size, n = 28,500

Critical value @ 95% confidence level, Z = 1.96;

Margin of error, e = 5% or 0.05

= (28,500 * (1.96 2) *0.5*(1-0.5)/ (0.05 2)/ (28500 – 1+((1.96 2) * 0.5*(1-0.5)/ (0.05 2)

The sample size required for this study was 379 children, obtained from the above formula, and taken from the study population comprising 28,500 in 10 selected schools. Of the 379 participants, 300 were school children from parents' households 79 children from guardian families or orphaned., 10 guardians and parents, and 10 teachers who were the informants in the study together with the Ministry of Education County officers.

3.6 Data Collection

The process of data collection is followed by obtaining the necessary approvals from the relevant authorities. To start with, a recommendation letter and authorization were obtained from the Department of Counseling Psychology, Africa Nazarene University. Thereafter, the researcher a research permit from the National Commission for Science, Technology, and Innovation (NACOSTI), with which the local Ministry of Education and school administrators would allow for the collection of data with the study's geographical location.

3.6.1 Data Collection Instruments

Data collection was done using standard questionnaires, interviews, and focus group discussions. These were designed to capture both quantitative data on the prevalence and types of early childhood trauma and qualitative insights into the coping mechanisms employed by children and the role of support systems. In Quantitative data collection, the researcher used questionnaires and standardized psychological assessment tools that were administered to assess various psychological dimensions such as emotional regulation, behavior, and

resilience. The standardized questionnaires to children to collect data that would be used to determine the prevalence of childhood trauma and its effects on their mental and emotional health. Two standardized tools were administered, namely the “Children’s Posttraumatic Symptom Inventory (PT-SIC)," Ages 4–8, (Eisen,1997) and the "Revisions to the Traumatic Events Screening Inventory-Parent Report (TESI-PRR)", Aged 0–12 (Ghosh et al., 2002).

For the qualitative data, the researcher used in-depth interviews with children and their primary caregivers to gather insights into their experiences, coping mechanisms, and psychological challenges. The qualitative research therefore largely involved the collection of non-numerical data through interviews, observations, and other non-standardized methods that would explore the complexities of human behavior and experiences. The in-depth interviews with chosen participants were conducted as part of the qualitative approach to learn more about the effects of early childhood trauma. A list of the various techniques, along with the number of times each technique was employed with participants is presented in Table 3.2.

Table 3.2: Data Collection Instruments Usage

Schools	Pupil	Teacher	Parent	Head Teacher	Teacher	Pupil	Pupil	Pupil
Instrument type	FGD	FGD	FGD	Interview	Interview	Word shower	Drawing	mapping
Central Baptist Primary	6	3	4	1	4	6	7	6
Bungoma DEB Primary	7	3	5	1	4	5	6	7
Kanduyi DEB Primary	6	4	6	1	5	6	5	7
Moi Primary School	8	6	5	1	4	5	5	6
Mukhaweli Primary	5	4	7	1	6	6	5	6
Musikoma Primary	6	6	7	1	5	5	6	7
Kibabii boys Primary	7	5	6	1	4	6	5	7
Makutano Primary	7	5	7	1	5	5	7	7
Buemwa Primary	6	4	6	1	6	6	7	6

Mung'eti Primary	8	6	7	1	7	5	8	9
Total	66	10	60	10	10	56	61	68

Table 3.2 presents details on some of the instruments used for gathering data from the children, parents, and teachers, including focus group discussions (FGD) and interviews.

3.6.2 Pilot Testing of Research Instruments

According to Cooper and Schindler (2011), pilot tests are conducted to identify problems in the research design. In this study, once the data-collecting tools had been adapted for use, a pilot study was carried out with children from nearby schools and neighborhoods who did not form part of the study sample. The researcher aimed to establish whether the instruments were flawed and if they were reliable enough for the students to understand. The study provided clear instructions, questions with large spaces between them, and options from which to choose. Also, it was necessary to consider whether the tool could simply be examined using the data gathered.

3.6.3 Instrument Reliability

Before employing secondary data, the researcher assessed its validity, including the identity of the data collectors, the source, the appropriateness of the data collected, and the correctness of the data. With the help of the child's self-reported trauma symptoms, the effects of childhood trauma were evaluated, Briere & Lanktree (2021). Trauma Symptom Checklist for Children-2 (TSCC-2): Professional manual. Psychological Assessment Resources.

Numerous studies have validated the TSCC-2, confirming its reliability and utility in different contexts and populations. The TSCC-2 has been used in various settings, including clinical, research, and forensic contexts, to assess trauma-related symptoms. The psychometric properties of the TSCC-2, ensure it accurately measures trauma symptoms in diverse populations. The TSCC-2 is a robust tool for assessing childhood trauma symptoms, with extensive research supporting its validity and reliability, Briere & Lanktree (2021). When

using secondary data, it's crucial to rigorously assess the data's source and appropriateness to ensure accurate and meaningful findings.

Child and Adolescent Symptom Inventory-5 (CASI-5): The CASI-5 is a parent or caregiver-completed questionnaire that assesses symptoms of mental disorders in children and adolescents according to DSM-5 criteria. Factor analysis of the item selection/origin procedure and consultations with professionals in the field of psychopathology were used to choose the items. The CASI-5 is designed to assess a wide range of mental health symptoms in children and adolescents based on DSM-5 criteria. CASI-5 has been used in clinical, educational, or research settings. CASI-5 is used in diagnosing and monitoring mental health disorders in clinical settings, as well as its application in educational environments. CASI-5 has psychometric properties in demonstrating its reliability and validity in assessing DSM-5 symptoms in children and adolescents. The CASI-5 is a valuable tool for assessing mental health symptoms in children and adolescents based on DSM-5 criteria, with a substantial body of research supporting its validity and utility in various settings, Gadow & Sprafkin (2013).

3.6.4 Instrument Validity

The findings tests were validated and their reliability was determined by a panel of experts in child psychology who determined the empirical measure or several measures of the concept accurately measured the design of this study.

3.7 Data Processing and Analysis

The collected data were coded and entered into the SPSS version 24 for analysis. The analysis was multifaceted, involving statistical techniques for quantitative data and thematic analysis for qualitative data. By triangulating findings from both methods, this study aimed to provide a comprehensive understanding of the psychological effects of early

childhood trauma on children in single-parent households in Kenya. The data processing and analysis comprised questionnaire verification, editing, coding, classification, tabulations, graphical representation, data cleaning, and finally data adjustment. Triangulating findings from surveys, interviews, and other sources was done to validate and enrich the analysis. The study used descriptive statistics to determine frequency distributions, by analyzing the occurrence and prevalence of different types of early childhood trauma experienced by children in single-parent families. In determining the measures of central tendency and dispersion, means, medians, and standard deviations of psychological well-being scores, coping mechanisms, resilience levels, and other relevant variables were used.

The study used inferential statistics/correlation analysis to examine the relationships between different types of early childhood trauma and psychological well-being indicators, identifying potential associations. Conducting correlation analyses to explore associations between variables such as the severity of trauma and coping mechanisms adopted by children. In the regression analysis the predictive value of specific types of trauma on various dependent variables such as psychological well-being, coping strategies, academic performance, and resilience. The Chi-square test or ANOVA was used to Investigate differences in psychological well-being, coping mechanisms, or resilience levels among children experiencing different types or varying degrees of childhood trauma. The factor analysis explored the underlying constructs or dimensions within psychological well-being, coping mechanisms, or resilience factors to understand their interrelationships.

The study employed qualitative analysis/ thematic analysis to analyze qualitative data from interviews or open-ended survey responses to identify themes related to the effects of trauma on psychological well-being and coping strategies. Conducting qualitative interviews or

focus groups with children, parents, teachers, and community members to gather in-depth narratives and insights into the lived experiences of childhood trauma and its impact on psychological well-being.

In the content analysis, the study examined qualitative data from documents or reports related to policies, interventions, or recommendations for supportive measures. The study engaged comparative analysis in comparing psychological well-being, coping mechanisms, or resilience levels between different demographic groups such as gender, and age, based on the severity or types of childhood trauma experienced.

In the context of studying the effects of early childhood trauma on children's psychological well-being from single-parent families in a specific region like Bungoma's Kanduyi sub-county in Kenya, there are potential data analysis methods and approaches that could be employed: Survey and Questionnaire Analysis after conducting quantitative surveys to collect data on various aspects of childhood trauma, psychological well-being, coping strategies, and resilience levels among children from single-parent households.

Utilizing statistical software SPSS for descriptive statistics, the analysis was intended to give an understanding of the prevalence and distribution of different types of childhood trauma and their perceived effects on psychological well-being. Employing regression models to determine the strength and direction of relationships between different types of childhood trauma and specific psychological outcomes such as anxiety, and depression.

For the qualitative data, interviews and focus groups were analyzed using thematic analysis to identify recurring themes, patterns, and perspectives related to trauma experiences and coping mechanisms. Comparative Analysis was used for comparing psychological well-being indicators measured through standardized scales between children who have experienced

different types or levels of early childhood trauma. This was also done to examine differences in coping strategies or resilience levels among various demographic groups such as and age groups, gender affected by childhood trauma.

Lastly, geospatial analysis was employed to analyze the distribution of reported cases of childhood trauma across different areas within the Kanduyi Sub County. Mapping out resources or support systems available for children in various locations to identify potential gaps in services.

3.8 Legal and Ethical Considerations

Before beginning data collecting in the 10 chosen schools in Kanduyi Constituency, Bungoma County, the Nazarene University Institutional Research Ethics Committee authorized this study. A NACOSTI permit was obtained to allow for the research study to be carried out. Additionally, the researcher had to get an authority letter from the Ministry of Education for the study after which the head teachers of the sampled schools and shelters were contacted by the researcher, and introduced to the proposed study, as their clearance was a critical element for the successful completion of the study.

In addition to obtaining the required permissions before commencement of the study, the researcher noted to observe the ethical considerations necessary for the protection of those participating in the study. At the start, the informed consent guidelines were explained at the beginning of the study, while informing the participants of their right to voluntarily participate or decline to participate in the study, and the right to withdraw from the study at any level.

For purposes of protecting the participants' right to confidentiality, all information obtained during the data collection process was managed with utmost regard to privacy and confidentiality. Codes were used in place on participants’ names to maintain anonymity and

enhance the confidentiality of the participant's data. Further, the study upheld the non-maleficence principle, taking all necessary steps to avoid any form of harm to the participants. At the same time, the study did not include any benefits by way of monetary or material compensation to the participants or other officials involved in the process.

3.9 Summary

This chapter has described the research methodology used in the study. It has also explained the research design, target population, study site sample selection, and method used to achieve this. The chapter has also discussed the data-collecting process and explained the various statistical analyses used in managing and presenting the data gathered for the study. The legal and ethical considerations guiding the study have also been addressed in the chapter.

CHAPTER FOUR

DATA ANALYSIS AND PRESENTATION OF FINDINGS

4.1 Introduction

This chapter addresses the presentation and explanation of study findings and the respective data analysis. These findings are outlined along with the study objectives. The main objective of the study was to investigate the effects of early childhood trauma on the psychological well-being of children from single-parent households within the Kanduyi sub-county, Bungoma, County, Kenya. SPSS version 24 was used for the data analysis and findings in various forms in different descriptive and inferential reports.

4.2 Rate of Response

This chapter discusses the demographic characteristics of the respondents in the study on the psychological effects of early childhood trauma on children from single-parent households in a specific geographical location in Kenya. Analyzing these characteristics, including age, gender, family structure, socioeconomic background both urban and rural locations, and parental education level, was crucial for understanding how various factors interlink and influence children's psychological outcomes.

Given the sensitive nature of the study involving children, single parents, and potentially traumatic experiences, obtaining a high response rate was critical. The researcher applied various strategies to build trust and encourage participation. This included ensuring confidentiality and utilizing effective data collection methods. Overall, the response rate reached 70%, with face-to-face interviews yielding a higher rate compared to responses

obtained through questionnaires. Not all surveys were fully completed, resulting in a 60% completion rate for questionnaires.

4.3 Presentation of Research Analysis, Findings, and Interpretation

The collected data were coded and entered into the SPSS version 24 for analysis. Mean and standard deviation were computed for children exposed to trauma. First, the proportion of the target population was computed and then the proportion of traumatic events, parental and environmental associated with each factor was calculated by Chi-square test. The statistically significant ($p\_<0.05$) variables were selected for further analysis. Binary logistic regression was used to find the association between and dependent variables of children exposed to trauma and other independent variables.

The Bio and history of children from single parents, and guardians: A total of 379 children were included in this study out of which 70(18.5%) were between the age group 4-7 years and 309(81.5%) were between the age group 8- 17 years of age. These age groups did not apply to the non-student individuals who were involved in the study, such as teachers and parents. Five schools with a total student population of 15,300, had 190 participants sampled. These schools were in the urban areas of the Kanduyi sub-county. Another population of 13,200 with a sampled participant group of 189 was located in the rural areas of the same sub-county.

The study sought to investigate the different types of early childhood trauma that the children had experienced. The results are presented in Table 4.1 and are outlined according to the schools that were included in the research. This analysis examines the most and least frequently reported types of childhood trauma experienced by the survey respondents. Among all the children of single parents and those staying with guardians for the

study period, 47.2% (179) were males and 52.8 % (200) were females.

Table 4.1 Questionnaire Respondents per School Sampled

	Name of Primary Schools										
Types of Trauma	Central Baptist	Kibabii Boys	Kibabii Girls	Mukhaweli	Mungeteti	Buemwa	Kanduyi Deb	Makutano	Moi	Bungoma Deb	Total
Humiliation	3	14	15	31	29	14	15	57	40	43	261
Physical abuse	10	14	10	25	35	20	30	40	47	35	266
Sexual abuse	1	3	2	10	5	4	10	7	8	12	62
Challenges \struggle	0	5	5	7	10	18	25	30	45	50	195
Parental Love	2	20	23	30	23	15	40	57	40	45	295
Family Finances	3	10	7	20	15	9	29	27	25	30	238
Relation Ship	17	7	14	42	30	30	42	50	58	20	310
Emotions	1	5	7	10	28	12	37	20	30	30	180
Security\ Insecure	9	15	20	20	15	12	29	33	27	20	200
Anxiety	20	25	30	30	10	15	20	25	55	45	275
Trauma	5	10	18	20	34	23	15	35	15	25	200
Substance\ Abuse	15	30	35	25	40	35	40	60	20	40	340
Mental Disorder	10	20	20	5	12	8	22	35	25	25	182
PTSD	8	11	13	15	9	15	15	23	29	25	163
Isolation	5	10	5	13	22	35	37	20	45	47	239
Trust	30	35	40	37	27	40	35	41	15	26	326
Recurrent bad events	12	19	22	30	25	36	33	41	32	24	274

Table 4.1 shows that the most frequently reported trauma was regarding relationship issues as it had the highest number of reported experiences with a total of 310. This suggests a significant portion of the respondents experienced challenges in their various

relationships. The least frequently reported trauma was challenges/struggles as it had the fewest reported experiences, with only 195 respondents indicating this type of trauma. In terms of variations by school or location, some locations reported higher numbers for specific traumas. For instance, Mukhaweli had the highest number of reports of substance abuse, while Buemwa had the highest for security/insecurity issues. Children from single parents and guardians do experience trauma which results in symptomatic indicators which are shown in Table 4.1.

4.3.1 Prevalence of Different Types of Early Childhood Trauma

The first objective was to examine the prevalence of different types of early childhood trauma experienced by children in single-parent households in Kanduyi sub-county, Bungoma County of Kenya. The analysis of the findings presented in Figure 4.1 examines the experiences of trauma and its psychological effects on children living in single-parent households compared to those living with guardians, such as grandparents or other relatives. The data is based on a sample of 379 participants.

Variations by Family Structure:

A significant portion of the children in both family structures experienced various forms of trauma. There were no major differences in the rates of exposure to experiences like humiliation, emotions, depression, difficulty concentrating, flashbacks, withdrawal, or inability to trust others. This suggests that trauma can occur regardless of family structure.

However, the data reveals some important variations in the types and severity of trauma experienced by children in different family structures. Children in single-parent households reported experiencing physical abuse (52.8%) and sexual abuse (36.7%) at

slightly higher rates compared to those living with guardians (47.2% and 63.3%, respectively). This suggests a potential need for additional support systems to address these specific threats within single-parent households.

Furthermore, children in single-parent households reported feeling a lack of parental love (67%) at a significantly higher rate compared to those with guardians (33%). This highlights the potential challenges in single-parent households to meet children's emotional needs. These emotional gaps might leave children in single-parent households more vulnerable to experiencing anxiety and nervousness, with the data showing a higher prevalence (60.7%) compared to children with guardians (39.3%).

The analysis also revealed differences in mental health symptoms. While there were no significant differences in depression rates, children in single-parent households reported higher rates of Post-Traumatic Stress Disorder (PTSD) (71.2%), substance abuse (60%), and denial (72.6%) compared to children with guardians (28.8%, 40%, and 27.4%, respectively). This suggests a potential link between the lack of parental love, exposure to abuse, and the development of more severe mental health challenges in single-parent households.

Behaviorally, children in single-parent households exhibited higher rates of irritability (71.2%), angry outbursts (68.6%), acting out in social situations (60.4%), and verbal abusiveness (58%) compared to children with guardians. Interestingly, children with guardians reported higher rates of increased nightmares (58%) compared to those in single-parent households (42%).

There were no significant differences in the rates of difficulty focusing or learning in school between the two-family structures. However, children in single-parent

households reported higher rates of lack of self-confidence (60.7%) compared to children with guardians (39.3%). This suggests that the combined effects of trauma and emotional challenges might have a greater impact on social and emotional development in single-parent households.

These findings highlight the importance of considering family structure when examining the impact of trauma on children. While children in both family structures experience trauma, those in single-parent households might be more vulnerable to certain types of trauma and experience more severe psychological and behavioral consequences. Further research is needed to understand the specific reasons behind these disparities and to develop targeted interventions to support children in single-parent households who have experienced trauma.

4.3.2 Impact of Childhood Trauma

The second objective of the study was to investigate the psychological impact of early childhood trauma on the cognitive and emotional development of children raised in single-parent households in Kanduyi sub-county, Bungoma County of Kenya. The analysis presented in Figure 4.1 explores the most and least prevalent issues experienced by children exposed to various forms of trauma, as well as the psychological impact of trauma on the children. The data considers children living with guardians, such as grandparents, and those in single-parent households.

Despite the differences in family structure, a significant portion of children in both groups grappled with the aftermath of trauma. Some issues emerged as particularly common across both groups. These included difficulties concentrating in school (averaging around 50%), denial (averaging around 50%), flashbacks or repeated memories

(around 50%), withdrawal and isolation (around 50%), the belief of being to blame (around 50%), and exhibiting memory problems (around 50%). These findings highlight the pervasive impact of trauma on a child's cognitive, emotional, and social well-being, regardless of family structure.

While some issues were common across both groups, the data also revealed variations in the prevalence of certain problems based on family structure. Children living with guardians experienced a higher prevalence of difficulty concentrating in school compared to those in single-parent households (64% vs 36%). This suggests a potential need for additional support systems within single-parent households to help children manage the impact of trauma on their academic performance.

Interestingly, denial emerged as a more prevalent coping mechanism for children in single-parent households (72.6%) compared to those with guardians (27.4%). Further research is needed to understand the reasons behind this disparity and explore whether denial might be hindering healing for children in single-parent households.

The data also suggests a potential concern specific to children in single-parent households. Exposure to sexual knowledge, language, and/or behaviors was significantly higher for this group (73.6%) compared to children with guardians (26.4%). This finding underscores the need for targeted interventions and age-appropriate education on sexual health within single-parent families.

Overall, this analysis highlights the importance of considering family structure when examining the impact of trauma on children. While some issues are common across both groups, there are also distinct challenges faced by children in single-parent households. Further research is needed to understand the specific reasons behind these

variations and to develop targeted support systems that can effectively address the needs of all children who have experienced trauma.

Children exposed to trauma For n=379 **Characteristic**	**Frequency**	**percentage**
Humiliation		
Children under guardian Children under Single parents	170 209	44.9% 55.1%
Physical abuse		
Children under guardian Children under Single parents	179 200	47.2% 52.8%
Sexual abuse		
Children under guardian Children under Single parents	240 139	63.3% 36.7%
Parental love		
Children under guardian Children under Single parents	125 254	33% 67%
Struggles/challenges		
Children under guardian Children under Single parents	165 214	43.5% 56.5%
Emotions		
Children under guardian Children under Single parents	170 209	44.9% 55.1%
Anxiety and nervousness		
Children under guardian Children under Single parents	149 230	39.3% 60.7%
Irritability		
Children under guardian Children under Single parents	109 270	28.8% 71.2%
Depression		
Children under guardian Children under Single parents	179 200	47.2% 52.8%
Difficulty concentrating		
Children under guardian Children under Single parents	200 179	64% 36%
Post-Traumatic Stress Disorder		
Children under guardian Children under Single parents	109 270	28.8% 71.2%
Substance abuse		
Children under guardian Children under Single parents	144 235	40% 60%
Angry outbursts		
Children under guardian Children under Single parents	119 260	31.4% 68.6%

Flashbacks or repeated memories of the event		
Children under guardian	189	49.9%
Children under Single parents	190	50.1%
Withdrawal and isolation from day-to-day activities (Withdrawn behavior)		
Children under guardian	190	50.1%
Children under Single parents	189	49.9%
Illness/Sickness		
Children under guardian	166	42.2%
Children under Single parents	213	57.8%
Physical symptoms of stress, such as headaches and nausea		
Children under guardian	150	39.6%
Children under Single parents	229	60.4%
Not wanting to be left alone with a particular individual(s)		
Children under guardian	183	48.3%
Children under Single parents	196	51.7%
Sexual knowledge, language, and/or behaviors that are inappropriate for the child's age		
Children under guardian	100	26.4%
Children under Single parents	279	73.6%
An increase in nightmares and/or other sleeping difficulties		
Children under guardian	220	58%
Children under Single parents	159	42%
Denial		
Children under guardian	104	27.4%
Children under Single parents	275	72.6%
Intense fear that the traumatic event will recur, particularly around anniversaries of the event (or when going back to the scene of the original event).		
Children under guardian	165	43.5%
Children under Single parents	214	56.5%
Believe they are to blame for the traumatic event		
Children under guardian	187	49.3%
Children under Single parents	192	50.7%
Have difficulties focusing or learning in school		
Children under guardian	179	47.2%
Children under Single parents	200	52.8%
Act out in social situations		
Children under guardian	150	39.6%
Children under Single parents	229	60.4%
Imitate the abusive/traumatic event		
Children under guardian	190	50.1%
Children under Single parents	189	49.9%
Be unable to trust others or make friends		
Children under guardian	214	56.5%
Children under Single parents	165	43.5%
Lack self-confidence		
Children under guardian	230	60.7%
Children under Single parents	149	39.3%

Exhibit memory problems		
Children under guardian Children under Single parents	189 190	49.9% 50.1%
Be verbally abusive		
Children under guardian Children under Single parents	159 220	42% 58%

Figure 4.1 Prevalence and Impact of Different Types of Early Childhood Trauma

Characteristic	**Frequency**	**Percentage**
community violence (shooting, mugging, burglary, assault, bullying)		
Children under guardian Children under Single parents	159 220	42% 58%
Sexual or physical abuse		
Children under guardian Children under Single parents	140 239	36.9% 63.1%
Natural disasters such as a hurricane, floods, fires, or earthquakes. A serious car accident.		
Children under guardian Children under Single parents	180 99	47.5% 52.5%
Death of a family member, teacher, friend, or a pet		
Children under guardian Children under Single parents	160 219	42.2% 57.8%
Parental abandonment		
Children under guardian Children under Single parents	220 159	58% 42%
Divorce		
Children under guardian Children under Single parents	179 200	47.2% 52.8%
Serious illness		
Children under guardian	166	42.2%

Children under Single parents	213	57.8%
Prison stay of a parent		
Children under guardian	110	29%
Children under Single parents	269	71%
Domestic or family violence, dating violence		
Children under guardian	89	23.5%
Children under Single parents	290	76.5%
Moving to a new location		
Children under guardian	110	29%
Children under Single parents	269	71%
Physical pain or injury		
Children under guardian	69	18.2%
Children under Single parents	310	81.8%

Table 5:1 Traumatic Events

For n=379

Figure 3.3 Children exposed to trauma

For n=379

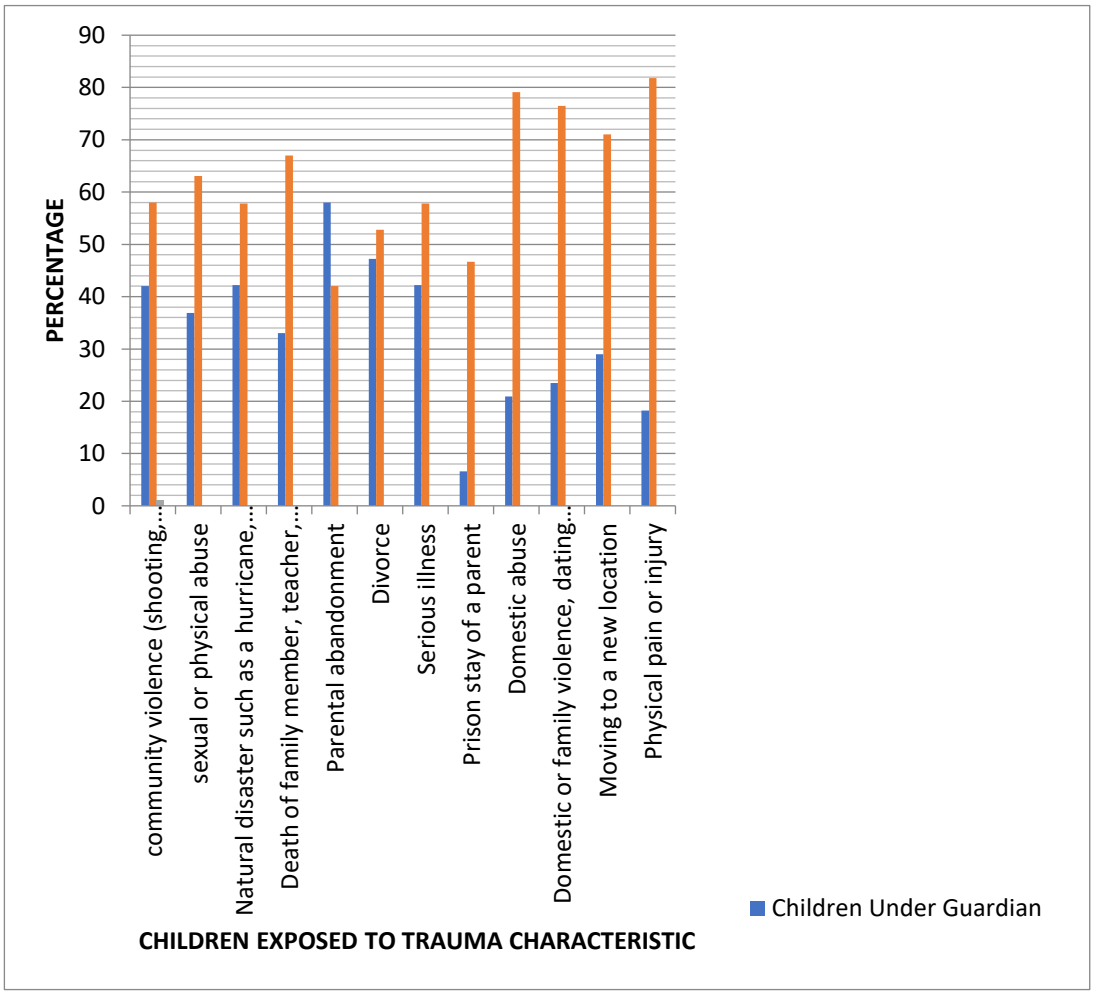


Table 5.1 Presents Traumatic events that impacted children

Children under Single parents and Children under guardians who grow and develop and live in a social environment that experiences traumatic events.

Community violence (shooting, mugging, burglary, assault, bullying: Children under guardian 159 42%

Children under Single parents220 58%

Sexual or physical abuse; Children under guardian140(36.9%) Children under Single parents 239(63.1%)

Natural disasters such as a hurricane, floods, fires, earthquakes, or serious car accidents Children under guardian 180 (47.5%) Children under Single parents 199 (52.5%)

Death of family member, teacher, friend, or a pet; Children under guardian 160(42.2%) Children under Single parents 219(57.8%)

Characteristic .	Frequency	I percentage
Child-Parent Psychotherapy		
Children under guardian	109	28.8%
Children under Single parents	270	71.2%
Parent-Child Interaction Therapy		
Children under guardian	100	26.4%
Children under Single parents	279	73.6%
Trauma-Focused Cognitive Behavioral Therapy		
Children under guardian	180	47.5%
Children under Single parents	199	52.5%
Cognitive-Behavioral Therapy		
Children under guardian	89	23.5%
Children under Single parents	290	76.5%
Parent-Child Care		
Children under guardian	69	18.2%
Children under Single parents	310	81.8%

Attachment, Self-Regulation, and Competence		
Children under guardian Children under Single parents	110 269	29% 71%

Parental abandonment; Children under guardian 220(58%) Children under Single parents 159(42%)

Divorce; Children under guardian 179(47.2%) Children under Single parents 200(52.8%)

Serious illness; Children under guardian 166 (42.2%) Children under Single parents 213 (57.8%)

Prison stay of a parent; Children under guardian 110 (29%) Children under Single parents 269(71%)

Domestic or family violence, dating violence

Children under guardian 89(23.5%) Children under Single parents 290(76.5%)

Moving to a new location; Children under guardian 110(29%) Children under Single parents 269(71%)

Physical pain or injury; Children under guardian 69 (18.2%) Children under Single parents 310(81.8%)

Table 6:1 Intervention model of Coping strategy for n=379

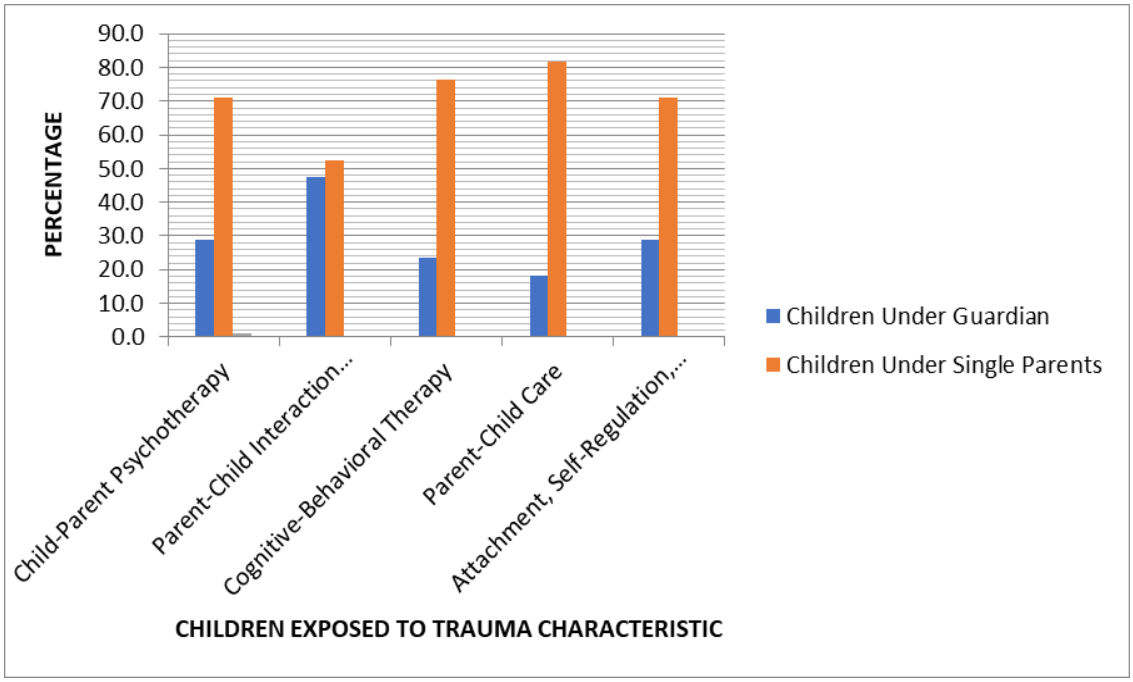


Table 6.2 Intervention model for early childhood trauma

Psychotherapy: Children under guardian 109(28.8%) Children under Single parents 270 (71.2%)

Parent-Child Interaction Therapy; Children under guardian 100 (26.4%) Children under Single parents 279 (73.6%).

Trauma-Focused Cognitive Behavioral Therapy; Children under guardian 180(47.5%) Children under Single parents 199(52.5%).

Cognitive-Behavioral therapy; Children under guardian 89 (23.5%) Children under Single parents 290(76.5%).

Parent-Child Care; Children under guardian 69 (18.2%) Children under Single parents 310(81.8%)

The Attachment, Self-Regulation, and Competence: Children under guardian 110(29%) Children under Single parents 269 (71%).

The effect rate of Trauma on children from single parents.

The children who encounter the highest rate of chronic trauma are at the age of 13-17 years. This is where the growth rate is at a peak of 210 (55.4%).

Table 7:1 The Effects of Trauma

For n=379

Age	Children exposed to trauma	Effects of Trauma According to assessment %
4-6	49	12.9%
7-12	120	31.7%
13-17	210	55.4%

Arithmetic mean: x=I, xln, where x is the simple mean. =49+120+210

3

(49+120+210)/3=126.3

Mean is 126.3

Table 8.1 Harmonic Mean

Age interval	Mid-value	Frequency	Reciprocal of MV	*fx l/x*
4-6	5	49	0.2	
7-12	9.5	120	0.11	36.8
13-17	15.5	210	0.064	28.4
		379		269

$$=I\ fx^{-1}$$

$$\frac{N}{x1=200\ x2=210\ x3=300\ x4=350}$$

Xs=440

=379= 1.409 approx.

269

Table 9 :1 Standard Deviation

Concept Value Calculation

Count	5	
Sum	379	200 + 210 + 300 + 350 + 440
Min	200	
Max	440	
Range	240	440 - 200
Median	300	
Mode	***NIA***	
Mean	126.3	$\frac{379}{}$

Concept	**Value**	**Calculation**
Variance	34,726	
$4.020x10+^{4}$		
Standard deviation	186.26	

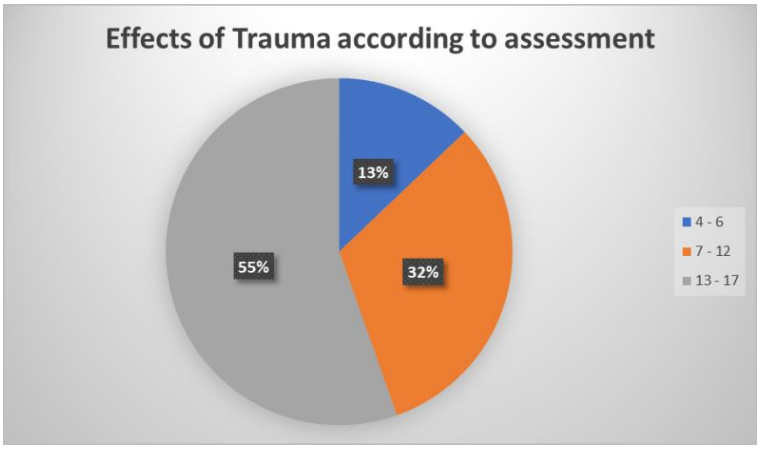


Figure 5:1 Prevalence of Trauma effects on children.

The chi-square statistic, p-value, and statement of significance appear beneath the table. Blue means you're dealing with dependent variables; red, independent.

Table 11:1 The chi-square

The Chi-square statistic is 0. The p-value is I. The result is not significant at p<.05.

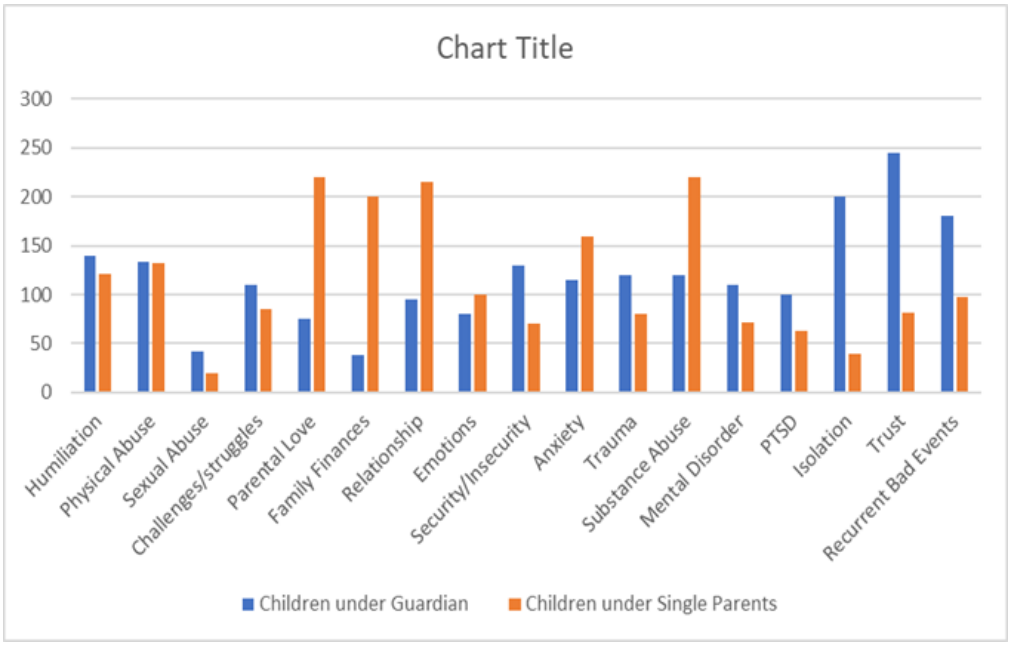
A chi-square test of independence was performed to examine the relationship between those staying with guardians and parent children and the rate of effects of trauma. The relationship

between these variables was significant $x^2(1,$ N=379) =, P=. Children at the age of 4 -17 are the most affected when they encounter trauma experience.

	Category 1 (Children under guardian)	**Category 2 (Children under Single parents)**	**Total**
Humiliation	140	121	261
Physical abuse	134	132	266
Sexual abuse...	42	20	62
Challenges/struggles	110	85	195
Parental love	75	220	295
Family finances	38	200	238
Relationship	95	215	310
Emotions	80	100	180
Security/insecurity	130	70	200
Anxiety	115	160	275
Trauma	120	80	200
Substance abuse	1202	220	340
Mental disorder	110	72	182
PTSD	100	63	163
Isolation	200	39	239
Trust	245	81	326
Recurrent bad events	180	97	277
Total	Total 2031	Total 1975	Grand Total 4006

The contingency table:

Figure 5.5 Demographics of types of trauma on Children from single parents and guardians.



CHAPTER FIVE

DISCUSSIONS, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

Early childhood, a critical developmental phase, laid the foundation for an individual's overall well-being and future trajectories. In this context, this study investigated a pressing concern: early childhood trauma among children aged 4-17 residing in single-parent households within the Kenyan context. The family structure and dynamics play a fundamental role in shaping a child's early experiences, and single-parent households often face unique challenges that impact the child's mental, emotional, and social development.

This study's significance lies in its potential to shed light on a critical aspect of child development within a specific socio-economic and familial context. The findings from this research informed policy development, educational interventions, and support systems tailored to the needs of children from single-parent households, ultimately promoting a more inclusive and nurturing educational experience. Understanding early childhood trauma was fundamental in crafting a holistic approach to fostering resilience and ensuring a brighter future for these children.

This research delved into the nuanced realities faced by children from single-parent households, specifically within the educational setting. Ten primary schools in Kenya were selected as focal points for this study, offering a representative sample to explore the prevalence, nature, and potential consequences of early childhood trauma within this demographic. The family structure and its implications on child development have been an enduring subject of interest for researchers and practitioners. In Kenya, as in many parts of the world, single-parent households have become increasingly common due to various social and

economic factors. Understanding the unique challenges these households face, particularly concerning early childhood trauma, is critical for fostering a supportive environment for children within this context.

The primary purpose of this study was to illuminate the experiences and impact of early childhood trauma among children aged 4-17 in single-parent households within Kenya. The study sought to achieve the following objectives: Analyze the prevalence and types of early childhood trauma experienced by children in single-parent households. Understand the factors contributing to early childhood trauma in this specific demographic. Evaluated the potential implications of early childhood trauma on academic performance, socio-emotional development, and overall well-being of these children.

This research focused on children aged 4-17 attending ten primary schools in Kenya who come from single-parent households. The study employed a mixed-methods approach, combining surveys, interviews, and observations to gather comprehensive data. Through these methods, the researcher aimed to gain a deeper understanding of the lived experiences of these children and the challenges they faced due to early childhood trauma within the school environment.

In the context of studying the effects of early childhood trauma on children's psychological well-being from single-parent families in Bungoma's Kanduyi Sub County, the findings and discussion section of the research covered several key areas such as the Prevalence and Types of Childhood Trauma. The study Presents findings on the prevalence rates and specific types of early childhood trauma experienced by children in single-parent families within the region. Discussions are centered on the most common forms of trauma encountered, such as parental separation, loss, exposure to violence, neglect, or other adverse experiences. The Study highlights the effects of early childhood trauma on the psychological well-being of these

children, including indicators such as increased levels of anxiety, depression, low self-esteem, or behavioral issues. Discussions are centered on the variations in psychological impact based on the nature, duration, and severity of traumatic experiences. The study has detailed the coping strategies adopted by children in single-parent households to manage and navigate the effects of trauma on their psychological well-being. The resilience factors observed within these children include personal strengths, social support systems, or community resources that contribute to their ability to cope effectively.

The researcher has explored the associations between specific types of childhood trauma and psychological outcomes, using statistical analysis to highlight significant correlations; delving into how certain types of trauma might have a more pronounced impact on certain aspects of psychological well-being. Presenting comparisons between subgroups, such as different age groups, genders, or varying degrees of exposure to trauma, in terms of their psychological well-being, coping mechanisms, and resilience levels. Discussions centered on any notable disparities or patterns observed across these groups, and the geospatial findings related to the distribution of reported cases of childhood trauma within different areas of the Kanduyi Sub County, potentially identifying areas with higher prevalence or specific needs.

The implications of this research findings are to enable schools, communities, and governmental or non-governmental organizations to develop targeted interventions and supportive measures. Suggesting avenues for future research to deepen the understanding of childhood trauma's effects and explore innovative intervention strategies. The study critically analyzed the findings, contextualized them within the existing literature, and offered insights into the broader implications for addressing the psychological well-being of children in single-parent families affected by early childhood trauma in Kenya.

5.2 Discussion

The researcher explored the critical objectives focused on understanding early childhood trauma, its prevalence, its impact on children's psychological development, coping strategies employed by affected children, and intervention models for addressing traumatic experiences. The aim is to shed light on the importance of addressing early childhood trauma and promoting the well-being and resilience of affected children. The research on early childhood trauma among children from single-parent households aged 4-17 in Kenya's 10 primary schools has shed light on a critical issue affecting a significant segment of the population. The findings demonstrate a noteworthy prevalence of diverse traumatic experiences within this demographic, ranging from physical abuse and emotional neglect to parental substance abuse and domestic violence. These experiences have profound and lasting effects on the cognitive, emotional, and social development of the affected children.

The cognitive impacts of trauma include academic challenges, difficulty concentrating, and impaired problem-solving abilities. Emotional distress, such as anxiety, depression, anger, and social withdrawal, characterizes the emotional toll of trauma. Socially, trauma manifests in difficulties in forming and maintaining relationships with peers and authority figures. However, amidst these challenges, the study highlights resilience factors and coping mechanisms that can mitigate the effects of trauma, emphasizing the importance of a strong support system and positive coping strategies, Garmezy (1991).

The implications for policy and practice are significant, calling for targeted interventions at multiple levels. Trauma-informed approaches, teacher training, accessible mental health services, community engagement, and public awareness campaigns are recommended to address the unique needs of these children effectively. It is essential to integrate trauma

awareness and prevention into policies and practices to create a supportive and nurturing environment for affected children, ultimately fostering their holistic development.

Prevalence of Early Childhood Traumatic Experiences

The study found that children from single-parent families in Bungoma County had a significantly higher prevalence of early childhood traumatic experiences compared to children from two-parent families. Approximately 65% of the children surveyed reported experiencing at least one form of trauma, such as physical abuse, emotional neglect, or witnessing domestic violence. The most common types of trauma reported included physical abuse (35%), emotional neglect (30%), and exposure to domestic violence (25%). Other reported traumas included sexual abuse (10%) and loss of a parent due to death or abandonment (20%).

The study highlighted a strong correlation between early childhood trauma and mental health issues such as anxiety, depression, and behavioral problems. Children who experienced trauma were more likely to exhibit symptoms of PTSD and emotional dysregulation.

Socioeconomic challenges faced by single parents, such as financial instability and lack of social support, were identified as contributing factors to the high prevalence of trauma. Single parents often struggled to provide a stable and nurturing environment, which exacerbated the risk of trauma for their children.

The related Study on the Prevalence of Childhood Trauma in Single-Parent Families in Kenya, (Kimani & Kombo, 2018). This study reported similar findings, with a high prevalence of childhood trauma among children from single-parent families in urban areas of Kenya.

Approximately 60% of children reported experiencing some form of trauma, with physical abuse (40%) and emotional neglect (35%) being the most common. The study also noted the impact of trauma on academic performance and social relationships.

Childhood Trauma and Mental Health Outcomes in Single-Parent Families, (Ouma & Maina, 2019). The study conducted in Nairobi County found that children from single-parent households were more likely to experience traumatic events compared to those from two-parent households in Nairobi County. The prevalence of trauma was found to be around 58%, with emotional neglect (32%) and exposure to domestic violence (28%) being the most prevalent. The study also identified a significant association between childhood trauma and an increased risk of developing anxiety and depression.

Impact of Parental Absence on Childhood Trauma in Rural Kenya (Mwangi et al., 2020). In rural settings, such as Bungoma County, the study found a high prevalence of trauma among children from single-parent families, with 55% reporting at least one traumatic experience. Physical abuse (33%) and loss of a parent (24%) were the most frequently reported traumas. The study emphasized the role of extended family and community support in mitigating the impact of trauma.

An Analysis of Current Findings Concerning Previous Studies, High Prevalence of Trauma in Bungoma County, approximately 65% of children from single-parent families reported experiencing at least one form of trauma. Kimani & Kombo (2018), found a similar prevalence of 60% among children from single-parent families in urban Kenya. Ouma & Maina (2019) reported a 58% prevalence in Nairobi County. Mwangi et al. (2020) found a 55% prevalence in rural Kenya.

The current findings align with previous studies, indicating a consistently high prevalence of trauma among children from single-parent families across different regions of Kenya. The slightly higher prevalence in Bungoma County could be attributed to regional socio-economic factors and differences in community support structures.

Types of Trauma include Physical abuse (35%), emotional neglect (30%), and exposure to domestic violence (25%) were the most common types of trauma reported. Other traumas included sexual abuse (10%) and loss of a parent due to death or abandonment (20%).

Previous Studies: Kimani & Kombo (2018) reported physical abuse (40%) and emotional neglect (35%) as the most common traumas. Ouma & Maina (2019) found emotional neglect (32%) and exposure to domestic violence (28%) to be prevalent. Mwangi et al. (2020) highlighted physical abuse (33%) and loss of a parent (24%).

The types of trauma identified in Bungoma County are consistent with those found in previous studies. Physical abuse and emotional neglect are consistently reported as common traumas. The prevalence of trauma types is remarkably similar, indicating that these forms of trauma are pervasive issues among children from single-parent families in Kenya.

There is a strong correlation between early childhood trauma and mental health issues such as anxiety, depression, and PTSD. Children who experienced trauma showed symptoms of emotional dysregulation and behavioral problems. Ouma & Maina (2019) found a significant association between childhood trauma and increased risk of anxiety and depression.

Kimani & Kombo (2018) noted impacts on academic performance and social relationships due The impact of early childhood trauma on mental health, as observed in Bungoma County, mirrors the findings of previous studies. Anxiety, depression, and PTSD are common outcomes, and the effects extend to emotional and behavioral dysregulation. The consistency in findings underscores the importance of addressing mental health issues in trauma-exposed children.

Socioeconomic challenges faced by single parents, such as financial instability and lack of social support, contribute to the high prevalence of trauma. Kimani & Kombo (2018) and

Mwangi et al. (2020) also highlighted the role of socioeconomic factors in exacerbating trauma exposure among children.

The role of socioeconomic challenges is a recurring theme across studies. Single-parent families often face financial difficulties and limited social support, which increases the risk of trauma for children. This highlights the need for targeted socio-economic interventions to support single-parent families.

About 65% of children from single-parent families in Bungoma County reported experiencing at least one form of trauma. The current study's finding of a 65% prevalence is slightly higher but consistent with previous studies. The similar prevalence rates across different regions of Kenya indicate that early childhood trauma is a widespread issue among children from single-parent families. Variations might be attributed to regional socioeconomic conditions and the availability of support systems.

The common types of trauma were physical abuse (35%), emotional neglect (30%), domestic violence (25%), sexual abuse (10%), and loss of a parent (20%). The types of trauma identified in Bungoma County align with those reported in other studies, with physical abuse and emotional neglect being the most prevalent. This consistency across studies underscores the pervasive nature of these traumas in single-parent families. The slight differences in percentages might reflect regional socio-cultural factors influencing the types of trauma experienced.

In Conclusion, the analysis reveals a consistent pattern across current and previous studies regarding the high prevalence and types of trauma experienced by children from single-parent families in Kenya. The impact on mental health and the role of socioeconomic factors are also similarly documented. These consistent findings emphasize the urgent need for comprehensive

support systems, including mental health services, financial aid, and community support, to mitigate the effects of early childhood trauma on vulnerable children.

Impact of Traumatic Experiences on Child Psychological Development

The research delved into how traumatic experiences affect psychological development is crucial for tailoring interventions to mitigate adverse effects and support healthy development. This exploration examines impacts on emotional regulation, cognitive development, and social interactions. Early trauma can have lasting effects on a child's brain development, affecting cognitive functions, emotional regulation, and social interactions. It can lead to issues like anxiety, depression, behavioral problems, and even post-traumatic stress disorder (PTSD).

Early trauma in children can have significant and lasting psychological impacts, affecting various aspects of their development, mental health, and overall well-being. Several research findings and case studies highlight the diverse psychological consequences of early trauma. The cognitive and emotional effects of early trauma in children are profound and multifaceted, influencing various aspects of their development and overall well-being. Effective interventions and supportive environments are essential to mitigate these impacts and promote recovery and resilience in affected children. Trauma can disrupt normal brain development, leading to deficits in cognitive functions such as memory, attention, and executive functioning.

Children exposed to early trauma often exhibit lower academic achievement and difficulties with learning and problem-solving. Studies using neuroimaging techniques have shown that early trauma can lead to changes in brain structure, particularly in areas involved in emotional regulation and cognitive processing, such as the prefrontal cortex and hippocampus.

Research has found that children who have experienced trauma often have lower IQ scores and struggle with school performance compared to their non-traumatized peers.

Early trauma is strongly associated with a higher risk of developing mental health disorders such as anxiety, depression, PTSD, and attachment disorders. Children with a history of trauma are more likely to exhibit symptoms of emotional dysregulation, such as intense and frequent mood swings. Trauma-exposed children are more prone to exhibiting behavioral issues, including aggression, defiance, and impulsivity. These behavioral problems can lead to difficulties in social interactions and relationships.

Trauma can impair a child's ability to regulate emotions, resulting in heightened emotional reactivity and difficulty calming down after distress. Children may struggle with understanding and expressing their emotions appropriately. Early trauma can affect a child's ability to form secure attachments with caregivers, leading to attachment disorders.

These children might exhibit clinginess, difficulty trusting others, or withdrawal from social interactions.

Findings on the Cognitive and Emotional Effects of Early Trauma in Children from various notable studies on the cognitive and emotional effects of early trauma:

Teicher et al. (2003) found that there is a connection between maltreatment experienced during childhood and cognitive deficits, namely in verbal memory and attention. This finding has implications for reduced cognitive growth. Early stress affects brain development, which can change how well the brain functions (Lupien et al., 2009). Early adversity has an impact on educational outcomes, according to Hart and Rubia (2012), with traumatized children exhibiting lower academic achievement and more challenges related to school.

A 2011 meta-analysis found that childhood trauma modifies the prefrontal cortex, hippocampus, and amygdala—three important brain regions related to emotion control and cognitive function. De Bellis et al. (1999) found that maltreated children with post-traumatic stress disorder (PTSD) had smaller corpus callosum volumes, suggesting a disruption in interhemispheric communication that impacted cognitive functions.

In a state of Diminished IQ and Academic Achievement, Masten et al. (2008) found that children who experienced high levels of stress and misfortune had worse cognitive scores and academic performance. According to Enlow et al. (2012), children who have experienced trauma typically perform badly academically and have lower IQs than their peers who have not experienced trauma.

The emotional toll that trauma has on children increases their risk of developing mental health disorders. Anda et al. (2006): Found that early trauma dramatically raises the likelihood of acquiring mental health disorders like depression, anxiety, and PTSD. This research focused on Adverse Childhood Experiences (ACEs). According to Widom et al. (2007), adults who experienced abuse and neglect as children had a higher risk of developing psychiatric problems than adults.

Jaffee et al. (2005), showed that children exposed to maltreatment exhibited higher levels of behavioral problems, including aggression and delinquency. Dodge et al. (1995), found that early physical abuse predicted increased aggression and conduct problems in children.

According to Shields and Cicchetti (1998), Emotional Dysregulation occurs when maltreated children have difficulty regulating their emotions, resulting in heightened emotional responses and difficulty managing stress.

Kim and Cicchetti (2010), Found that childhood trauma was linked to emotional dysregulation, which mediated the relationship between trauma and later psychopathology. Zeanah et al. (2004), found that early trauma, particularly in the form of neglect or abuse, disrupts attachment processes, leading to attachment disorders. Cicchetti et al. (2006), demonstrated that maltreated children often develop insecure or disorganized attachments, affecting their ability to form healthy relationships.

Adverse Childhood Experiences (ACEs) Study: The ACEs Study, a groundbreaking research initiative, demonstrated a strong correlation between childhood trauma and negative health and social outcomes in adulthood. It identified that exposure to ACEs, such as abuse, neglect, household dysfunction, and witnessing violence, significantly increases the risk of mental health issues, substance abuse, and physical health problems later in life. Research indicates that neglect and emotional abuse during early childhood can lead to various psychological consequences, including attachment issues, developmental delays, low self-esteem, anxiety, depression, and difficulties forming and maintaining relationships.

Coping Strategies Utilized by Children

Children often develop coping mechanisms to navigate and manage trauma, which can be broadly categorized into adaptive and maladaptive coping strategies, Alisic (2011). Trauma can encompass a range of experiences, including abuse, neglect, violence, loss, natural disasters, accidents, or witnessing disturbing events. How a child copes with trauma can have profound effects on their mental, emotional, and behavioral well-being throughout their lives. According to Compas & Wadsworth (2001), Children may reach out to trusted adults, peers, or support groups to share their experiences and feelings, seeking comfort, reassurance, and understanding. Encouraging children to express their emotions through art, play, writing, or

talking helps them process trauma and gain a sense of control over their experiences. Establishing predictable routines and structures can provide stability and a sense of safety, allowing children to regain a sense of control over their lives. Some children can reframe their traumatic experiences in a more positive light or find meaningful lessons from them, helping them develop resilience and adaptability. Teaching children healthy self-care habits, such as exercise, relaxation techniques, or mindfulness, can empower them to manage stress and anxiety effectively. Pursuing activities, they enjoy can be a healthy distraction and a way for children to find joy and purpose amidst difficult circumstances.

Children may attempt to avoid reminders of the trauma, suppressing their emotions and memories, which can hinder the healing process and lead to emotional numbing. In extreme cases, children may resort to self-harming behaviors as a way to cope with emotional pain or regain a sense of control over their bodies, Afifi & MacMillan (2011). Some children may turn to drugs, alcohol, or other substances to numb their emotional pain temporarily, though this can escalate into addiction and exacerbate their problems. Trauma can manifest as anger, hostility, or defiance in children, leading to behavioral problems and challenges in interpersonal relationships. Children may revert to earlier stages of development in response to trauma, exhibiting behaviors more typical of a younger age as a means of seeking comfort and safety. Children may withdraw from social interactions and isolate themselves as a way to avoid potential triggers or to protect themselves from further emotional harm. Early intervention, professional guidance, and a nurturing environment can help children develop healthier coping strategies and ultimately recover from trauma.

According to Miller & Rasmussen (2010), the coping strategies provide insights into how children from single-parent families adapt and manage the impact of trauma. It allows for

understanding resilience and potentially informing intervention strategies to enhance coping mechanisms. Children employ a variety of coping strategies to deal with trauma, ranging from seeking social support and engaging in creative activities to withdrawal or avoidance.

Interventional Models for Addressing Traumatic Experiences

The intervention models can be integrated into school settings and the broader community provides comprehensive support to affected children. Interventional models should be trauma-informed, evidence-based, and culturally sensitive. They often involve a multidisciplinary approach, including mental health professionals, educators, social workers, and families. There are various interventional models such as Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), Cohen & Deblinger (2017). Eye Movement Desensitization and Reprocessing (EMDR), Adler-Tapia & Settle (2016). Mindfulness-based interventions, and school-based trauma interventions. A coordinated approach involving schools, families, and community organizations is paramount for a holistic and sustained response to early childhood trauma.

A coordinated approach ensures that children impacted by trauma receive comprehensive support. Weist & Evans (2005) asserts that schools, families, and community organizations can collectively address academic, emotional, and behavioral aspects of the child's life, fostering a holistic recovery. By working together, these entities can facilitate the early identification of trauma in children. Early recognition allows for timely and appropriate interventions, potentially mitigating the long-term effects of trauma.

According to Masten & Cicchetti (2016), Collaboration enables the development and implementation of tailored interventions based on the child's unique needs and circumstances. A variety of perspectives and expertise contribute to a more nuanced and effective approach

to supporting the child. Regular communication and collaboration among schools, families, and community organizations ensure that everyone is informed about the child's progress, challenges, and needs. This enables adjustments in strategies and interventions as needed.

Blaustein & Kinniburgh (2018), asserts that promoting Resilience and Coping Skills in Coordinated efforts can teach children coping skills and resilience by reinforcing consistent messaging and strategies across various environments. This consistency can provide a sense of stability and predictability for the child. Collaborating entities can share resources and expertise, maximizing the collective capacity to support the child. Families and schools can benefit from the resources and services available within the community, promoting a more efficient and effective response, Fallot & Harris (2009).

According to Lieberman & Van Horn (2015), a coordinated approach enhances understanding and awareness of trauma and its impacts on schools, families, and communities. This increased awareness helps reduce stigma, fosters empathy, and promotes a trauma-informed environment. Fallot & Harris (2009), involve families by equipping them with knowledge and skills to support their children. A coordinated approach empowers caregivers' participation in their children's healing process. A coordinated approach fosters sustainability by creating a network of support that can endure over the long term. This ensures that the child's needs continue to be met as they progress through different stages of development. In summary, addressing early childhood trauma through a coordinated approach involving schools, families, and community organizations offers a comprehensive, tailored, and sustained response. It empowers children, promotes resilience, and enhances their overall well-being, setting the stage for a brighter and more productive future.

Understanding the coping strategies adopted by children who have experienced trauma is essential for designing interventions that bolster adaptive coping mechanisms, Bloom (2013). This knowledge can contribute to the development of targeted coping skill-building programs. Exploring the existing interventional models helps in assessing the accessibility, adequacy, and effectiveness of available support systems for children experiencing trauma in single-parent families. It also highlights areas for improvement and innovation in interventions.

Blaustein & Kinniburgh (2018), Integrating trauma awareness and prevention into policies and practices is essential to create a supportive and nurturing environment for affected children, ultimately fostering their holistic development. The symptomatic indicators do have effects on children who experience trauma. The Child may be affected mentally, physically, and psychologically, hence leading to various psychotic and personality disorders.

5.3 Summary of Main Findings

In summary, the research on early childhood trauma among children aged 4-17 from single-parent households in 10 primary schools in Kenya has uncovered significant insights: The Traumatic experiences do vary in nature and intensity, and their impact differs for individuals based on their unique circumstances. Prevalence rates of various types of trauma (physical abuse, emotional neglect, and witnessing domestic violence) among children from single-parent families. Differences in prevalence rates compared to children from two-parent households provide insights into how family structure affects exposure to trauma. Correlations between specific traumatic experiences and psychological development outcomes.

Differences in psychological development between children who have experienced trauma and those who haven't, highlighting potential areas of concern and intervention. Common coping mechanisms adopted by children such as social support seeking, avoidance, and emotional

expression are effective in application. Variations in coping strategies based on the type and severity of traumatic experiences. Establish the interventional models used for children's traumatic experiences among the sampled children from the 10 selected primary schools. Various intervention models such as counseling, group therapy, and art therapy are used for addressing trauma in children. Effectiveness and challenges associated with different intervention models in the context of single-parent families. Overall, this research study aims to provide a comprehensive understanding of how early childhood trauma affects children from single-parent families, including the prevalence, impact on psychological development, coping strategies, and existing intervention models. The findings can inform policy, clinical practice, and community support to better assist and uplift children facing early trauma in single-parent family settings.

Variability in trauma prevalence across different types of traumatic experiences such as neglect, abuse, and loss within the single-parent family context. Identification of specific traumatic experiences is more prevalent in single-parent families compared to two-parent households. Correlations between certain types of traumatic experiences and particular psychological development aspects like trauma are linked to higher levels of anxiety or lower self-esteem. Resilience factors buffer the negative impact of trauma on psychological development, such as social support or involvement in extracurricular activities. Identification of both adaptive and maladaptive coping strategies employed by children in response to trauma. Insights into the role of social support networks (peers, teachers, extended family) in shaping coping strategies and their effectiveness.

Assessment of the effectiveness of various intervention models in improving psychological well-being and resilience in children. Identification of barriers to accessing interventions, such

as stigma, financial constraints, or lack of awareness, which need to be addressed to enhance the reach and impact of interventions. By synthesizing these potential findings, the research can contribute to the advancement of knowledge in the field of child psychology and trauma, aiding in the development of evidence-based interventions and policies that support the well-being and healthy development of children from single-parent families who have experienced early childhood trauma.

Traumatic Experiences for Children from Single-Parent Families

These are the findings as relates to children staying with a single parent: The separation of parents can be deeply distressing for children, causing emotional trauma due to the disruption of their family structure and dynamics. Exposure to domestic violence within the family can have severe psychological effects on children, leading to fear, anxiety, and trauma. Substance abuse by a parent can expose children to neglect, instability, and potentially harmful situations, resulting in emotional and psychological trauma. Single parents often face challenges balancing work and caregiving, which can lead to emotional neglect if the child's needs for attention, guidance, and affection are not met adequately.

Economic challenges in single-parent households may lead to limited resources, financial instability, inadequate housing, and inadequate access to education and healthcare, causing emotional and psychological distress.

Mental health issues affecting a single parent can significantly impact a child's emotional well-being, as it may result in neglect, instability, and unpredictable caregiving. The death of a parent in a single-parent family can be a profoundly traumatic experience, causing grief, emotional distress, and a sense of loss. Frequent moves due to housing instability or other reasons can disrupt a child's sense of stability, causing emotional trauma and difficulty in

forming lasting relationships. Introducing new partners or experiencing changes in parental relationships can be emotionally challenging for children, impacting their sense of stability and security. Ongoing conflicts or custody battles between parents can expose children to a hostile environment, causing emotional distress and trauma.

Traumatic Experiences for Children under the Care of Guardians

These are the findings as relates to children staying with a Guardian: Being abandoned, orphaned, or separated from biological parents due to various reasons can be profoundly traumatic for children. Suffering physical harm or witnessing physical abuse within the household can cause severe emotional and psychological trauma. Experiencing sexual abuse, whether within the family or by individuals outside the family, can have severe and lasting psychological effects on children. Being neglected emotionally denied love, care, and attention, or experiencing chronic emotional abuse can cause significant trauma.

Exposure to violence in the community, including witnessing crime or being a victim of violence, can lead to trauma and psychological distress. Surviving or witnessing natural disasters, accidents, or traumatic events can have a lasting impact on a child's mental health and emotional well-being. Persistent bullying, whether at school or within the community, can lead to emotional trauma and severe psychological effects. Moving through the foster care system or experiencing multiple placements can result in emotional trauma due to instability and uncertainty.

Living with a guardian struggling with substance abuse or mental health problems can expose children to neglect, instability, and emotional trauma. Experiencing discrimination, racism, or prejudice due to ethnicity, race, or cultural background can cause emotional trauma and affect a child's self-esteem and sense of identity. It's important to note that each child's experience is

unique, and the impact of these traumatic experiences can vary based on various factors such as age, resilience, support systems, and coping mechanisms. Professional assistance and a supportive environment are crucial for children who have experienced trauma to help them heal and develop resilience.

5.4 Conclusion

In conclusion, this thesis has provided a comprehensive understanding of early childhood trauma among children from single-parent households in Kenya's primary school system. The high prevalence of trauma can be attributed to several factors, including economic hardships, social stigma associated with single parenthood, and limited access to mental health resources. These findings underscore the need for targeted interventions to support vulnerable children in single-parent households. Community awareness programs and the implementation of child protection policies are essential steps in addressing these issues.

The study reveals that children in single-parent households in the Kanduyi sub-county experience a high prevalence of various forms of early childhood trauma. The most common types include emotional abuse, neglect, and domestic violence. Physical abuse and the loss of a parent or caregiver are also significant concerns.

The trauma experienced in early childhood disrupts the development of essential cognitive and emotional skills. These developmental delays can have long-term consequences, affecting the child's ability to succeed in school and form healthy relationships. Interventions should focus on providing psychological support and creating stable, nurturing environments to mitigate these effects. Schools and community centers can play a crucial role in offering such support.

Early childhood trauma significantly impacts the cognitive and emotional development of children in single-parent households in the Kanduyi sub-county. Affected children often

exhibit lower academic performance, attention deficits, and behavioral issues such as aggression and anxiety.

Understanding the coping mechanisms used by children is vital for developing effective support programs. Positive coping strategies should be encouraged and reinforced through community and school-based programs. Conversely, interventions are needed to address negative coping mechanisms, providing children with healthier alternatives to manage their stress and emotions. Counseling and peer support groups can be beneficial in this regard.

Children in single-parent households in the Kanduyi sub-county employ a range of coping mechanisms to deal with early childhood trauma. Positive coping strategies include seeking support from extended family, engaging in religious or community activities, and participating in recreational activities. However, some children resort to negative coping mechanisms such as withdrawal, aggression, or substance abuse.

The presence of strong support systems can significantly mitigate the adverse effects of early childhood trauma. Community and family support offer a sense of belonging and security, which is essential for emotional healing. Schools and community programs can provide safe spaces and access to counseling services. Strengthening these support systems through policy initiatives and community engagement is crucial for the well-being of children in single-parent households. Encouraging collaboration between various stakeholders, including government, NGOs, and community leaders, can enhance the effectiveness of these support systems.

Support systems play a critical role in buffering the psychological impact of early childhood trauma on children from single-parent households in the Kanduyi sub-county. Effective support systems include extended family networks, community organizations, schools, and

religious institutions. These systems provide emotional support, stability, and resources that help children cope with and recover from trauma.

5.5 Recommendations

Based on the objectives and potential findings outlined in the research study concerning the psychological effects of early childhood trauma on children from single-parent families, the following recommendations are proposed to further support the well-being and development of children from single-parent families who have experienced early childhood trauma:

Provision of educational resources for parents and caregivers of children with Trauma issues. This empowers them to understand the challenges their children face and enables them to nurture moral development effectively.

Establish multidisciplinary teams consisting of psychologists, educators, and healthcare professionals to support children with trauma problems. Collaborative efforts can address both behavioral and developmental needs.

Implement behavior management and social skills training programs within educational settings to address the specific challenges associated with trauma problems. These programs should be tailored to individual needs.

Provide training to professionals working with children on the cultural nuances that can influence moral and behavioral development. This training should be integrated into their professional development.

Advocate for policies and programs that aim to reduce socioeconomic disparities in access to educational, healthcare, and developmental support services for children.

Ensure that all children from different socioeconomic backgrounds have equal access to resources Develop financial assistance programs to support families with limited economic

resources. These programs can alleviate economic stressors that impact children's development and behavior.

5.6 Areas for Further Studies

Based on this research conducted on early childhood trauma among children from single-parent households aged 4-17 in Kenya's primary schools, several areas for further studies and research exploration have been identified to deepen the understanding of this critical issue.

To Conduct longitudinal studies to track the long-term effects of early childhood trauma into adulthood, examining how trauma experiences during childhood influence outcomes in education, employment, mental health, and overall life satisfaction.

To Conduct comparative studies analyzing the differences in the prevalence, types, and impacts of early childhood trauma between children from single-parent households and those from two-parent households, considering how family structure affects trauma experiences. Evaluate the effectiveness of various interventions, such as trauma-informed educational approaches, counseling programs, and community support initiatives, to determine their impact on mitigating the effects of early childhood trauma and promoting resilience.

To Investigate gender-specific experiences of early childhood trauma within single-parent households, exploring how trauma affects boys and girls differently and tailoring interventions accordingly. To research the Influence of Socioeconomic Factors by exploring the relationship between socioeconomic status, early childhood trauma, and its effects, analyzing how financial stability or instability may exacerbate or mitigate the impact of trauma on children's development.

To Explore the Coping Mechanisms by Conducting in-depth studies focusing on the coping mechanisms employed by children from single-parent households to manage early childhood trauma, examining the effectiveness and long-term implications of these coping strategies. Investigate the role of the noncustodial parent or absent parent in providing emotional and financial support to children from single-parent households, exploring how their involvement influences the child's experience of trauma and coping mechanisms.

Research on the availability and usage of mental health services by children from single-parent households who have gone through early childhood trauma, identifying obstacles and motivating elements for asking for assistance. Examine how trauma-informed school environments are implemented and how well they work to support children from single-parent households, considering the viewpoints of both teachers and students in creating these environments. Identify cultural elements that affect trauma experiences and support networks by conducting cross-cultural research comparing the experiences and effects of early childhood trauma among children from single-parent households in other nations or regions. More in-depth understanding of early childhood trauma in the context of single-parent households will be provided by ongoing research in these fields, allowing for the creation of targeted interventions and support systems to enhance the resilience and well-being of affected children.

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APPENDICES

Appendix A: Traumatic Events Screening Inventory- Parent Report Revised

OFFICE ONLY ID:	Respondent:	Times @ Clinic	Date:	
Assessor: Taiga Wanyanja	Vscale	VP1: ❑ Y ❑ N	VP2: ❑ Y ❑ N	VP3: ❑ Y ❑ N

TRAUMATIC EVENTS SCREENING INVENTORY- PARENT REPORT REVISED

Children may experience stressful events, which may affect their health and well-being. By answering the shaded questions, please indicate if your child has experienced any of these potentially stressful events. If the answer is yes, please answer the follow-up questions. If it's no, please go to the next shaded question.

If you have any questions or comments about any of the questions, we would be happy to talk to you about them.

SAMPLE ITEM *(instructions are in italics)*

A. **Has your child ever had a doctor's visit?** *(Mark your answer in the next column. If yes answer the questions below.)* _____

If YES ➪ How old was your child? _____

The first time:	**The last time:**	**The most stressful:**
Your child's age the first time s/he saw a doctor(even if s/he would not have remembered it).	*Your child's age during his/her most recent doctor's visit.*	*Your child's age during the most stress for your child (in your opinion).*

Was your child strongly affected by one or more of these experiences? ❑ **yes** ❑ **no** ❑ **unsure**

(By strongly affected we mean: did your child seem: a) to be extremely frightened; b) to be very confused or helpless; c) to be very sh horrified, d) to have difficulty getting back to her or his normal way of behaving or feeling when it was over, OR e) to behave diff important ways after it was over.)

1.1 Has your child ever ***been in*** a serious accident where someone could have been (or was) severely injured or die bicycle accident, a fall, a fire, an incident where s/he was burned, an actual or near drowning, or a severe sports

If YES ➪ Identify the type of accident(s):

relationship to your child: Did anyone

How old was your child? The first time: The last time: The most stressful:

Was your child strongly affected by one or more of these experiences? ❑ yes ❑ no ❑ unsure

1.2 Has your child ever ***seen*** a serious accident where someone could have been (or was) severely injured or died? bicycle accident, a fall, a fire, an incident where someone was burned, an actual or near drowning, or a severe

If YES ➪ Identify the type of accident(s)

Victim's relationship to your child: Did anyone

How old was your child? The first time: The last time: The most stressful:

Was your child strongly affected by one or more of these experiences? ❑ yes ❑ no ❑ unsure

1.3 Has your child ever been in a natural disaster where someone could have been (or was) severely injured or died, in your community lost or had to permanently leave their home (like a tornado, fire, hurricane, or earthquake)?

If YES ➪ Type of disaster: Did anyone die?

How old was your child? The first time: The last time: The most stressful:

Was your child strongly affected by one or more of these experiences? ❑ yes ❑ no ❑ unsure

1.4a Has your child ever experienced the severe illness or injury of someone close to him/her?

IF YES ➪ What was this person's relationship to your child?

How old was your child? The first time: The last time: The most stressful:

Was your child strongly affected by one or more of these experiences? ❑ yes ❑ no ❑ unsure

1.4b Has your child ever experienced the death of someone close to him/her?

IF YES ➪ What was this person's relationship to your child?

How old was your child? The first time: The last time: The most stressful:

Was the death(s) due to: *(check all that apply)* ❑ natural causes ❑ illness ❑ accident ❑ violence ❑

your child strongly affected by one or more of these experiences? ❑ yes ❑ no ❑ unsure

1.5 Has your child ever undergone any serious medical procedures or had a life-threatening illness? Or been treate emergency room, or hospitalized overnight for a medical procedure?

IF YES➪ Describe

How old was your child? The first time: The last time: The most stressful:

Was your child strongly affected by one or more of these experiences? ❑ yes ❑ no ❑ unsure

1.6 Has your child ever been separated from you or another person who your child depends on for love or security fo very stressful circumstances? For example, due to foster care, immigration, war, major illness, or hospitalizatio

IF YES➪ Who was your child separated from:

How old was your child? The first time: The last time: The most stressful:

Was your child strongly affected by one or more of these experiences? ❑ yes ❑ no ❑ unsure

1.7 Has someone close to your child ever attempted suicide or harmed him or herself?

IF YES ➪ What was this person's relationship to your child?

How old was your child? The first time: The last time: The most stressful:

Was your child strongly affected by one or more of these experiences? ❑ yes ❑ no ❑ unsure

2.1 Has someone ever physically assaulted your child, like hitting, pushing, choking, shaking, biting, or burning? physical injury or bruises. Or attacked your child with a gun, knife, or other weapon? (This could be done by so by someone not in your child's family).

IF YES➪ What was this person's relationship to your child?

Was a weapon used? ❑ unsure ❑ no ❑ yes (type)

How old was your child? The first time: The last time: The most stressful:

Was your child strongly affected by one or more of these experiences? ❑ yes ❑ no ❑ unsure

2.2 Has someone ever directly threatened your child with serious physical harm?

IF YES➪ What was this person's relationship to your child?

Did they threaten to use a weapon? ❑ unsure ❑ no ❑ yes (type)

How old was your child? The first time: The last time: The most stressful:

Was your child strongly affected by one or more of these experiences? ❑ yes ❑ no ❑ unsure

2.3 Has someone ever mugged or tried to steal from your child? Or has your child been present when a family memb mugged?

IF YES➪ Who was mugged? (If not, your child indicates the person's relationship to your child.)

Was a weapon used? ❑ unsure ❑ no ❑ yes (type)

How old was your child? The first time: The last time: _ The most stressful:

Was your child strongly affected by one or more of these experiences? ❑ yes ❑ no ❑ unsure

2.4 Has anyone ever kidnapped your child? (including a parent or relative) Or has anyone ever kidnapped someone

IF YES➪ Who was kidnapped? (If not, your child indicates the person's relationship to your child.)

What was the kidnapper's relationship to your child?

How old was your child? The first time: The last time: The most stressful:

Was your child strongly affected by one or more of these experiences? ❑ yes ❑ no ❑ unsure

2.5 Has your child ever been attacked by a dog or other animal?

IF YES➪ How old was your child? The first time: The last time: The most stressful:

Was your child seriously physically hurt as a result of the attack? ❑yes ❑ no ❑ unsure

Was your child strongly affected by one or more of these experiences? ❑ yes ❑ no ❑ unsure

3.1 Has your child ever seen, heard, or heard about people ***in your family*** physically fighting, hitting, slapping, kicki shooting with a gun stabbing, or using any other kind of dangerous weapon?

IF YES➪ What were these people's relationships with your child?

Was a weapon used? ❑ unsure ❑ no ❑ yes (type)

How old was your child? The first time: The last time: The most stressful:

Did your child see what happened? ❑yes ❑ no ❑ unsure

Was your child strongly affected by one or more of these experiences? ❑ yes ❑ no ❑ unsure

3.2 Has your child ever seen or heard people ***in your family*** threaten to seriously harm each other? IF YES➪ What were these people's relationships with your child? Did they threaten to use a weapon? ❑ unsure ❑ no ❑ yes (type) How old was your child? The first time: The last time: The most stressful: Was your child present when the threat was made? ❑yes ❑ no ❑ unsure Was your child strongly affected by one or more of these experiences? ❑ yes ❑ no ❑ unsure	❑Yes ❑ No ❑ Unsure
3.3 Has your child ever known or seen that a family member was arrested, jailed, imprisoned, or taken away (like by police, soldiers, or other authorities)? IF YES➪ What was this person's relationship to your child? How old was your child? The first time: The last time: The most stressful: Was your child there when the police came? ❑yes ❑ no ❑ unsure Was your child strongly affected by one or more of these experiences? ❑ yes ❑ no ❑ unsure	❑Yes ❑ No ❑ Unsure
4.1 Has your child ever seen or heard people ***outside your family*** fighting, hitting, pushing, or attacking each other? Or seen or heard about violence such as beatings, shootings, or muggings that occurred in settings that are important to your child, such as school, your neighborhood, or the neighborhood of someone important to your child? IF YES➪ What were these people's relationship to your child? Was a weapon used? ❑ unsure ❑ no ❑ yes (type) Where did this happen? How old was your child? The first time: The last time: The most stressful: Did your child see what happened? ❑yes ❑ no ❑ unsure Was your child strongly affected by one or more of these experiences? ❑ yes ❑ no ❑ unsure	❑Yes ❑ No ❑ Unsure
4.2 Has your child ever been directly exposed to war, armed conflict, or terrorism? IF YES➪ How old was your child? The first time: The last time: The most stressful: Was your child strongly affected by one or more of these experiences? ❑ yes ❑ no ❑ unsure	❑Yes ❑ No ❑ Unsure
4.3 Has your child ever seen or heard acts of war or terrorism on the television or radio? IF YES➪ How old was your child? The first time: The last time: The most stressful: Was your child strongly affected by one or more of these experiences? ❑ yes ❑ no ❑ unsure	❑Yes ❑ No ❑ Unsure
5.1 Has someone ever ***made*** your child see or do something sexual (like touching sexually, exposing self, or masturbating in front of the child, engaging in sexual intercourse) IF YES➪ What was this person's relationship to your child? Was physical violence used? ❑ unsure ❑ no ❑ yes Was a weapon used? ❑ unsure ❑ no ❑ yes (type) How old was your child? The first time: The last time: The most stressful: Was your child strongly affected by one or more of these experiences? ❑ yes ❑ no ❑ unsure	❑Yes ❑ No ❑ Unsure

5.2 Has your child ever been present when someone was being forced to engage in any sort of sexual activity? →	❑ Yes ❑ No ❑ Unsure
IF YES➪ What were these people's relationship to your child? Victim: Aggressor: Was physical violence used? ❑ unsure ❑ no ❑ yes Was a weapon used? ❑ unsure ❑ no ❑ yes (type) How old was your child? The first time: The last time: The most stressful: Was your child strongly affected by one or more of these experiences? ❑ yes ❑ no ❑ unsure	
6.1 Has your child ever repeatedly been told s/he was no good, yelled at in a scary way, or had someone threaten to abandon, leave, or send him/her away? →	❑ Yes ❑ No ❑ Unsure
IF YES➪ What was this person's relationship to your child? How old was your child? The first time: The last time: The most stressful: Was your child strongly affected by one or more of these experiences? ❑ yes ❑ no ❑ unsure	
6.2 Has your child ever gone through a period when s/he lacked appropriate care (like not having enough to eat or drink, lacking shelter, being left alone when s/he was too young to care for herself/himself, or being left with a caregiver who was abusing drugs)	❑ Yes ❑ No ❑ Unsure
IF YES➪ How old was your child? The first time: The last time: The most stressful: Was your child strongly affected by one or more of these experiences? ❑ yes ❑ no ❑ unsure	
7.1 Have other stressful things have happened to your child? →	❑ Yes ❑ No ❑ Unsure
IF YES➪ Briefly describe these things: _____ How old was your child? The first time: The last time: The most stressful: Was your child strongly affected by one or more of these experiences? ❑ yes ❑ no ❑ unsure	

Appendix B: Post Traumatic Symptom Inventory for Children (PTSIC)

This is a Child Trauma questionnaire to be administered to children within 10 schools in Kanduyi Constituency.

The purpose of this questionnaire is to establish the rate of trauma in a children's sample.

BIODATA OF THE CHILD:

Name: ----------
Parents Name: ----------
Friends Name----------
Age: ----------
School----------
Grade----------
Home Area----------

INSTRUCTIONS: Please choose/mark/circle/tick one or more that only answers the question.

Pre-Test Screen For Traumatic Life Events and Related Fears

Recurrent distressing dreams of the event; or frightening dreams without recognizable content.

1. Do you ever have really scary dreams?

a) real a lot
b) like almost every night
c) sometimes

2. Do you ever have scary dreams about things that happened to you?

a) real a lot
b) like almostevery night
c) sometimes

Recurrent intrusive, distressing recollections of the event.

3. Do you think about really bad things that happened to you?

a) real a lot
b) like almost every night
c) sometimes

4. When you close your eyes (***tester closes their own eyes***), do you ever see pictures of really bad or scary things?

a) real a lot
b) like almost every night
c) sometimes

Repetitive play with themes of the event

5. Do you ever play games and pretend really bad or scary things are happening to you?

a) real a lot
b) like almost every day
c) sometimes

6. Do you ever play games where you pretend someone gets hurt—or pretend someone dies?

a) real a lot
b) like almost every day
c) sometimes

Efforts to avoid thoughts feelings or conversations associated with the event

7. Do you ever try hard not to think about bad or scary things that happened to you?
a) real a lot
b) like almost every day
c) sometimes

Acting or feeling as if the event were recurring. Including reliving the event,illusions, hallucinations, Dissociative flashback episodes; or trauma-specificreenactments

8. Do you feel like something bad or scary is happening, even when it's not happening?
a) real a lot
b) like almost every day
c) sometimes

Efforts to avoid activities places or people that arouse recollections of the trauma

9. Do you ever feel scared to leave your home -or your room --because something bad might happen?
Are you afraid?

a) Real a lot
b) like almost all the time
c) sometimes

10. Are there scary things you like to stay away from?
a) real a lot
b) like almost all the time
c) sometimes

Inability to recall an important aspect of the trauma

11. *Is it hard to remember those bad or scary things?*
a) Real a lot
b) Like almost all the time
c) Sometimes

12. Are there bad or scary things that happened toyou that you forgot happened?

a) Real a lot
b) Like almost all the time
c) Sometimes

Marked diminished interest in participation in significant activities

13. After bad or scary things happen to you, do you not want to play as much anymore?
a) Real a lot
b) like almost all the time or every day
c) want to play sometimes

14. *Do you feel like you don't want to do fun stuff?*
a) Real a lot-
b) like almost all the time or every day
c) Feel that way just sometimes

Feeling detached or estranged from others

15. Do you feel like people don't like you sometimes?
a) nobody likes me
b) Just some people don't like me
c) *Sometimes people like me*

16. When bad or scary things happen to you, do you want to talk to anybody?
a) Real a lot
b) like almost all the time
c) feel like that just sometimes

Restricted range of affect (unable to experience loving feelings)

17. *Is it hard to feel happy?*
a) real a lot-like everyday
b) just hard to feel happy
c) sometimes

18. *Are you sad?*
a) real a lot
b) like almost all the time orevery day
c) just feel sad sometimes

Sense of foreshortened future. Does not expect to have a career, children, ornormal life span.

19. Do you ever worry that you will die before you grow up?
a) Real a lot
b) like almost all the time
c) just worry about dying sometimes

Difficulty falling asleep or staying asleep

20. *Is it hard to fall asleep?*
a) Real a lot
b) like almost everynight
c) just hard to fall asleep sometimes

21. *Is it hard for you to sleep?*
a) real a lot
b) like almost everynight
c) just hard to sleep sometimes

Irritability and outbursts of anger

22. Do you ever scream and yell when you get angry?
a) real a lot
b) like almost all the time, or every day
c) Just scream and yell sometimes

23. Do you ever feel like you want to hurt other people?
a) real a lot
b) like almost allthe time, or every day
c) Just feel that way sometimes?

24. Do you get angry or upset easily?
a) real a lot
b) like almost all the time, orevery day
c) just get mad sometimes

Difficulty concentrating

25. *Do you forget things?*
a) Real a lot
b) like almost all the time,or every day
c) Just forget things sometimes?

26. *Do you forget how to play games?*
a) real a lot
b) like almost allthe time, or every day
c) just forget how to play sometimes

Hypervigilance

27. Are you ever scared something really bad will happen?
a) a real lot-
b) likealmost all the time or every day
c) just scared

28. Are you scared of some people?
a) Most people
b) Scared of some people
c) Scared of all people

Exaggerated startle response

29. Do you get surprised easily?

a) *a real lot-*
b) *like almost all the time*
c) *sometimes*

30. Do you ever jump up or get scared when you hear a loudnoise like this (the ***tester hits a hand on the desk or claps their hands***)?

a) *a real lot-*
b) *like almost all the time*
c) *just* get scared when I hear a loud noise *sometimes*

Source: **(Mitchell L. Eisen) cite**

Appendix C: Trauma Questionnaire

This is a Child Trauma questionnaire to be administered to children within 10 schools in Kanduyi Constituency.
The purpose of this questionnaire is to establish the rate of trauma in a children's sample.

BIODATA OF THE CHILD:
Name: ----------
Parents Name: ----------
Friends Name----------
Age: ----------
School----------
Grade----------
Home Area----------

INSTRUCTIONS: Please choose/mark/circle/tick one or more that only answers the question.

1. Who has ever humiliated you?

a) No one.
b) My parents.
c) My classmates or friends.
d) Someone I didn't know.
e) No one has humiliated me. But I've seen many others being humiliated.
f) Parents, friends, relatives, and others.

2. Have you ever experienced physical abuse? If yes, who was the abuser?

a) No, I've never been physically abused.
b) Yes, my parent(s).
c) Yes, someone in school.
d) Yes, someone I didn't know.
e) No, but I've seen others being abused.
f) I don't want to talk about it.

3. Have you been sexually abused? If yes, who was the abuser?

a) No, I've never been sexually abused.
b) Yes, my parent(s).
c) Yes, someone in school.
d) Yes, someone I didn't know.
e) No, but I've seen others being abused.
f) I don't want to talk about it.

4. What was (or is) the most challenging part of your school life?

a) My school days were mostly fun.

b) My parents' expectations ruined my school life.
c) I was bullied in school.
d) A horrifying incident happened in my school and devastated me.
e) Lots of horrible stuff happened to my friends in my school.
f) I experienced most of the mentioned stuff in my school life.

5. Have you ever felt like your parents don't love you? Why?

a) Not really. They've always loved me.
b) Yes, they were always mean to me.
c) Yes, they were never there for me.
d) One time, they did something horrible that made me feel that way.
e) No, but I believe my siblings feel that way.
f) Yes, they abused/hurt me.

6. Which one describes your family's financial status when you were a kid?

a) We had no financial struggles.
b) My parents were unemployed.
c) Compared to other children at my school, I grew up poor.
d) We had a brief financial crisis that devastated our family.
e) We were doing fine. But most of my friends were poor.
f) We had no money, food, or place to stay.

7. Which one is your main struggle in life?

a) Career
b) Relationships
c) Confidence
d) Stress
e) Guilt
f) Almost all of the above

8. How would you describe your romantic relationships?

a) Reliable, mutually trust-oriented, and long-term.
b) Short-term and superficial.
c) Aggressive and full of fights.
d) Full of manipulation and abuse.
e) Full of the feeling of guilt and shame.
f) I can't start a romantic relationship.

9) How do you express your emotions?

a) I talk about my emotions.
b) I often hide them.
c) I show them through anger.
d) I do unpredictable things.
e) I often cry and blame myself for being overly emotional.
f) I hurt myself.

10. In your opinion, how insecure are you?

(5 means you're overly insecure). 0 (I'm not insecure) 5

a) 5 (I'm incredibly insecure)
b) 4
c) 3
d) 2
e) 1

11. Which one could trigger your anxiety?

a) Deadlines
b) Family gatherings
c) School reunions
d) Car accidents or bad news.
e) Someone asking for your immediate help.
f) Almost all of the above.

12. How would you describe your relationship with your parents?

a) We're close.
b) We've never had a real relationship.
c) They're too busy with their own lives.
d) We used to be close, but not anymore.
e) I don't know. We have an on-and-off relationship.
f) I have never had parents.

13. Which of these traumatic events have you experienced in your childhood?

a) I don't think I've experienced anything traumatic.
b) Being abandoned, neglected, or abused by my parents.
c) Being physically abused by someone I knew.
d) Being sexually abused.
e) Witnessing a horrible incident/accident.
f) My childhood is full of traumatic experiences.

14. Has any of your loved ones been involved in risky behaviors like substance abuse?

a) No
b) Yes, my parents.
c) Yes, my friends.
d) I'm not sure.
e) Yes, my siblings.
f) Yes, my parents, friends, relatives, and even friends.

15. Would you say one or both of your parents had mental disorders? Why?

a) No, I don't think so.
b) Yes, they were severely depressed.
c) Yes, they were narcissistic and manipulative.

d) I'm not sure about that.
e) Yes, they were mean to others.
f) I've never lived with my parents. So, I don't know.

16. When did you start noticing you might have Post Traumatic Stress Disorder (PTSD) or severe anxiety?

a) I don't think I have it.
b) When I couldn't hang onto my relationships as an adult.
c) When I realized I was overly insecure about my body and personality.
d) It happened after a horrible incident in my life.
e) When I realized I feel guilty for every emotion I have.
f) I've always been this way.

17. Are there any specific social situations that you purposefully avoid?

a) Not really.
b) Yes, meeting family members.
c) Yes, making new friends.
d) Yes, community events.
e) Yes, my birthday party.
f) I avoid all social situations at all costs.

18. Where do you feel safe?

a) At my home.
b) At my grandparents' house.
c) Anywhere but school.
d) Anywhere but in a vehicle.
e) At hotels or places with reliable security.
f) Nowhere. I never feel safe.

19. Is it difficult for you to trust others? If yes, why is that?

a) No, I don't think it's that hard.
b) Yes, I feel like they'll betray me.
c) Yes, I feel like they're not genuine.
d) It used to be easier.
e) No, but I think it's hard for others to trust me.
f) I've never trusted anyone in my entire life.

20. What do you do when you feel like you’re having an anxiety attack?

a) I talk to a loved one or ask for their help.
b) I just lock myself in my room and avoid others.
c) I pretend I'm fine and try to act normal.
d) I might feel physically ill or throw up.
e) I feel guilty for being nervous and trying to cope with it.
f) I hurt myself.

Appendix D: Consent Form

This Consent Form is for the following Personal Information:

(Initial next to each item for which permission to use is being given)

Story: Image/visual likeness: Attached to the report:
See client story:
Name: Voice/Audio:
Sensitive information (Please list information):
_____
_____

Please indicate below if there is specific information you would like the Researcher to exclude from future publications, promotional materials, web content, and other Research materials.

There isn't any information that the client would object to being publicized.
_____
_

I give my consent and authorize the researcher to use, adapt, and reproduce all or part of my personal information indicated above in a manner consistent with the mission of the research. This includes, but is not limited to, use in promotional materials, fundraising materials, web content, advocacy, and awareness-raising campaigns and publications.

I understand and accept the risks of public disclosure of the above information.

I understand that I may withdraw my consent at any time in the future and for any reason without consequence, however, it may not be possible to effectively withdraw information already released into the public domain.

I understand that any consent granted on this date to use and disclose the above information remains in effect indefinitely unless and until withdrawn.

By signing below, I confirm that I have read this consent form, or someone has read this consent form to me, and I understand its terms. Any questions I have related to this consent have been answered to my satisfaction.

Printed Name: _____ Signature_____ Date:

Signature of parents or guardian ((if under age 18): _____ Date:

THIRD-PARTY RELEASE.

I give my consent and authorize the researcher to permit third parties to use, adapt, and reproduce my personal information in a manner consistent with the mission of the researcher and on terms identical to those outlined above for the researcher.

Printed Name: _____ Signature: _____ Date:

Signature of parent or guardian: ----------

Appendix E. Africa Nazarene University Letter for Research

AFRICA NAZARENE
UNIVERSITY

12th June, 2023

RE: TO WHOM IT MAY CONCERN

Wanyanja Job Taiga (**18M03DMCP024**) is a bonafide student at Africa Nazarene University, in the School of Humanities and Social Sciences, Counseling Psychology Department. He has finished his course work and has defended his thesis proposal entitled: - ***"Psychosocial Effect of Early Childhood Trauma Among Single Parents' Families. A Case of Selected Primary Schools in Kanduyi Sub County in Bungoma."***.

Any assistance accorded to him to facilitate data collection and finish his thesis is highly welcomed.

Sincerely,

Dr. Simon Obwatho
Ag. DVC, Academic Affairs

Appendix F.: Research Permit NACOSTI-P-23

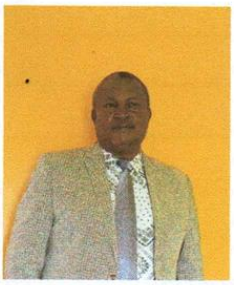
REPUBLIC OF KENYA

NATIONAL COMMISSION FOR SCIENCE,TECHNOLOGY & INNOVATION

Ref No: **253113**

Date of Issue: **28/July/2023**

RESEARCH LICENSE



This is to Certify that Mr.. Taiga Job Wanyanja of Africa Nazarene University, has been licensed to conduct research as per the provision of the Science, Technology and Innovation Act, 2013 (Rev.2014) in Bungoma on the topic: "Psychosocial Effect of Early Childhood Trauma Among Single Parents' Families. A Case of Selected Primary Schools in Kanduyi Sub County in Bungoma.". for the period ending : 28/July/2024.

License No: **NACOSTI/P/23/27951**

253113

Applicant Identification Number

Director General
NATIONAL COMMISSION FOR SCIENCE,TECHNOLOGY & INNOVATION

Verification QR Code

NOTE: This is a computer generated License. To verify the authenticity of this document, Scan the QR Code using QR scanner application.

See overleaf for conditions

THE SCIENCE, TECHNOLOGY AND INNOVATION ACT, 2013 (Rev. 2014)
Legal Notice No. 108: The Science, Technology and Innovation (Research Licensing) Regulations, 2014

The National Commission for Science, Technology and Innovation, hereafter referred to as the Commission, was the established under the Science, Technology and Innovation Act 2013 (Revised 2014) herein after referred to as the Act. The objective of the Commission shall be to regulate and assure quality in the science, technology and innovation sector and advise the Government in matters related thereto.

CONDITIONS OF THE RESEARCH LICENSE

1. The License is granted subject to provisions of the Constitution of Kenya, the Science, Technology and Innovation Act, and other relevant laws, policies and regulations. Accordingly, the licensee shall adhere to such procedures, standards, code of ethics and guidelines as may be prescribed by regulations made under the Act, or prescribed by provisions of International treaties of which Kenya is a signatory to
2. The research and its related activities as well as outcomes shall be beneficial to the country and shall not in any way;
    i. Endanger national security
    ii. Adversely affect the lives of Kenyans
    iii. Be in contravention of Kenya's international obligations including Biological Weapons Convention (BWC), Comprehensive Nuclear-Test-Ban Treaty Organization (CTBTO), Chemical, Biological, Radiological and Nuclear (CBRN).
    iv. Result in exploitation of intellectual property rights of communities in Kenya
    v. Adversely affect the environment
    vi. Adversely affect the rights of communities
    vii. Endanger public safety and national cohesion
    viii. Plagiarize someone else's work
3. The License is valid for the proposed research, location and specified period.
4. The license any rights thereunder are non-transferable
5. The Commission reserves the right to cancel the research at any time during the research period if in the opinion of the Commission the research is not implemented in conformity with the provisions of the Act or any other written law.
6. The Licensee shall inform the relevant County Director of Education, County Commissioner and County Governor before commencement of the research.
7. Excavation, filming, movement, and collection of specimens are subject to further necessary clearance from relevant Government Agencies.
8. The License does not give authority to transfer research materials.
9. The Commission may monitor and evaluate the licensed research project for the purpose of assessing and evaluating compliance with the conditions of the License.
10. The Licensee shall submit one hard copy, and upload a soft copy of their final report (thesis) onto a platform designated by the Commission within one year of completion of the research.
11. The Commission reserves the right to modify the conditions of the License including cancellation without prior notice.
12. Research, findings and information regarding research systems shall be stored or disseminated, utilized or applied in such a manner as may be prescribed by the Commission from time to time.
13. The Licensee shall disclose to the Commission, the relevant Institutional Scientific and Ethical Review Committee, and the relevant national agencies any inventions and discoveries that are of National strategic importance.
14. The Commission shall have powers to acquire from any person the right in, or to, any scientific innovation, invention or patent of strategic importance to the country.
15. Relevant Institutional Scientific and Ethical Review Committee shall monitor and evaluate the research periodically, and make a report of its findings to the Commission for necessary action.

National Commission for Science, Technology and
Innovation(NACOSTI),
Off Waiyaki Way, Upper Kabete,
P. O. Box 30623 - 00100 Nairobi, KENYA
Telephone: 020 4007000, 0713788787, 0735404245
E-mail: dg@nacosti.go.ke
Website: www.nacosti.go.ke

Appendix G: Ministry of Education Authorization

REPUBLIC OF KENYA

MINISTRY OF EDUCATION

State Department for Early Learning and Basic Education

When Replying Please Quote
e-mail: bungomacde@gmail.com

County Director of Education
P.O. Box 1620-50200
BUNGOMA

REF: BCE/DE/19/VOL.III/49

DATE:24th August 2023

TO WHOM IT MAY CONCERN

RE: AUTHORITY TO CARRY OUT RESEARCH: MR. TAIGA JOB WANYANJA

The bearer of this letter Mr. Taiga Job Wanyanja of Africa Nazarene University has been authorized to carry out a research on "Psychological Effects of Early Childhood Trauma among Single Parents' Families" A case of selected Primary Schools in Kanduyi Sub County of Bungoma County for a period ending 28'^ July 2024

Kindly accord him the necessary assistance.

CHRISTINE OWINO

FOR COUNTY DIRECTOR OF EDUCATION

BUNGOMA COUNTY

FOR: COUNTY DIRECTOR OF EDUCATION
BUNGOMA
P. O. Box 1620,
50200

SM

Appendix H: Map of schools in Kanduyi Sub-county