CHILD-FRIENDLY APPROACHES AND PSYCHOTRAUMA OUTCOMES AMONG RESCUED STREET CHILDREN IN SELECTED CHILDREN'S HOMES IN KINSHASA, DEMOCRATIC REPUBLIC OF CONGO

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NAIROBI, KENYA

July, 2022

DECLARATION

DECLARATION

I, the undersigned, declare that this thesis is my original work and has never been presented or duplicated elsewhere for the award of degree in any University.

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DEDICATION

This thesis is dedicated to every child in the world who suffers from any sort of abuse and in particular, to my niece Fidelia Lakwiti Kilanda, who is one of those children.

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Above all, to God be the glory for he has made my dream become a reality, for I have been privileged to get a chance to do my Masters in Counselling Psychology.

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ABSTRACT

This study was carried out to identify the effect of child-friendly approaches on psychological trauma among rescued street children in three selected Children's Homes, in Kinshasa, Democratic Republic of Congo. The research established the psycho-trauma outcomes among rescued street children in selected Children's Homes. It determined the influence of music and dance on psycho-trauma outcomes among rescued street children in selected Children's Homes; identified the influence of storytelling on psycho-trauma among rescued street children in selected Children's Homes; and examined the influence of meditation on psycho-trauma among rescued street children in selected Children's Homes. Moreover, Gestalt Theory and Attachment Theory guided the study. The Mixed-Methods convergent parallel design was employed to collect and analyse quantitative and qualitative data simultaneously. The quantitative data was analysed using statistical methods of the SPSS program. The study used a total sample of 142 rescued streets children of the three selected Children's Homes. The sampling procedure was the extreme case sampling. The first stage, baseline, consisted in selecting through the intake forms of the children the extreme cases. The study employed PCL-5 Child Self-report to screen the trauma symptoms before and after the intervention. The second stage was the intervention stage, which was the implementation of the child-friendly approaches. The third stage was the post-intervention stage, which consisted on screening the trauma levels after the intervention. The findings revealed that before the intervention the trauma level of all the participants was significantly higher than the level of trauma after intervention. The expected results of the current study show gradually an improvement on the psycho-trauma outcomes among rescued street children of the three selected Children's Homes, and learning of the new socio-emotional coping skills by the children. The study established that child-friendly approaches such music/dance, storytelling and meditation were effective in treating traumatized rescued street children. In addition, it was noted that the awareness of the personnel on the traumatic experience of the children and its consequences increased, therefore the quality of life and relationships between the caregivers and the children was promoted. The study recommended that the government should support and accompany those institutions that are willingly to work for the wellbeing and protection of street children. This includes training the social workers and caregivers in counselling skills especially when working with traumatized children to compensate where counsellors cannot reach.

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ABBREVIATIONS AND ACCRONYMS

ACACE: American Counselling Association Code of Ethics

ADTA: American Dance Therapy Association

ANOVA: Analysis of Variance

APA: American Psychiatric Association

BAI: Beck's Anxiety Inventory

BDI-II: Beck's Depression Inventory II

BERS-2: Behavioural and Emotional Rating Scale2

CA: Children's Act

CAPS-CA: Clinician Administered PTSD Scale for Children and Adolescents

CCIs: Charitable Children's Institutions

CEAT: Creative Expressive Arts Therapy

CIDI: Composite International Diagnostic Interview

COVID-19: Corona Virus Disease 2019

CRC: Convention on the Rights of the Child

CSC: Consortium of Streets Children

CUEA: Catholic University of Eastern Africa

DES: Dissociative Experience Scale

DISC: Diagnostic Interview Schedule for Children

DRC: Democratic Republic of Congo

DSM-5: Diagnostic and Statistical Manuel of Mental Disorders 5th edition

DSS-20: Dissociative Symptoms Scale 20 items

DTS: Davidson Trauma Scale

HADS: Hospital Anxiety and Depression Scale

HIV/AIDS: Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome

HSCL-25: Hopkins symptoms checklist-25 items

HTQ: Harvard Trauma Questionnaire

IES-6: Impact of Event Scale-6

MINI: Mini International Neuropsychiatric Interview

NCTSN: National Child Traumatic Stress Network

PCL-5: PTSD Checklist for DSM-5

PCL-C-5: PTSD checklist Child self-report for DSM-5

PDS: Post-traumatic Stress Diagnostic Scale

PSS-I: PTSD Symptom Scale Interview

PSOM-S: Positive State of Mind Scale

PTSD: Posttraumatic Stress Disorders

RAAS: Revised Adult Attachment Scale

RATS: Reaction of Adolescents to Traumatic Stress

SDQ-5: Somatoform Dissociation Questionnaire- for DSM 5

SDQ-20: Somatoform Dissociation Questionnaire-20 items for DSM5

SPSS: Statistical Package for the Social Sciences

TSQ: Trauma Screening Questionnaire

UCLA-PTSD-5: The University of California at Los Angeles Posttraumatic Stress Disorder Reaction Index for DSM-5

UN: United Nations

UN-GACC: United Nations Guidelines for Alternative Care of Children

UNESCO: United Nations Educational, Scientific and Cultural Organization

UNICEF: United Nations Children's Fund

USA: United States of America

WCSC: World Cup for Street Children

WHO: World Health Organisation

YCPC: Young Child PTSD Checklist

OPERATIONAL DEFINITION OF KEY TERMS

Child

A child is a human being aged between 0 and 17 years, and who is not only able to defend or protect himself or herself but also unable to provide for his or her needs. Such a person is vulnerable to abuse and maltreatment. Consequently, he or she depends on adults and needs love, care, protection, attention and a good environment to grow well and healthy morally, physically, psychologically, spiritually and socially in order to be fully integrated into the society.

Child-Friendly Approaches

Child-friendly approaches are techniques or methods adapted or applied to children, which are easy to use, in the process of healing their mind according to their age. They include healing their thoughts and beliefs that influence their behaviours and feelings.

Psycho-trauma

Psycho-trauma is a psychological or emotional shock that a person experiences after an adverse event. Such a shock is harmful for the person, impeding his or her wellbeing, and causing his or her dysfunction.

Psycho-Trauma Outcomes

Psycho-trauma outcomes are symptoms of psychological or emotional shock, such as anxiety, sadness, fear, irritability, isolation, anger, hyperactivity, avoidance, nightmares and so on.

Rescued Street Children

Rescued street children are children saved and recovered from the streets. These are children who once lived on the streets before being taken to go and live elsewhere such as in centres, homes, or foster families where most of their needs are met.

Children's Home

A children's home is a charitable institution or a residential place or a centre where rescued street children live and are cared by the persons who are not their biological parents.

CHAPER ONE

INTRODUCTION

1.1. Introduction

Globally, the number of “street children” who comprise of homeless minors who live and survive on the street has been growing. These children, according to the Consortium of Street Children, run away from their natural families after being subjected to physical and emotional torture, corporal punishment, forced labour, abject poverty and neglect just to mention but a few. Majority of these children have even been disowned by their own family members because of problems with their mental health, substance misuse, their sexual preference or even following allegations that they participated in sorcery (CSC, 2018). Moreover, the death of parents and other ills that haunt many families today are other reasons that force these children to find a “home” on the streets of many of our towns and cities. While living on the street, the children experience violence in all its forms, which results into different forms of trauma. Some of these children are rescued from the street by the police and brought to the juvenile prisons where they often go through another traumatizing experience of violence. After some time, they are sent to different children’s homes where they go through a process of rehabilitation and re-education. Even though many researchers have been focusing on the rehabilitation and re-education of rescued street children, few, if any, have addressed the psychological trauma among street children. If not addressed, the knowledge gap of the problems that these children faced may never be resolved during the process of their reintegration and re-socialization. The purpose of this research was to analyse the impact of child-friendly techniques on the psychotrauma outcomes of rescued street children living in selected children's homes in Kinshasa, Congo.

1.2.Background of the study

Every child should be raised in a family context. United Nations Guidelines for Alternative Care of Children (UN-GACC) (2009), Children's Right Convention (CRC) and The Children's Act (2001) states that children's well-being and protection are best served when they are raised in a healthy family setting. Children need special care and love to enable them to enjoy fundamental human rights pertaining to their state of life in order to grow up to be healthy, responsible, confident and innovative individuals who can promote comprehensive development of the society. Provision of such needs is the responsibility of parents, the government and other groups that have the interest of children at heart. However, the challenges of life, together with political conflicts and civil wars have increased the number of broken families, pre-marital pregnancies, economic difficulties and irresponsible parents. The aftermath of HIV/AIDS has created a situation whereby family bonds are decreasing. Consequently, many children are left unattended to, abandoned or in poor conditions forcing some of them to seek refuge on the streets. These children are found in most public places, such as markets, near supermarkets and along the city/town streets and roads. The so-called "street children" are well organized in small groups with clear leadership that watches over each group. This situation, however, is a diversion from the ideal nature where a child is born in a family that provides him or her with love, care and protection. Such provisions are every child's right. Unfortunately, the reality of street life denies the children such basic rights exposing them to crime, violence, insecurity and abuse, including sexual abuse and child exploitation. An affirmation that their experience on the street is traumatizing is not an exaggeration.

According to Bereiter (2017), any occurrence or sequence of events or circumstances that one perceives as emotionally and physically dangerous and that have long-term negative impacts on one's ability to function and bodily, social, emotional or spiritual well-being result in

trauma. Bereiter (2017), also holds that these series of events that are physically and emotionally harmful can be family violence, separation from a parent, divorce or separation of the parents, neglect, unsafe environment, repeated physical, verbal, sexual and psychological abuse, domestic violence experienced or witnessed, death of a loved one and lack of the basic needs. When all these situations or events are not resolved, people respond, react and behave physically and emotionally in different ways to protect or defend themselves to what they are experiencing for their survival. This is an automatic reaction that one cannot control, the so-called "fight-flight-freeze" response that start in the amygdala, which is the part of the human brain responsible of perceiving fear. Then the amygdala communicates this perceived danger to the hypothalamus, which stimulate the automatic nervous system to engage in the "fight or flight" response (Nunez, 2020), that is to run away or to react or behave in order to defend oneself from the danger. Some of these responses or reactions include anger, fear, irritability, sadness, disbelief, denial, shock, confusion, frustration, anxiety, shame, guilt, mood swings, self-blame, loneliness, hopelessness, helplessness, sleeping difficulties, withdrawing, numbness, nightmares, difficulty of concentration, racing heartbeat, hyperactivity, aggressiveness, insomnia and agitation. All these reactions are "alerts" that show that there is a problem. They are the symptoms or outcomes of the psychological trauma experienced.

Many street children experience symptoms or outcomes of psychological trauma. In observing the recued ones in the homes, one may notice all these reactions and antisocial behaviours. If not addressed, these psycho-trauma outcomes continue to harm thousands of these children and for those rescued and living in the homes find difficulty in adapting to the rehabilitation programs. Therefore, this study will be of help especially for children and their caregivers and for many who get in touch with the street children or even other children.

United Nations Statistics show that almost 150 million children in the World are living and sleeping on the streets, parks and buildings; where they seek some warmth, comfort and security. Of these, there are 30 million in Africa, 30 million in Asia, 60 million in South America and the rest of the 30 million elsewhere. These kids do not want to be on the streets, but they have no choice but to live there due to a variety of factors. Armed paramilitary groups exploit them and abuse them to the fullest extent possible. Armed groups use them as human shields and weapons of mass destruction throughout the world. As a result, a large number of them become "kid warriors" (UN statistics, 2018).

After the loss of their parents, many of these youngsters find themselves on the streets, mostly after fleeing war from host homes. Others are unable to afford even basic necessities such as clothing, health care and education since their households are too poor.

In Africa, especially with wars and ethnic conflicts, the situation is even more serious. African cities have become homes to many thousands of street children. For instance, according to UN statistics (2018) there are 25,000 street children in Morocco and 200,000 in Kinshasa; the capital city of the Democratic Republic of Congo.

More than 250,000 to 300,000 children are reported to be homeless in Kenya, comprising 60,000 in the capital city of Nairobi alone, as per Consortium of Street Kids (CSC, 2018).

CSC (2018) further states that some of the children are forced to go to the streets because of the irresponsibility of their parents who have become alcoholic and drug addicts at the expense of their family support and parental responsibilities, and thus the children live in vagrancy

Although many non-profit organizations have come to help to rehabilitate these destitute children by providing them with material support, they unfortunately forget or overlook the

psychological trauma. In part, this might explain why some of these children end up returning to the street even after being placed in centres where all their material needs are taken care of.

In situations of war or accidents, people often forget that after material assistance has been provided, they must also think about psychological support to address the trauma experienced by children. Adults often forget that even if children do not speak, they are the most vulnerable and need to be cared for.

The phenomenon of "street children" is challenging and many strategies are implemented to eradicate it. Some of these strategies include: the placement of children in host families or in authorized institutions, the adoption of laws, various sensitizations to the question, like the World Cup for street children organized in Rio de Janeiro in 2014 in tribute to South Africa, which hosted the first edition of the competition in 2010 (The Guardian, 2014).

Street children are often victims of discrimination and violence in all its forms and this contributes repeatedly to traumatic experiences. Sadly, the prejudice, discrimination and stigma in adults are so prevalent regarding these children and this does not help their situation. It makes it difficult for "reformed" or rehabilitated street children to find acceptance and to reintegrate into society. It is clear that such children would need good psychological support to help them to overcome their difficulties and heal their psychological trauma.

Despite the fact that many researches have been carried out to underline the need for educational and psychosocial support, little has been done to address the trauma using child-friendly approaches. Psycho-traumatic experiences mark thousands of children throughout the world. Children find themselves living with grandparents or other family members because of political conflicts, natural disasters, family violence and armed conflicts. In addition, with the current and multifaceted crisis that threatens the families, such as divorce,

single-parent families, blended families or families with two parents of the same sex, the lives of thousands of children are at risk because they live continuously in a state of shock. About 300 million children throughout the world are being subjected to all sorts of abuse that can cause physical and mental stress or even death, according to the United Nations on the protection of victimization (UN, 2020). To end their pain, a traumatized youngster may flee to the street or take their own life if they can no longer defend or protect themselves.

According to UNESCO, psychologically traumatized students, particularly in Africa are showing signs of behavioural and emotional problems that impair their ability to learn. In order to address this critical issue, a holistic intervention is needed that promotes not only educational but also psychosocial and follow-up aspects of these children and families (UN, 2020).

According to Fact for Families (2018), thousands of children and teens all over the world see suicide as a solution to their psychological trauma problems, which is often associated with the feelings of sadness, confusion, anger, hyperactivity stress and pressure to succeed and financial uncertainty. This concerns the children's homes who work with rescued street children with behavioural and mood disorders caused by the stressful and traumatic experiences on the streets.

In US for example, statistics shows that forty thousand (40,000) teenagers commit suicide annually. This means that someone dies in every 12 minutes because of psychological trauma experiences (WHO, adolescent mental health 28 September, 2020).

UNICEF (2018) reported that 4.7% of global suicide prevalence among many children is caused by major depressive disorders due to psychological trauma. The prevalence rates in North America is at 3.7%, East and South-East Asia at 4.0%, South America at 4.0%, Asia at 8.6%, and 6.6% in Africa. In 2019, India alone accounted for 17.8% of suicide cases globally

due to mental illness among traumatized children. The National Crime Bureau of India reported 381 daily suicide cases in teenagers. These children are often rejected and neglected and unable to understand that they can turn their lives around. Consequently, they think suicide is a permanent solution to their problem (Sharma, 2020). This shows the gravity of the situations and the consequences if the trauma outcomes are not addressed in children.

As reported by Murunga (2019), the WHO estimates that 1408 people commit suicide each year in Kenya, which is 4 deaths daily. In 2018 alone, the Kenya National Bureau of Statistics reported 421 deaths in which majority were teenagers and young people. This is caused by poor mental health (Murunga, 2019). The Kenyan media reports cases of children committing suicide every day because of a range of the psychological trauma outcomes such as bullying, stress, disappointment, shame, loneliness, anxiety, physical and sexual abuses, substance abuse and fear of the future. After being harassed and mocked by her teachers and peers at school for having menstruation, a 14-year-old Kenyan girl committed suicide in 2019.This was a traumatic experience for the little girl who perceived herself to be dirty and without dignity in front everybody. She felt frustrated, scared, embarrassed, nervous, disappointed, lonely and left out even by her teachers who were supposed to protect and help her. She was hopeless, helpless and insecure in this environment and life was no longer worth living for her. The only solution according to her was to commit suicide.

In the Democratic Republic of Congo, the situation is more serious than one can imagine. There are around 700,000 street children in Congo, according to UNICEF estimates, of which 200,000 are all in Kinshasa. The so-called street children aged 6 to 18 come from the most vulnerable segment of the city of Kinshasa, 46% of whom are girls and 54% are boys. The main reasons that pushed these children to migrate to the streets are 40% personal. That is to say that they are linked to the desire for independence, search for adventure or peer pressure. Then, the interpersonal reasons which are directly linked to the problems of abuse and family

violence, fights, divorces, separations, death of parents, accusation of witchcraft and lack of affection and abandonment account for 32% of the factors that makes children flee to the streets. Economic reasons, which are mainly linked to poverty, lack of food and money or simply rejection and irresponsibility of parents, represent 23% of the causes that led to the departure from the family home. Moreover, other children are victims of the phenomenon of rural exodus, seeking employment in the capital or fleeing armed conflicts and growing insecurity in the periphery of their municipalities, territories and chiefdoms (UNICEF, 2018).

The living conditions of these children in Kinshasa are simply mindboggling. These children live and sleep in sheds, containers, in carcasses of vehicles, tires, in gutters or in the open streets of Kinshasa. The types of violence they face are varied. Mental violence is common in girls while physical violence is common in boys. The violence that surrounds the rituals of passage, which is evident by the scars that the children bear, does not represent pride or joy, but rather signifies negative feelings such as sadness, shame, fear, anger and so on (Gretry et al., 2019).

Lepidi (2019) observed that the street has its codes and its laws. The new "shégués" who arrive must receive a kind of "baptism" as a rite of passage for days or even weeks. Those who are already baptised commonly known in Kinshasa as the "Yankees", martyr the newcomers in order to harden them. They beat, sodomize and slash their bodies with razor blades before urinating on them.

The children say that they belong to a team, which usually consists of about ten members. They survive through begging and stealing. The girls even engage in prostitution if they are not racketed. For them to be strong and to keep up with this hell, the children smoke and use all kinds of drugs. For instance, they snort glue and drink artisanal alcohol.

These addictions, as stated by Lepidi (2019) compound the violence of the traumatic shocks that the children had faced in the past, have heavy psychological consequences such as body scar shame, fear of what may happen at any moment, sadness and the anger and desire to revenge. Sometimes, these children become mute or only express themselves by screaming.

Psychological trauma is an emotional or mental shock experienced by an individual. After an adverse or distressing event that is above a child's capacity to cope, he or she may suffer short or long-term consequences in all the aspects of his or her life. This impedes him or her from functioning well.

Statistics indicate that the number of street children has been increasing in many cities and towns in Africa. These children are subjected to violence and traumatic experiences that require counselling. However, their troubled lives make it difficult to complete a talk therapy session between 45 minutes and one hour. As a result, there is need to come up with counselling approaches that suit the unique needs of these children considering their age and the hardships that they may have faced before migrating to the streets and in the streets. The current study's researcher was inspired to look into the impact of child-friendly approaches on the psycho-trauma consequences of recovered street children in children's homes in Kinshasa City, the Democratic Republic of Congo.

1.3.Statement of the Problem

Living in the street is a stressful and traumatizing experience for children who are already vulnerable due to their age because they have to fight and struggle for their survival. These experiences cause anxiety, sadness, fear and feelings of hopelessness and helplessness. The only way to express what these children think and feel is to react violently or aggressively, to steal, to perform any kind of antisocial behaviour, abusing alcohol and other substances, and even to commit suicide. Their circumstances cause psychological trauma that pushes them to

engage in antisocial behaviours. Such behaviours are major concerns and a problem that needs to be addressed as soon as street children are rescued and placed in children's homes. When entering in the children's homes in Kinshasa, we observe all these antisocial behaviours and the interaction between the children is marked by verbal and physical violence. This make it difficult for the caregivers' work. Hence, the whole environment and the neighbourhood suffers, especially the schools where these children study. Therefore, failure to address this problem may lead not only to physical and mental illness but also to suicide cases that are currently being reported in DRC. This study is conducted in a bid to better understand the impact of child-friendly approaches on the psychological trauma of rescued street children in Kinshasa, the Democratic Republic of Congo.

1.4.Significance / Justification of the Study

In my personal experience, passing through the streets of different cities in our African countries and seeing thousands of children in the streets, the so-called "street children", has always attracted my attention; especially the violence that one can read on the faces of these children.

In addition, counselling children is not easy, and counselling traumatized children is very difficult. First, a child attention is very limited; he or she is not able to sit for a talk therapy of 45 minutes or one hour with questions/answers. I realised that children need approaches adapted to them. At their age, they learn much better through games interacting with one another. This motivated me to search for some child-friendly approaches that may work and help rescued street children in selected children's homes in Kinshasa, the Democratic Republic of Congo.

Therefore, this study will be of benefit for rescued street children and those who work with them. It can be used to enable street children to understand their feelings, negative thoughts,

physical and emotional reactions that influence their behaviours, and learn new ways of thinking positively about themselves and those around them. They can also learn to be resilient, self-motivated besides acquiring socio-emotional coping skills on how to deal with the adversities of life. This study will also be beneficial to parents and caregivers who work and live with the children in that it will enable them to learn the importance of their relationship with the children. The study findings will create awareness among stakeholders on how to help street children to overcome any barrier in their self-growth and to promote self-esteem using child-friendly approaches.

1.5.Objectives of the Study

The purpose of this study was to identify the effect of child-friendly approaches on rescued street children's psychological trauma in Kinshasa, the Democratic Republic of Congo, which is why this study was conducted. The study's aims were as follows:

1. To describe the psycho-trauma outcomes among rescued street children in a children's home, in Kinshasa, DRC.
2. To determine the influence of music and dance on psycho-trauma among rescued street children in a children’s home, in Kinshasa, DRC.
3. To identify the influence of storytelling on psycho-trauma among rescued street children in a children's home, in Kinshasa, DRC.
4. To examine the influence of meditation on psycho-trauma among rescued street children in a children's home, in Kinshasa, DRC.

1.6.Research Questions

1. What are the psycho-trauma outcomes among rescued street children in a children's home, in Kinshasa, DRC?

2. How can music and dance influence psycho-trauma outcomes among rescued street children in children's homes in Kinshasa, DRC?
3. What is the influence of storytelling on psycho-trauma outcomes among rescued street children in children's homes in Kinshasa, DRC?
4. How does meditation influence psycho-trauma outcomes among rescued street children in children's homes in Kinshasa, DRC?

1.7.Theoretical Framework

Gestalt and attachment theories led the research. These two theories complement each other in the sense that both emphasize the importance of a good and positive day-to-day relationship and interaction between children and their parents or caregivers for their wellbeing and development to be safeguarded. Gestalt theory and Attachment theory were helpful in that they consider children's experience and behaviour in the context of their situations or stories both past and present.

The care a child gets during his or her formative days has a significant impact on the development of a child's connection (Fraley, 2010). In contrast to individuals who have experienced violence, abuse or neglect, those who receive love, care and support from their parents or carers are likely to feel safe and secure in their relationships with their parents or caretakers, which may lead them to run away from their homes. Losing the chances of survival that come with being loved, cared for and provided for all the requirements as a child means that a youngster may be pushed to live on the streets.

A human being has many needs including food, water, love, understanding, education, care, housing, appreciation, belonging, relationships and family for his or her wellbeing. Being focused in the awareness of the "here and now" experience is important in building secure relationships. According to Maslow, these needs motivate human behaviour at any particular time. When satisfied, a person moves towards his or her self-actualization. On the contrary,

people are likely to experience anxiety, mistrust and fear when their needs are not satisfied (Huit, 2007). Therefore, children who do not feel loved and cared for also lack good relationships with their family members, which is likely to encourage them to run away from home in search of happiness on the streets.

1.8.Scope and Delimitation of the Study

In Kinshasa, the Democratic Republic of Congo, three children's homes were studied for their child-friendly practices and the psycho-trauma outcome of rescued street children.

The study was conducted within three children's homes in two areas of the City, Ngaba Municipality and Tchangu Municipality, where a large number of street children are found, but with few homes. However, it has been difficult to get the exact number of all the institutions because they are not registered. The study explored the psycho-trauma outcomes and how best they can be treated to help these children to restart a new and better life like other children of their age, either returning back to their families or being adopted by other families after their stay in children's homes.

The study focused on identifying the effect of child-friendly approaches on the psychological trauma among rescued street children. The child-friendly approaches included music and dance, storytelling and meditation. The study was limited to a sample of 150 individuals from age 7 to 17 years old.

1.9.Limitation and assumptions of the study

First, the study was done to Kinshasa, in DRC, and the researcher had to travel up to the field since the study was an intervention. Due to COVID-19 situation, it was not easy to start in time, the restrictions made it difficult to reach the study areas. The children's homes were obliged to decrease the number of children; the researcher had to wait for the new intakes to begin the research and to find the sample groups, it took more time than the researcher expected.

For political reasons, some information concerning the children's homes were not disclosed to the researcher who was considered in the beginning as a ministry of social affairs member. However, the permit letter of the Catholic University of Eastern Africa (CUEA) was sufficient and cleared the doubts and fears, and the permission was given to the researcher and her assistants to do the study without any problem.

Kinshasa is a big city and the distances are huge. Travel and communication means of the researcher and her assistants were a great challenge, nevertheless we held out until the end of the intervention. Lastly, human work is never perfect, the methodological procedures, research design, and theories used in this study may not give a 100% accuracy in findings. Nevertheless, as a researcher, I have followed the steps of doing the research to the latter.

CHAPTER TWO

LITERATURE REVIEW

2.1.Introduction

Gestalt theory and Attachment theory are the foundations of this research and they are presented and discussed in detail in this chapter. There are gaps in our knowledge that can be filled by looking at the findings from other studies that are similar. The study's conceptual framework is also explained in this chapter.

2.2.Theoretical Framework

Based on Gestalt and Attachment Theories, this study was conducted this research.

2.2.1. Gestalt Theory

Gestalt theory was developed by Fritz Perls, a psychotherapist with his wife Laura Perls in the years 1940-1950. Gestalt, in German, means the whole. According to Perls, human beings function as a whole, body, mind and soul. It is therefore important to remember that therapy works to assist people become informed in the here and now, including their thoughts, feelings and bodily sensations. For Perls, a therapist should not focus on the person's past experience, but help him or her to bring the past into the present. Perls believed that an individual's growth might occur when one is aware of his or her present reactions, emotions, thoughts and feelings.

Some creative or artistic initiatives are employed in Gestalt theory to assist a person focus on the "here and now." As per Eren (2016), a few of these methods are:

The unfinished business, is the conflict and trauma of the unresolved past stressful experiences, whose effects continue in the present moment. The event may pass, but the feelings such as guilt, shame, anxiety, fear and difficulties in building and maintaining relationships may last for a long time. For children, it may continue up to adulthood impeding

him or her from functioning well. Gestalt theory is relevant to the current study, through art therapy like dance and music, storytelling and meditation in addressing the unfinished business that could have been the cause of not functioning well in the present moment.

The empty chair is another technique used in Gestalt Theory, which is an exercise that helps a person to talk or dialogue with an empty chair imagining that the author of his or her traumatic experience is seated on that chair at that time. He or she should talk with the person saying all what he/she is able to say about the traumatic event. In the session, **children** are able to articulate their sentiments and emotions regarding the distressing occurrence using this method. In the sexual assault case, children have a hard time talking about the trauma they have been through. This technique helps in overcoming this challenge without the fear of feeling judged.

There is also the **dream's analysis technique**, which is not a dream interpretation, but acting or dramatizing the dream as if it is happening at that particular time. In this case, people are allowed to exaggerate what they are dramatizing using movements and different tones of voice in order to analyse all the elements of the dream: what happened, where, who was present and what was the function of each individual or thing in the dream, to understand the link between the dream and the traumatic event. In this study, during the intervention, many children said to have nightmares.

Meditation and Mindfulness is also used in Gestalt Theory to address the blocks of energy in the body, notifying and situating all the body sensations. In this case, part of the body the energy is blocked, where tension or resistance in the body is situated. This may be caused by the internal conflict of the traumatic event that was not resolved or by a stressful event.

There is also **role-play** in Gestalt Theory that is helpful, especially with traumatized people, especially children. With role-play, people may play different roles, as victims and as perpetrators. They may act with the counsellor as if the event is just occurring at that time by

expressing their feelings and emotions. This technique helps one to be aware of the self while helping the other person in healing by teaching coping skills. It helps to explore and express emotions, feelings, frustration and anger about an event or a person without feeling guilty or ashamed of having one's own point of view (Overman, 2018).

Strengths and Weaknesses of Gestalt Theory

Gestalt Theory is a holistic approach that focuses on the wholeness of the person. In this theory, self-awareness is important in learning to appreciate real time experiences. This awareness includes self-acceptance, interpersonal relationships and the sense of responsibility of choices in the "here and now" experience. The holistic approach helps to understand the person in his/her context and culture. It also pays attention to body language, especially non-verbal communication in working with culturally diverse people. Since recalling past traumatic experiences can be very painful. Gestalt's Theory helps in bringing the past into the present with a kind of self-examination to support self-regulation. This restores emotional equilibrium and helps in changing feelings, beliefs and behaviours. For Gestalt, self-awareness cannot be explained by the unconscious, but by the "here and now" experience or by the present-awareness of what is going on now (Olson, 2017)

One of the weaknesses of Gestalt Theory is inadequate psycho-education in the process because the person brings his/her real experience, facts and the therapist is just the facilitator. In addition, Gestalt theory is time consuming because it uses numerous interventions, such as role-play, empty chair, drama and art therapy for children. Dealing with the feelings and emotions of stressful events poses a risk of causing more trauma to a person. The counsellor must be careful in concluding the session in order to help the person to re-adjust and return to a normal state until closure takes place (Olson, 2017).

Relationship between Trauma and Gestalt Theory

Trauma affects one's body, mind and spirit. An emotional shock of the past can affect the wellbeing of a person. Gestalt theory focuses on the awareness of wholeness of a person in the healing process, bringing up the issues of the past that may impede the person to move forward for his/her self-actualization with a sense of responsibility.

The life of human beings, especially the life of street children is full of stressful or traumatic events that cause anxiety, anger, fear, depression, suicidal ideation, isolation and so on. The events may pass but the psycho-trauma outcomes may last for a long time. A child who has lost a parent, who has experienced or witnessed physical, sexual, psychological violence suffers long term effects. Gestalt Theory helps in teaching people to remain focused in any one time, accepting themselves and the situation, being aware and responsible in addressing their feelings, emotions, behaviours and thoughts regarding things that are happening at the moment. Gestalt Theory helps in releasing emotional and physical blocks of the trauma placing emphasis and awareness on the present moment.

2.2.2. Attachment Theory

Attachment is a strong emotional bond between two people such as a child and his or her mother. It is a feeling of love, care and understanding towards another person. It is also a strong connection with someone who loves another and in whose presence one feels secure. This idea of attachment was coined by a psychotherapist John Bowlby, who studied the consequences of separation on new-borns and parents. For Bowlby, sobbing, screaming and clutching are the most severe behaviours new-borns use to avoid being separated from a parent.

Because of the anticipated threat of losing these survival advantages, these attachment behaviours are an automatic response. A person's routines and habits for creating and

maintaining connections from childhood through maturity are guided by what Bowlby called "attachment behavioural system," which includes these behaviours (Fraley, 2010).

More than often, the quality of care that children receive during their early years determines how attached they become as adults. When a person's parents or caretakers provide them love and support, they are more likely to succeed in whatever they choose to do in life. In families where violence, abuse or neglect has been a regular occurrence, children are more likely to be anxious and fearful of their parents / caregivers. Homelessness is a real possibility for these children. A child's natural instinct is to flee from those who are expected to care for and love him or her. As a result, it may be necessary for abused children to leave their homes and live on the streets.

Attachment styles in children are dependent on their initial relationships with parents and caretakers from a continuous spectrum of emotion management (Kennedy, 2004). There are four types of attachment styles:

Secure Attachment Style: As a result of their secure attachment style, these youngsters are more likely to view others as helpful, competent, and worthy of respect. In addition to being resilient, these youngsters are able to connect with others in a positive way. On the contrary, street children are considered unworthy of respect and they do not relate positively with others because they are exposed to all kinds of violence that make them to behave the way they do.

Anxious-Avoidant Attachment Style: As a general rule, kids with a nervous attachment style are less able to cope with stress. To avoid creating meaningful relationships, they are more prone to isolate themselves and refuse to seek help. Antisocial behaviours, such as lying and bullying are more common among them, as is a tendency to isolate themselves from others. The rescued street children's behaviours in some children's homes can be explained by

this. Aggression, both verbal and physical is prevalent. Trauma on the streets may be to blame for their antisocial behaviours.

Anxious-Resistant Attachment Style: Anxious-avoidant children are on the other end of the spectrum. As a result, they are more prone to rely on their primary caregivers for emotional support. This can lead to social isolation because of their out-of-control emotional outbursts and their tendency to isolate themselves from their peers.

Disorganized Attachment Style: Children that have an unorganized form of attachment are more likely to show signs of violence, disruptive behaviour and social isolation as a result of separation anxiety. They are more inclined to view others as dangers rather than sources of support and as a result may engage in defensively aggressive behaviours (Kennedy & Kennedy, 2004).

There are 3 kinds of attachment discussed by Ainsworth, like Bowlby and they are secure, avoidant and resistant attachment.

The Secure Type is when a youngster turns to his or her mother for protection and comfort and receives that care and love on a regular basis. The mother is typically described as a caring and affectionate individual. As a result of a lack of affection and care, majority of street children have fled their families.

The Avoidant Type is as a result of lack of care, love and safety, a child dislikes or runs away in his or her mother. Typically, the mother is seen as rejecting the child's bonding behaviour when this form of mothering is present. This is exactly what these saved street children have been going all through. They have had a traumatic upbringing and now they are back on the streets.

The Resistant Type is a period during which a youngster prefers to remain close to their mom. Many people think of their mothers as being inconsistent when it comes to their children’s care (Fraley & Spieker, 2003). As a result, a child's attachment style has the

potential to contribute to later interpersonal issues as well as psychological harm. Using the attachment theory as a framework, this study shows how it may be used to understand and handle street children.

Strengths and Weaknesses of the Attachment Theory

One of the strengths of the Attachment Theory is that it explains the behaviours of rescued street children such as their antisocial behaviours. In addition, the attachment theory is based on the children's relationship with the parents or caregivers from childhood, especially with the mother who is an important figure for a child. In fact, the nine-month pregnancy period creates a strong bond between a mother and a child. After birth, the new-born is surrounded by parents and family members who have strong influence on his or her life. This shapes a child's behaviour and personality. Separating children from their family environment creates anxiety and psychological imbalance because the family is the first environment where they learn how to behave from childhood to adulthood. Children who experience love and care, protection and a good relationship are likely to grow securely and are able to overcome all the adversities of life. On the contrary, a child who experience violence at home, lack of love, care, protection and relationship difficulties is traumatised and likely to escape from home and end on the streets, where he or she continues to live the same traumatising experience.

In contrast, the Attachment Theory suffers from numerous flaws that limit its usefulness. To begin with, it does not consider other factors that may influence children's behaviour. At a certain age, children may still detach from their parents and caregivers and interact with their friends. This has a lot of influence on children's lives. They may end up on the streets due to peer pressure, even though they had a good relationship with their parents or caregivers, in search of their independence from their family, to be free on the streets and create peer attachment.

Another limitation is that, children who are so much protected and attached to their parents or caregivers may still have problems and not be able to live on their own, because they have always been relying on their parents. This may have consequences in their future lives. They may always be seeking for somebody to rely on in case of parents death, they may not be able to live with other people. If the attachment figure is unavailable, they may still run away and end up on the streets.

Relationship between Trauma and Attachment

Some children who have experienced violence, loss of one or both parents, sexual abuse and neglect among others feel that their homes are no longer a secure or safe places for them. They may think that the solution is to escape from that environment. These traumatic events may affect their relationship and the attachment style with their family members, especially the caregivers. These children may have attachment difficulties in all their relationships not only during childhood, but also up to adulthood. The attachment theory can help to reduce the negative impact of trauma from the attachment styles and help children to build a secure relationship with their caregivers and the other children in the children's homes. This is one of the current study's objectives.

Erozkan (2016) found out that a positive relationship in childhood allows the child to have a potential for emotional connectedness later in life n his research on the link between attachment types and childhood trauma. It also helps them to build a safe and secure relationship with people, and establish positive self-esteem. On the contrary, children who were subjected to trauma experience difficulty in making and sustaining friendships.

Therefore, the most common sign of trauma among rescued street children is fear. Fear of what happens, fear of the future, and fear of "what if", fear of a man or woman figure, fear of life itself and fear of everything. This creates anxiety or stress that makes their life difficult after being rescued.

The Gestalt and Attachment theories complement to each other and are suitable to inform and guide the current study.

2.3.Review of Empirical Studies

Studies have been carried out to explore art therapy and its use to address the psycho-trauma outcomes of traumatized children, especially of war and natural disasters. Art therapy may involve musical activities, which include listening, dancing, creative writing; poetries, drawing, storytelling and drama. According to Davis (2010), art therapy can be a powerful intervention in dealing with children and adolescent who have experienced trauma.

The current study concentrated on child-friendly approaches and psycho-trauma outcomes among selected rescued street children living in children's homes in Kinshasa, DRC. The study considered the psycho-trauma outcomes and how they manifest among rescued street children. Furthermore, the study established the influence of dance, music, storytelling and meditation on the psycho-trauma outcomes among rescued street children.

2.3.1. Psycho-trauma Outcomes among Rescued Street Children

On entering these Children's Homes and observing these rescued street children, one realizes the degree of the psychological trauma that they have experienced on the street through emotional and behavioural symptoms. These include irritability, fear and anger, with little or no provocation, which is typically expressed in the form of verbal or physical aggression towards their companions. One also notices their hyper vigilance, exaggerated movements and reactions, jumping all over, performing violent games, pinching one another, avoiding adults, and some of them are profoundly sad. This problem needs to be addressed as soon as they are admitted in the home, so that they are able to fully benefit from the rehabilitation and education program of the home. Many studies have shed light on the psycho-trauma

outcomes when working with different groups of traumatized individuals, adults and children.

Morrison (2017) conducted a study in Kamloops, Canada, on the advantages of Therapeutic Relationship with children who had experienced acute trauma. The study adopted a case study approach with a yet another pre-test-post-test design to assess trauma symptoms before and after personal therapy. The study was carried out with children aged from 3 to 17 years suffering from PTSD symptoms who were chosen randomly. The study aimed at examining the symptoms or outcomes of trauma experienced by children. The study used interview guide and free drawing tools to gather data about the symptoms of trauma. The findings showed that there were different types of trauma with a variety of symptoms or outcomes, such as feelings of loss, anxiety, fear, depression, anger, confusion, displacement and others. The research gave indications of proper treatment and the suitability of art therapy in working individually with children and not as a group. The current study instead was an intervention working with three groups of children aged from 7 to 17 years old living in three different children's homes to study and address the symptoms of trauma using child-friendly approaches, which included music/dance, meditation, and storytelling.

Research by Shenk et al. (2014) examined the relationship between childhood abuse and symptoms of psychological distress in the United States. The study used a sample of 110 female children aged between 14 and 19 years. The researchers analyzed three potential factors that mediate the relationship between maltreatment and PTSD symptoms: respiratory sinus arrhythmia, cortisol secretion and avoidance. The findings showed that not all the children who experienced maltreatment develop PTSD symptoms according to DSM-5 criteria. Children who have the possibility of remembering and coping with feelings, thoughts and emotions related to traumatic events with awareness and acceptance were less likely to develop a Post-Traumatic Stress Disorder. For those who developed PTSD a range of

symptoms were present. These symptoms included avoidance, demonstrating that maltreated children avoid painful events. Using a longitudinal study that lasted for a year was a risk because relying on a large group of participants for a long period may result to loss of some of them in the process. In order to mitigate this risk, the current study was an intervention study of one month working with children from 7 to 17 years old. Shenk et al. (2014 used only female participants from 14 to 19 years old focusing on analysing three factors mediating the relationship between maltreatment and PTSD symptoms such as respiratory sinus arrhythmia, cortisol secretion and avoidance. However, the current study focused on children both females and males, examining trauma symptoms such fear, avoidance, hyper-vigilance, and as describe in DSM5.

In their study on the posttraumatic stress disorder (PTSD) symptoms in children and teens German researchers studied the incidence, kinds, and symptoms of traumatic incidents, as well as their link to post-traumatic stress disorder (PTSD) and gender. 159 children aged 7 to 16 years were randomly selected for a survey study using the Clinically Prescribed PTSD Scale for Youths (CAPS-CA). In children and teens who have been physically molested, the intensity of symptoms is significantly higher than in those who have been physically assaulted. Specifically, a greater severity of symptoms was found in females compared to males, especially in relation to sexual abuse, extra-family trauma and the role of victims. Among the symptoms included fear, anger, isolation, sadness, anxiety, sleep difficulties, nightmares and so on.

The survey by Loos et al. (2015) focused on examining the symptoms of different types of trauma experienced by children and adolescents and the frequency of the events. The CAPS-CA of DSM5 scale was used to measure the PTSD symptoms. The findings highlighted the severity of symptoms in relation to the children's gender. The current intervention study screened the trauma symptoms in 150 rescued street children, boys and girls, with PCL5-

Child self-report. For the systematic review and meta-analysis of 25 prior research papers in Sub-Saharan Africa, the authors Laureen et al. (2019) conducted the survey. The research looked at the frequency of PTSD on a national and regional level in Sub-Saharan Africa. Six of the countries had national surveys, two from Liberia (67 percent and 68 percent for every study participant), one from Rwanda (69 percent), one from Sierra Leone (71 percent) and two from South Africa (69 percent and 71 percent respectively) (72 percent & 77 percent). They conducted an additional 19 studies that were indicative of an entire country. Several researchers at the locations conducted the poll from October to November of this year. There were a total of 58.887 participants, 31.672 of them were female and 27.215 were male, aged between 15 and 65 years old. Citizens, long-term residents, and refugees all took part in the discussion. To classify people as having or not having PTSD, the research used interviews and questionnaires to measure the trauma levels of participants. Qualitative and quantitative data were gathered through the use of a probabilistic sampling process and random samples. Self-reported screening instruments administered by professional researchers and trained data collectors were utilized in 16 investigations, according to the researchers. Six studies utilized the Harvard Trauma Questionnaire (HTQ), while six studies utilized the PTSD Checklist-Civilian Version (PCL-C). The Trauma Screening Questionnaire (TSQ) and the Davidson Trauma Scale (DTS) were utilized in two separate studies (DTS). One study utilized the Post-traumatic Stress Diagnostic Scale (PDS) while another utilized the Impact of Event Scale-6 (IES-6). Structured or semi-structured interviews were used in the remaining nine research projects. Mini International Neuropsychiatric Interview (MINI) and the PTSD Symptom Scale Interview (PSSI) were utilized in four research, respectively (PSS-I). The Composite International Diagnostic Interview was utilized in two separate studies (CIDI). The bulk of research (58.3%) showed high levels of PTSD symptoms, while the minority (8%) found low levels. Data from adolescents in 20 countries were excluded from the study since the findings

suggested that working with minors (participants under the age of 18) was challenging. But only five countries had statistics on teens. Study participants were asked to complete a questionnaire about their exposure to war, violence and other traumatic experiences in order to provide an accurate picture of the prevalence of PTSD symptoms. People in the study were found to have high levels of PTSD symptoms as defined by DSM-5.

The survey studies' participants were aged between 15 and 65 years, but none of them used CAP-CA-5 to measure the PTSD symptoms for children, the current intervention study used CAP-CA-5 to measure the symptoms of trauma among selected children.

In Kaduna, Nigeria, Sheik et al. (2016) carried out a descriptive characterization of psycho-trauma, mental trauma and post-traumatic stress in children and adolescents who had been internally displaced. A cross-sectional survey of 74 children and teens was conducted as part of the project. Conflict-related trauma was quantified using a difficult life event checklist. After a traumatic event, children and teenagers' responses to stress were studied using the response of adolescents to stress (RATS). When it came to measuring the effects of trauma on adolescents' minds, Hopkins Symptoms Checklist was used. The Scientific Interview Guide for Youth (DISC) was used to diagnose post-traumatic stress disorder.

As a result of the post-election violence conflict, children and teenagers who were forcibly displaced suffered from psychological suffering. Nevertheless, the incidence of mental trauma and PTSD revealed that children could have reduced PTSD symptoms such as worry, anxiety, sadness, loneliness and isolation by living with parents and obtaining psychosocial assistance.

According to Assefa (2020) studying the prevalence of depression and anxiety among individuals with COVID-19 in Ethiopia's St. Peter Specialised Hospital Treatment Centers, there were varied findings. The study included 422 patients with COVID-19 who were hospitalized to St. Peter Specialized Hospital for COVID-19 and a psychiatric hospital as part

of an institutional cross-sectional study. Using the Hospital Anxiety and Depression Scale, which consists of 14 items, we assessed participants' levels of stress and depression (HADS). Poor backing, average support, and significant support were grouped into three major categories. A patient who received poor assistance was extremely nervous and depressed, whereas a patient who received intermediate support was somewhat anxious and depressed. All of the patients had some level of anxiety.

In addition, Pogma Tama (2016) conducted an investigation to explore the trajectory of street children accused of witchcraft in Pointe Noire, in Congo Republic. The findings of the study were from a sample of 15 children aged between 11 and 15 years. A longitudinal qualitative method was used. According to the study, violence and substance abuse in the street was found to be a challenge for rescued children to adapt in the children's homes because of their anti-social behaviours and the PTSD symptoms associated with addiction.

In a similar study, Nyagwencha et al. (2018) looked at depression and anxiety in mistreated teenagers in several Kenyan children's homes. Anxiety disorders, anxiety, and post-traumatic traumatic stress (PTSD) were all shown to be prevalent among adolescents who had been abused or neglected while living in Kenyan Charitable Children's Institutions (CCI). A total of 341 teenagers aged 13 to 18 years old participated in the study in Nairobi, Kenya.

The Harvard Trauma Questionnaire (HTQ), Beck's Anxiety Inventory (BAI), and Beck's Depression Inventory-II (BDI-II) were used to examine trauma outcomes (BDI-II). According to the findings, 63.2% of CCI participants had previously been abused or neglected. Anxiety and depression afflicted the vast majority. All of the participants were filled with dread.

This showed that abused and neglected children remain traumatised and develop emotional disorders especially fear, which may lead to anxiety and depression. They always have fear of the possibility of undergoing the same traumatic experience. Due to their vulnerability,

children do not have any defence. Therefore, they need support, care and love from adults. Experiencing abuse and neglect creates a feeling of insecurity among children who develop more anxiety, and fear in their relationships. This may explain why some of these child victims escape from home as it is for many of the rescued street children living in the children's homes.

The research by Nyagwencha et al. (2018) focused on the incidence of PTSD symptoms among teenagers with a background of abuse and neglect who reside in CCIs in Nairobi. Associated with the childhood of recovered street children are examined in the current study, not just abuse and neglect. They have been through a lot of trauma since they came from the streets. Consequently, focusing on abuse and neglect alone may not provide a whole picture of the situation.

The study of Nyagwencha et al. used the Harvard Trauma Questionnaire (HTQ), Beck's Anxiety Inventory (BAI) and Beck's Depression Inventory II (BDI-II) to measure the trauma outcomes. The current study employed CAPS-CA-5 to measure the trauma outcomes because it gives a fuller picture. Trauma in Kenyan school children was examined by Mbwayo et al. (2020) in urban and rural settings. When Kenyan children were exposed to widespread post-election violence, the study found out that they were more likely to suffer from post-traumatic stress disorder (PTSD). Two thousand eight hundred and eighty-two students from both rural and urban areas, ranging in age from eleven to seventeen years, completed the UCLA PTSD Reaction Index. The study was designed to examine the effects of post-election violence on the participants' symptoms of post-traumatic stress disorder (PTSD). The study found that nearly half of all students (47 percent) had seen or heard of someone they cared about being fired at, beaten or killed while in school (42 %). PTSD symptoms were present in more than a quarter of the subjects according to the DSM-5. Children's emotional suffering should be recognized by Kenyan school teachers, according to a new study. Adapting

empirical approaches for assisting mental health interventions to address symptoms of PTSD in children was also advised by the report for psychosocial counsellors.

According to a similar survey study done in Kinshasa in DRC by the OFPRA (Office Française de Protection des Réfugiés et Apatrides) in 2015, about 70% of street children aged between 3 to 18 years have been accused of witchcraft. Most of them were orphans. The study used interviews and observation of more than 50 children to describe the trauma outcomes. These children were sent away after being subjected to terror and violence. Others escaped after the traumatising experience was unbearable in order to find refuge on the streets where they continued to suffer the same experience of violence of all kinds. These children have antisocial behaviours such as stubbornness, aggressiveness, laziness, pensiveness, loneliness, sadness, and fearfulness. The trauma is even evident by observing their eyes.

Witnessing traumatic events could be harmful for children with long-term effects. This also applies to hearing the story of traumatic events, especially of the tragic loss of loved ones. This could lead to emotional distress, behavioural and cognitive disturbances in children. The same is true for the experience of rescued street children living in the children's homes who have experienced and witnessed many traumatic events.

The gap in the aforementioned studies is that they were surveys that used large samples. Some were longitudinal studies carried out at the same time in many different places and using many different instruments. This made it difficult to analyze data objectively and many participants were not considered. Some findings were not concluded. Others focused on recognising PTSD symptoms among school children without involving teachers and without addressing the symptoms. They just recommended that teachers should be trained to recognize the trauma outcomes in children without explaining what should be done once they recognize a child with trauma.

The current study therefore focused on addressing trauma symptoms in selected rescued street children of three Homes in Kinshasa City in DRC. The study was a one-month intervention that used PCL-C-5 Child Self-Report to screen trauma symptoms before planning the intervention and after the intervention to identify the effect of child-friendly approaches on the psycho-trauma outcomes among rescued street children. The caregivers and teachers were involved during the intervention.

The reviewed studies highlighted that a vast majority of individuals in the world experience a variety of traumatic and post-traumatic events with short and long-term consequences, and with a variety of symptoms. Researchers agreed that the most common symptom of trauma is fear. The other symptoms are linked to fear. Fear arises from the painful experience that may lead to behavioural, cognitive, emotional, physical, and social disturbances.

According to Robinson et al. (2020), emotional and psychological trauma, especially for children, is the result of any event that disrupts a child's sense of safety, such as neglect (physical, verbal and sexual abuse), an unstable or unsafe environment (domestic violence), and separation from a parent (serious illness; loss of loved ones). A child's normal responses to these abnormal events are fear, anger, shock, denial, irritability, hyper-vigilance, disbelief, confusion, difficulty concentrating, mood swings, anxiety, shame, guilt and self-blame, isolation or withdrawing from others, sadness and hopelessness.

2.3.2. Music/Dance and Psycho-trauma among Rescued Street Children

Older individuals, particularly youngsters, benefit from music and dance as creative art therapy approaches. They have been around for well over a half-century now. Also known as expressive treatments, they are a type of treatment. People with health or educational issues benefit from music therapy because it alters their psychological, physical, cognitive and social functioning (Malchiodi, 2014). However, dance/movement therapy uses body movements to integrate feelings, thoughts and emotions because they are all linked to one

another (ADTA - American Dance Therapy Association, 2014). Songs were used in the current study to examine their impact on rescued street children's psycho-trauma.

Theoretical review of Music Therapy for Posttraumatic Stress in Adults in the United States was conducted by Shack (2017). A total of 164 people, ranging in age from 18 to 65, were included in the study. All of the participants were chosen at random. An exploratory design was used in the study, which was based on observation. Symptoms of post-traumatic stress disorder were assessed using surveys on Evaluation of Exposure to Trauma or Significant Adversity before undergoing music therapy for relief. Results showed an increase in self-worth and a decrease in isolation, an improvement in quality of sleep, and a decrease in anxiety symptoms. There was, however, no significant improvement in the levels of sadness and social satisfaction.

Beck et al. (2018) also looked at the effectiveness of music therapy in treating refugees with posttraumatic stress disorder (PTSD). An outpatient mental health clinic for refugees was used as the setting for a randomized, controlled trial with non-inferiority design. Many of the migrants who were treated with music therapy had been diagnosed with post-traumatic stress disorder (PTSD).

Trauma, life quality (WHO-5), dissociative symptoms (SDQ-20, DSS-20), and adult attachment were measured using questionnaires (HTQ) at the beginning and end of therapy (RAAS). To reduce refugees' trauma symptoms and improve their overall well-being, the study found out that including music and imagery into refugee treatment was beneficial.

There is a void here because previous studies did not include children in their research. They concentrated on refugees between the ages of 18 and 60. Children, as well as adults, are affected by the trauma of war. Consequently, the current study examined how music and dance could be used to help recovered street children aged 7 to 17 deal with their trauma. Five sessions of the intervention were held. We began our first session by talking about what

had happened and how we were going to respond to it. After listening to the first pre-selected song, the second session's goal was to assist the youngsters better understand and process their traumatic previous experiences, their feelings in relation to them, their unresolved issues and any energy blocks they may have. Third episode, with the second predefined music, the children learnt preselected dance routines to help them examine their feelings, thoughts, and beliefs via the body movement of the dance. The third predefined song and dance moves were performed at the fourth session, which helped the participants focus and think about their abilities, their dreams and how they could attain them if given the means and the proper environment. The final session, the post-intervention session was held on Friday.

The study focus on rescued street children residing in children's homes, rather than traumatized adult refugees from war or sexual abuse.

Israeli researchers conducted another study to examine the emotional influence of national music on young and older persons with varying signs of post-traumatic stress disorder (PTSD). A poll of 144 young individuals (average age 29) and 132 adults was employed in the study (mean age 68). Researchers conducted a study following the Israeli-Gaza conflict of 2014 in an effort to examine the emotional consequences of listening to patriotic and patriotic-themed national anthems, as well as songs sung on Memorial Day. Questionnaires were used to gauge participants' levels of PTSD symptoms. Young individuals with lower levels of post-traumatic stress disorder (PTSD) were shown to be more sensitive to the negative impacts of sad national songs than their older counterparts, who were found to be more sensitive to the positive benefits of happy national songs. When it comes to sad national songs, older folks with higher PTSD symptoms were more likely to experience unpleasant feelings when listening to them, but this was not the case for younger people.

This shows how important it is to select the right tunes for music therapy sessions. Some people's trauma symptoms may be exacerbated by sad music that evoke the incident that

caused the trauma, whereas cheerful songs may alleviate those symptoms. It all relies on the severity of one's traumatic stress symptoms.

Unlike Bensimon's survey study, the current study was a direct intervention study with rescued street children now residing in the children's homes.

In the USA, Christenbury (2015) carried out a study on the combined use of song-writing and art to promote healing in a child who had been traumatized. The study used song-writing to address trauma in a 6 years old abused child, who had followed one year of therapy sessions without successful result. The study was an intervention of six months. The results showed that there was an improvement in terms of the symptoms of trauma.

Christenbury (2015) used just one child while the current study worked with a sample of 142 children.

There was a study done in Sweden on Injury group music and imagery with women over the age of 18 who were suffering from post-traumatic stress disorder (PTSD). The study was a randomized, controlled trial using a combination of quantitative and qualitative methodologies. PCL-5, dissociation experiencing scale (DES), positive state of mind scale (PSOM-S) and Hopkins symptoms checklist (HSCL-25) were used in the study to quantify PTSD symptoms (SDQ-5). Twelve weekly sessions of trauma-focused group music and imagery therapy were conducted as part of the study (Clinical Trial) 45 female volunteers were chosen at random to participate in the study. The overall ratings of all the trauma assessments employed in the study changed from the foundation stage up to the post intervention stage, according to the findings.

For children with PTSD symptoms related to sexual abuse, Stolk (2015) carried out a pilot study in South Africa employing music, theatre, and painting as creative expressive arts therapy. From 9- to 12-year-olds, 37 children were surveyed. A quasi-experimental design was used for this study. It was determined that the Young Child PTSD Checklist (YCPC) had

30 items, separated into four subscales that measured re-experiencing (reliving the trauma), avoidance (avoiding the trauma), heightened arousal, and functional impairment. We used a Likert scale from 0 to 4, with 0 denoting extremely rarely or never and 4 denoting daily. The study's validity and reliability were lowered by attrition and translation issues, according to the findings. There was no guarantee of content similarity because the participants relied on translators for support. To make matters even more complicated, there wasn't a native African equivalent of the phrase that the translators needed. As a result, there was no discernible effect of CEAT in reducing PTSD symptoms, and no role for coping was found. To validate CEAT as a feasible therapy for children with PTSD symptoms, the study recommended that further research be done, with a greater focus on cultural and socioeconomic factors.

The study worked with children between 9 and 12 years old without considering the translation of the questionnaires before the research was done. This did not help the research to achieve its objectives. Therefore, the current study, worked with children from 8 to 17 years old where translation of the questionnaires in the local language was done before the intervention to facilitate understanding for the youngest participants.

Creativity Arts in Counselling for Traumatized Children was evaluated by Westrhenen et al. (2019) in South Africa. A total of 125 children aged 7 to 13 were included in the research. Drawing, music/movement and story-telling were used in four sites to examine the feasibility and effectiveness of Creative Arts in addressing post-traumatic stress symptoms, behavioural issues, and post-traumatic growth among traumatized children. There were no randomizations in this multicentre, non-randomized control experiment. Both at the beginning and at the end of treatment, questionnaires were utilized to assess post-traumatic distress, post-traumatic growth and behavioural issues. Research revealed that engaging in creative activities including drawing, music/movement and storytelling could help alleviate symptoms of post-traumatic stress disorder (PTSD), particularly avoidance and hyperarousal.

Aside from one study in South Africa, no other African countries, particularly Kenya, have conducted research on music therapy. It is widely accepted as a technical field in various nations, according to (Wangala, 2015). It has yet to acquire traction in Kenya, considering the country's strong musical tradition. Only the University of Pretoria in South Africa offers a Master's degree program in music therapy.

Wangala (2015) wrote an article on Global Development about the Magoso School in Kibera slum in Nairobi, which offers music therapy every morning to its more than 500 students to help them to overcome violence and traumatic experiences, to combat anxiety, using poetry, songs and drumming.

According to the findings of all the reviewed studies aforementioned, music and dance therapies seem to be relevant in treating trauma symptoms in children and in adults.

2.3.3. Storytelling and Psycho-trauma among Rescued Street Children

Storytelling is a narrative therapy intervention technique that helps to organize people's thoughts, find meaning and purpose and establish their identity. It helps to understand oneself better in a confusing and sometimes lonely world (Ackerman, 2021).

Using a study procedure for a controlled study of efficiency and mechanisms of change, Kangaslampi et al. (2015) conducted a study in Thailand with a sample of 80 children aged 9 to 17 years old who were randomly selected for narrative exposure - based for immigrant children traumatized by war. To conduct the study, researchers used a Randomized Controlled Trial. The effects of trauma on children were assessed using the C-PTCI (Children's Post-Traumatic Cognitions Inventory). The study found out that youngsters who have been exposed to war and organized violence are more likely to suffer from post-traumatic stress disorder. It is of critical importance to the entire world that we provide them with the best evidence-based support we can. Using storytelling of their traumatic experiences helped in reducing the trauma symptoms.

In Albania, Muhammed (2016) explored the impact of storytelling, reading and watching movies on the psychological and physical growth and wellbeing of traumatized children coming for individual therapy. The findings showed that storytelling could be a modern method of entering into the inner life of children to help them to acquire or improve their cognitive skills such as reasoning and attention. It also helped children to become more motivated and participative in class or group activities.

The use of visual arts in therapeutic for distressed children in South Africa was studied by Westrhenen et al. (2019). Storytelling was utilized in an evaluation study to lessen anxiety and anger in six 12-year-olds who had experienced trauma. Study participants were youngsters who sought individual therapy. Measurements of symptoms were made using the CAP methodology. This procedure does not just focus on the children's traumatic experiences but also on the negative feelings and thoughts that are related with these experiences. Interpersonal relationships were an important part of the program's goal of fostering coping skills and enhancing resilience.

A study that Stolk (2015) did focussed on Creative Expressive Arts Therapy as an intervention for traumatized children with PTSD symptoms caused by sexual abuse in South Africa. The participants were 37 children aged from 8 to 12 years old randomly selected in a non-profit clinic specialized in child abuse. The study was quantitative research using interviews and questionnaires to measure the symptoms before applying the arts therapy interventions among them storytelling. The findings show that after the sessions, the children experienced less trauma symptoms.

There were four parts to the therapist's story concerning a child. As a young hero, sitting comfortably in a familiar spot, the child eventually became bored or fatigued and was compelled to go to rescue someone else's life. When a hero embarked on a quest in the second phase, he or she usually felt powerful, content, thrilled and capable of accomplishing

what was necessary. When a menace confronted the hero in the third phase, he had to decide whether to combat the threat, flee away or make friends with it. Gifts were given to the hero after he defeated the menace. Everyone had to make a connection to their own personal narratives in the conclusion. Developing resiliency and coping mechanisms was one of the goals.

Trauma-related emotional and behavioural symptoms were not addressed in prior studies, which relied on storytelling to teach coping strategies and cognitive abilities. For the purpose of this study, researchers intended to investigate the impact of narrative on the psycho-trauma results, to address unsolved concerns and to help people to be focused on the present and to strengthen coping abilities as well as cognitive capabilities.

The previous studies worked with children individually during the therapy sessions while the current study focused on rescued street children living in children's homes, employing personal and group therapy. The former studies were case studies while the current study is an intervention study.

The reviewed studies used simple narrative stories told by the therapists. The current study is an intervention that consisted of telling the children's own stories by themselves about the traumatic event and their feelings, thoughts and beliefs about it. The intervention was done in three stages: the first stage consisted of exploring the traumatic event, after debriefing on stressful events or difficult situations that one may encounter in life. Later, the children were asked to think about their past traumatic events, what happened, what their reactions were and feelings about the events. Later, each child was asked to tell his or her personal story expressing all the feelings and emotions that may arise and that may be addressed. In the second stage the children were asked to think about their present experience since coming to the children's home. Then each one was asked to tell his or her story and narrate their experience. The third stage consisted of telling their stories focusing on the future, on whom

they may want to become, their dreams and what they needed to do at that particular moment to achieve their goals. No further studies have been found in Africa and in the Democratic Republic of Congo particularly on storytelling as therapy.

2.3.4. Meditation on Psycho-trauma among Rescued Street Children

Meditation is a mindfulness technique that teaches a person to develop awareness and to experience the present moment. This can reduce stress and anxiety. This helps the person to be in contact with himself or herself and the environment and to cultivate awareness. Furthermore, meditation helps to encourage the development of healthy coping mechanisms and the development of a sense of mindfulness and present-moment awareness. (Sibinga et al. 2016). Yoga is a form of meditation, which adopts a specific posture of the body; Pranayama is a simple form of meditation which includes repeating positive words.

A study by Crews et al. (2016) examined the efficacy of Yoga to cultivate self-compassion in survivors of sexual abuse. A survey was used to gather qualitative data from five female teenagers between the ages of 14 and 15. The participants were all adults who had been sexually abused as children. Before and after therapy, the effects of trauma were evaluated through the use of interviews and questionnaires. An increase in self-compassion and community-connectedness, as well as a mind-body connection, was found in the study participants.

The study by Crews et al. (2016) was a survey aiming at collecting qualitative data of the influence of yoga on the trauma outcomes among female victims of sexual abuse. The current study was an intervention using meditation to establish its effect on the psycho-trauma outcomes among rescued street male and female children living in children's homes.

Culver et al. (2015) conducted a pilot study on the use of Yoga in Haitian orphanages to reduce trauma-related discomfort and emotional and behavioural issues among children. The study used a randomized controlled trial design and was quantitative research, with a sample

size of 76 children who were orphans. The children were aged between 7 and 17 years old. The study's intervention included yoga, meditation and breathing exercises. The results showed reduction in trauma related symptoms.

Quantitative data were collected using a randomized controlled experiment by Culver et al. (2015). Qualitative and quantitative data were collected using a mixed research sequential explanatory design. Unlike the earlier findings by Culver et al. (2015), which was conducted in an orphanage, the current study was conducted in three rescue houses for street children.

Another study was done by Pradhan (2015) on Trauma interventions using mindfulness meditation as therapy for chronic PTSD. The study was a pilot study that used interview and questionnaire to measure the symptoms of trauma before and after the intervention. The participants were 4 adolescents aged between 14 and 19 years. Among them, two had sexual trauma and two had physical accident trauma. The findings showed a significant decrease in PTSD symptoms.

Yoga-based therapy groups for traumatized boys in urban environments were studied by Beltran et al. (2016). The investigation was conducted using a quantitative approach. Ten boys between the ages of 8 and 12 with histories for early childhood trauma took part in the study. The procedure was a 12-week yoga-based psychotherapy. A Behavioural and Emotional Rating Scale2 (BERS2) was used to assess trauma symptoms. From the findings, participants showed significant improvements in interpersonal strength and family involvement.

In British Columbia, Bonnel (2016) studied the impact of yoga with techniques such as mindfulness and meditation on children and youth who had experienced trauma and suffered from the effects that trauma can have on their mind, spirit and body. The study sample size was 7 participants. The findings indicated that Yoga/meditation helped the participants to

gain inner strengths, peace of mind and muscle relaxation. It also increased their self-confidence and self-esteem.

The study by Bonnel (2016) shed light on the physical, emotional and behavioural benefits of meditation techniques in reducing trauma symptoms in traumatized children and adolescents. Meditation, therefore, improves psychological wellbeing and reduces negative effects of stress among vulnerable individuals (Sibinga et al. 2016). The current study examined the effect of meditation on the psycho-trauma outcomes, which consisted of repeating positive words or phrases several times, after a few minutes of breathing and relaxation exercise. The intervention was done in three stages: meditating about their past traumatic events, the here and now experience and what to achieve in the future while remaining focused in the present moment.

Therefore, Arts Therapy such as music and dance movements, storytelling and meditation are relevant in working with traumatized children, especially rescued street children. They may bring about changes in their thoughts that can free up victims' minds. It may help them to replace their negative feelings and thoughts about themselves and about others and the world around them, which may create anxiety, stress, anger and fear. They may learn to replace these negative feelings and thoughts with positive ones being focused in their here and now experiences. These rescued street children generally have low self-esteem and they consider themselves not to be worthy and able to obtain a position in society in the future. The child-friendly approaches may help them to increase self-esteem, reduce stress, be positive, and increase their awareness and self-confidence. It may build resilience and teach new coping skills. Unfortunately, no recent researches have been found on the arts as therapy such as music, dance, storytelling and meditation in Africa. Trauma among rescued street children is treated with talk therapy and formal activities such as sports.

2.4.Research Gaps

Even though many research works have been done on issues relating to traumatized children and their challenges, a lot still needs to be done. Previous studies revealed that these children have experienced a lot of violence and terror and therefore were traumatized. Trauma is best treated with child friendly-approaches, especially Arts therapy. Music, Dance, Storytelling, and Meditation therapies are widely recognized and used as a professional field in some countries in the world. However, despite its obvious usefulness and widespread application, arts therapy has yet to acquire traction in Africa cultures (Wangala, 2015). There are fewer studies in Africa on Arts Therapy. This current study focussed on identifying the effect of child-friendly approaches on psychological trauma among rescued street children. First, it described the psycho-trauma outcomes among these specific children. Then it ascertained the influence of some selected child-friendly approaches on the psycho-trauma outcomes among these specific rescued street children.

Surveys and case studies are the most common types of previous studies, which collect and analyse data in qualitative or quantitative ways. Sequential explanatory mixed methods design was utilized to gather and analyse primary and secondary data in two phases in the current interventional investigation. First, it assessed the trauma using quantitative data, which helped the next stage. After the treatment, qualitative data was collected. The results were integrated and interpreted statistically. At the end, the trauma was assessed again to establish the effects of the treatment on the symptoms to verify the null hypotheses.

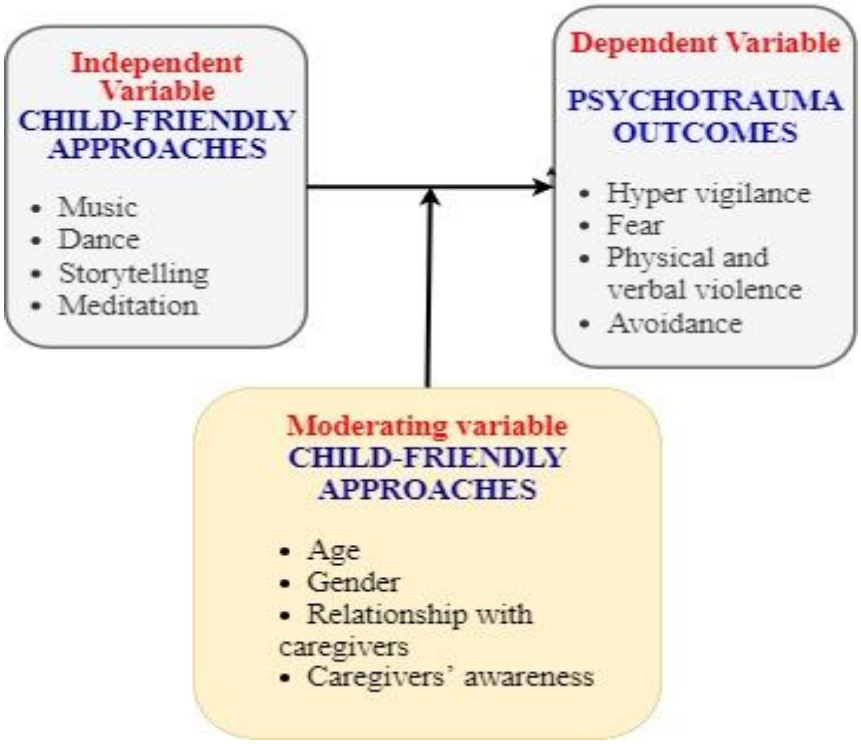
The reviewed studies worked with a variety of children, both in the children's homes, in the streets and in their families. This made the follow up of the children difficult, which might have affected the results. The current study focused on working with selected rescued street children living in three specific children's homes in the same area, in Kinshasa, DRC thus

allowing for a good follow up with the aim of not losing any children from the beginning to the end of the research.

2.5.Conceptual Framework

The researcher's understanding of the connections between the different parameters in his or her study is what is known as a conceptual framework. Consequently, the research investigation is possible to identify the factors required. It serves as the researcher's "roadmap" while they pursue their research (Mc Gaghie et al. 2001).

Figure 1: Conceptual Framework



Source: Author, 2022

The study's independent variable is child-friendly approaches and the dependent variable is psycho-trauma outcomes. Manipulating or applying child-friendly approaches may cause or provoke change in the psycho-trauma outcomes among rescued street children. Such a change may include producing emotional calmness, mental freedom, relaxation, happiness, inner strength, self-determination, self-confidence and awareness. The moderating variables

of the study are the children's age, relationship with caregivers and the caregivers' awareness.

2.6.Chapter Summary and Conclusion

The findings of the previous studies showed that there is need to explore the psychological trauma experienced by rescued street children. In order to better understand the impact of child-friendly techniques, this study was conducted. Psychological trauma among rescued street children in children's homes, in Kinshasa, DRC. Gestalt and Attachment Theories guided the study besides helping in teaching new coping skills to enable the children to adapt to hostile situations in life. It plays a vital role in teaching resilience, which is the ability to resist life's shocks and trauma, to get up, to rebuild oneself (Bernard, 2020). According to Bernard (2020), it helps people with trauma to find a state of balance despite what they suffered in life. The independent variable was child-friendly approaches, which included music and dance, storytelling and movies and meditation. The elements that were enshrined under the independent variable were hypothesised to bring about emotional calmness, mental freedom, relaxation, happiness, inner strength, self-determination, self-confidence and awareness. The dependent variable was the psycho-trauma outcomes that included hyper-vigilance, fear, physical and verbal violence and avoidance. The study took into consideration the children's age, gender and their relationship with caregivers and the caregivers' awareness.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1.Introduction

This chapter presents the research design, the study area, study population, sampling method and sample size. Data collection instruments, research instrument pre-testing, information quality assurance, data collection processes, method of data analysis and ethical considerations.

3.2.Research Design

This study used a combination of methodologies convergent parallel design to establish the effect of child-friendly approaches on psycho-trauma outcomes among rescued street children. Researchers utilized a mixed-techniques convergent parallel design, which calls for them to conduct quantitative and qualitative aspects of the investigation simultaneously, weigh the methods equally, analyse the two components separately, then combine the results (Creswell & Pablo-Clark, 2011). The current study segmented this design in three phases simultaneously. The initial step was to gather basic data, such as the names, ages and other identifying characteristics of the children involved through the intake forms of the children. This helped in collecting qualitative data and selecting the traumatized cases. Then trauma was measured to collect quantitative data using PCL5-Child Self-report as interview, to plan for the intervention since the study was done with children. The second stage was the intervention stage which was the implementation of the child-friendly approaches and collecting qualitative elements through observations and ticking of the mood chart of emotions and feelings. The third stage was the post-intervention stage, which consisted of screening the trauma levels to compare and integrate all the results.

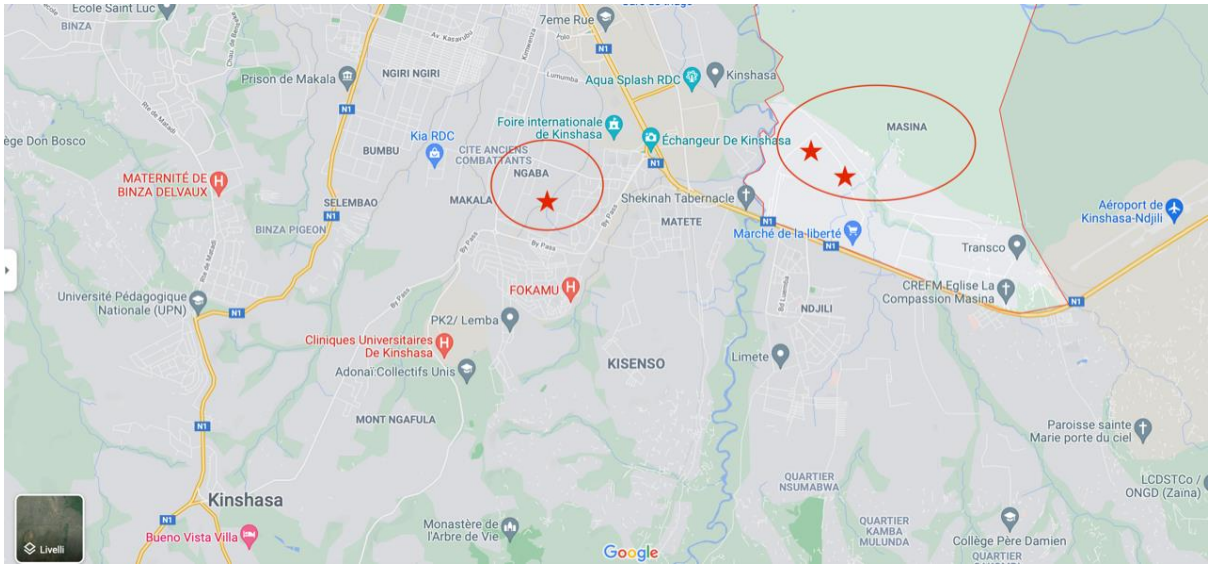
The convergent parallel design was chosen in this study because it helped the researcher to collect at the same time quantitative and qualitative data, analyse them separately and

integrate the results. Quantitative data provided the trauma levels measured with PCL-5 questionnaire, and qualitative data offered information on the children from the observation of their behaviours. Quantitative data were presented in tables while qualitative data in a narrative form to support each other. The strength of this design is that it enables the researcher to gather information that uses the best features of both quantitative and qualitative data collection in relation to the context of the study.

3.3. Study Area

Kinshasa is the capital city in the Democratic Republic of Congo, DRC. Though there are many children's homes in the city, three centres that were purposively selected for the study were Jeunes au Soleil Children's Home, Les enfants d'abord Children's Home and Amour et Liberté Children's Home. The homes are situated in Ngaba and Masina Municipalities in Kinshasa (see Figure 2 below). These three specific children's homes were selected because the rescued street children live in these homes, which was convenient to administer and follow-up on the treatment. Moreover, all the participants could only have the same timetable for all the activities under such a home set up making follow up even easier.

Figure 2: Location of the Study Area in Kinshasa



3.4. Target Population

Due to Covid-19 situation, many children had to leave the Homes. The DRC Government asked the homes to reduce the number of the children, anticipating their reunification process with their families for their safety and protection. According to the directors of the three selected children's homes, they could only accommodate between 50 and 60 children. The study focused on the rescued street children present at that particular moment who were aged between 6 and 17 years. The personnel interacting directly with the children were well informed during the study process to make them aware of the study. The target population for this study was 240 individuals in children's homes.

3.5. Sample and Sampling Procedures

A sampling procedure is a method used for selecting a subset of a larger population for inclusion in a research project (Ogula, 2005). The severe case sampling approach may be used to screen for trauma symptoms and then randomly choose a sample from individuals who show them during an interview. This type of purposive sampling is done by targeting the cases that are uncommon or that highlight remarkable effects of a phenomenon in the study, as stated by (Gerstiser, 2014). Only children experiencing trauma symptoms were the focus of this investigation. As a result, the sample size was calculated using Slovin's formula (Slovin, 1960).

The formula is: $\mathrm{n} = \frac{N}{1+N(e)^2}$

Where:

n = the sample size

N = the total population

e = level of confidence (0.05)

N = 240

Therefore, $n = \frac{240}{1+240(0.05)^2}$

$$n = \frac{240}{1+0.6}$$

$$n = 150$$

The targeted sample size of the study was 150 participants. However, the study focused only on the children presenting trauma symptoms at the time of the intervention. Thus 124 children who accepted to participate freely.

3.6.Data Collection Instruments

The study employed PCL-5 Child Self-report tool in three phases.

Phase One: Baseline Data

The baseline phase involved the use of the intake forms to select children from the homes before administering the PCL5-Child Self-report as an interview. The interview was conducted because the participants, who were minors, had to be screened to ascertain their trauma levels before planning the intervention. The inclusion criteria was that only children who had spent at least one month in the homes were eligible for recruitment.

Phase Two: Intervention Stage

The second phase was the implementation of the child-friendly approaches, which involved one month intervention of five sessions with three groups: group A (Jeunes au Soleil Children's Home), group B (Les enfants d'abord Children's Home) and group C (Amour et Liberté Children's Home). Each group received a different intervention of five sessions lasting two hours each.

The First Session involved gathering all the children from each home for a debriefing about what the intervention involved. Debriefing also sought to create rapport and a safe environment. At the end of debriefing, participants voluntarily signed the informed consent forms, which were explained in the local language. The caregivers assisted them. The group rules were also settled in the first session.

After the debriefing session, an intervention involving three sessions then followed. At the end, the last session (the fifth session) an evaluation of the intervention was done using the PCL5-Child Self-report to establish the changes. However, before and after each session an interview was done with emotion-feeling images to enable the children address and cope with their feelings and emotions that arose in the process, and to collect qualitative data.

From the second session, the groups were divided, each group received a different intervention.

Group A included rescued street children from Jeunes au Soleil Children's Home who received music and dance intervention.

The Second Session consisted of debriefing about stressful life events, the feelings, thoughts, beliefs and behaviours that can be experienced after traumatic events. Then some relaxation exercises with slow music of a first selected song accompanied by the counsellor's talk followed to help the children to explore their traumatic past events, their feelings about them, the unfinished businesses and all the blocks of energy in their body. At the end there was a debriefing, which consisted of sharing how they were feeling before, during and after the exercise. This session lasted for two hours to allow everybody to share and open up.

The Third Session with group A started with debriefing on the feelings they experienced and shared in the first session and how they were feeling at that time. Then, some relaxation exercises with slow music and the performance of the second preselected music and dance

followed. This was done while they continued to explore the here and now feelings, thoughts and beliefs in addition to the body movements of the dance. At the end, there was a debriefing and sharing on how they were feeling after the dance and if some blocks of the energy had been released. This session lasted two hours.

The Fourth Session was teaching of the coping skills with the preselected third music and dance. There was first a debriefing on the last session, screening of feelings and their thoughts at that particular time with mood images to tick accompanied with some relaxation exercises. Then the performance of the third preselected song and dance, which helped the participants to focus and think of their strengths, future, dreams and how to achieve them if given all the means and a proper environment. At the end, there was a debriefing and sharing about their strengths, dreams and goals, what they could do to achieve the and how they could resist in front of all the adversities of life. The "Cube of Peace" which was done by the counsellor, had six faces with short phrases in each, such as "I am the first to love", "We forgive each other", "We love each other", "We help each other", "I listen to the other", "I play with everybody", was used to help the children to learn some socio-emotional skills.

The Fifth Session was the evaluation of the intervention. In addition, PCL5-Child Self-report test was administered to screen the trauma levels after the intervention.

Group B included the rescued children of Les enfants d'abord Children's Home. This group received storytelling intervention that consisted of telling their own stories about the traumatic event and their feelings, thoughts and beliefs about it.

The Second Session, which lasted for two hours, consisted of exploring the traumatic event. After the debriefing on stressful events, some relaxation exercises performed with the help of the counsellor's guidance were done to help the children to think about their past traumatic events, what happened and their reactions and feelings about the events. Later, each child told

his or her personal past traumatic story expressing all the feelings and emotions that arose during the exercise. A debriefing was then carried out based on what the participants had shared. The session ended with a relaxation exercise to help them to come back to their normal life.

In the Third Session, after debriefing on the previous session, the relaxation exercise guided the children to think about their experience in the present moment since they were now in the Children's Home. Each of the children then told their stories, what is happening here and now, and their experiences in the Children's Home.

The Fourth Session consisted of telling their stories focusing on the future. They talked about what they wanted to become, their dreams and what they intended to do at the moment to achieve their goals. This session sought to help them learn some coping skills to build self-esteem, to be focused in the awareness of what they should do currently and how they should do it. The "Cube of Peace" was also done by the counsellor to help the children to learn some socio-emotional skills.

The Fifth Session was an evaluation based on the intervention. PCL5-Child Self-report test was administered to screen the trauma levels after the intervention.

Group C included the children from Banabakintu - Amour et Liberté Children's Home. The three intervention sessions were guided meditation and fifth session was the evaluation of the intervention.

In the Second Session, after the debriefing, there was a relaxation exercise with a slow preselected music accompanied by the counsellor's words. This sought to help the participants reflect on their traumatic events and their relationship with their family members linked to the traumatic events experienced in the past being aware of all their body reactions. They reported if there was any pain or tension in a part of the body. They also noted the

heartbeat rate and the breathing, all the bodily sensations, all the emotions and feelings that arose at that time. Later, there was a moment of sharing what came to their mind and how they were feeling about it at that time. Then a debriefing was done after the sharing followed by a relaxation exercise to try to bring them back to normal status. The session lasted two hours.

In the Third Session, after the debriefing on the last session, the relaxation exercise, a second preselected slow music with the counsellor's talk helped to direct the children to reflect on their current experiences since they were in Children's Home and on their relationship with the caregivers and all the other children. While reflecting, they listened to their body reactions and noted any block of energy or body pain and how they felt at that particular moment. After the sharing, a debriefing was done.

The Fourth Session was done with the third preselected slow music after the relaxation exercise and guided by the counsellor's talk. It consisted of reflection on their future, their dream careers and their plans to achieve those dreams. They learned some coping skills such as being focused and resilient. They also learned how to think positively about themselves, knowing their strengths and weaknesses, how to focus on what they can control, how to encourage and work together to help each other. The "Cube of Peace" was used to help the children learn some socio-emotional skills.

The Fifth Session was the evaluation of the intervention. In addition, PCL5-Child Self-report test was administered to screen the trauma levels after the intervention.

Phase Three

After intervention in phase two, phase three was the post intervention test, the re-administering of the PCL5-Child Self-report to all the groups to screen the trauma levels and to see if there was any improvement from the beginning until the end of the interventions.

Then comparing the groups, a conclusion was made to see which intervention was the best in addressing psycho-trauma outcomes among the selected rescued street children.

Administration and Scoring

Prior to a session, patients can fill out the PCL-5 Child Self-report, which can also be used by participants in research studies. It takes about five to ten minutes to finish. One can calculate the severity of a certain symptom cluster in the DSM-5 by adding up the individual item scores inside that cluster, for instance by calculating the mean of the clusters' values. One of the most common symptoms of post-traumatic stress disorder (PTSD) is reliving the horrific experience over and over again in one's mind and body. Cluster B (items 1-5) covers re-experiencing symptoms, which are repeated disturbing memories, dreams of the traumatic event, flashbacks, physical reactions and prolonged psychological distress. Avoidance symptoms are included in Cluster C (items 6-7), such as distressing memories, thoughts, feelings or external reminders of the event. Items 8-14 in Cluster D (negative cognitions and mood) include sentiments like a lack of interest in objects or activities from the past, a feeling of being cut off from others, difficulty recalling the traumatic incident, difficulty sleeping, and a tendency to get agitated easily. Anxiety-inducing symptoms such as aggressiveness, hypervigilance, and antisocial behavior fall under Clusters E (items 15-17 or 20).

Interpretation

In order to make a tentative diagnosis, PCL-5 severity ratings were taken into account. Also taken into account was the assessment's purpose. When screening or looking for prospective cases, a sharp decline score was considered. When trying to make a preliminary diagnosis or reduce false positives, a greater cut-point score was taken into account.

Therefore, the average of the scores before or after the treatment, or the intervention, were supposed to indicates 1 for no trauma, 2 for minor trauma, 3 for mild trauma level, 4 for high trauma level and 5 for severe trauma level.

Evidence for the PCL-5 Child Self-report suggests that an average of 3-4 points change represent clinically significant change, 2 means an individual responded to treatment with minimum change and may need more time and should continue the treatment, while 1 means an individual has not responded to treatment (VA – U.S Department of Veterans Affaires - National Centre for PTSD).

3.7. Pilot testing

The pre-testing of tools and research instruments was done at Petite Flamme Project, in Mikondo Municipality in Kinshasa. The Petite Flamme Project aims to reduce the rampant phenomenon of street children in Mikondo, helping them in their families. It works with rescued street children from 6 to 15 years old, and with the parents of these specific street children to assist them with basic needs, and to offer a social and professional training to the families in order to assist and sensitize them in order to become conscious, independent and accountable and support the family. Parents' support and sensitization.

A sample of 50 children ranging in age from 6 to 15 years was used for the pre-testing. As a way to ensure that research instruments were accurate and reliable, the feedback from pre-testing was used to improve the instruments if necessary. It was clear that the usage of local language was critical throughout the entire process.

3.8.Data Quality Control

To put it in another way, quality control is the effort and methods that researchers put into place to make sure the integrity and accuracy of data is acquired by their selected methodology or instruments. (Lavankras, 2008).

3.8.1. Reliability and Validity of the Research Instruments

Everyone can benefit from and value research that is both credible and valid. An instrument's dependability is measured in terms of how consistently it measures something, as well as how easily the results can be replicated in a repeated experiment. To what extent do the results actually reflect what they purport to reflect is what we mean by "validity." It is possible for a measuring device to be dependable yet not valid. According to Middleton (2019), if a piece of evidence is valid, it is typically also trustworthy.

The Cronbach's Alpha Test of consistency was used to evaluate the validity of quantitative data. According to Mugenda & Mugenda (2003) 0.7 is the dependability threshold for Social Science Studies.

The validity of the content of the instruments was done by the supervisors of the study by reading and judging the PCL-5 Child self-report, to evaluate if the instruments were adapted to children and measuring trauma. The supervisors' recommendations were taken into consideration. While the reliability of the instruments were determined by conducting a pilot study at Petite Flamme Centre, by testing the language, to see if the participants understood the questions. It was found that the instruments should be translated in the local language to make it easy for the children to understand, since most of them had primary level not completed. After the translation of the items and the pilot study, the PCL-5 Child Self-report questionnaire was found to be suitable for the rescued street children in testing the trauma levels.

3.8.2 Trustworthiness and credibility

Credibility, reliability, conformability, transferability, and authenticity are all aspects of trustworthiness that Linconl and Guba (1994) say must be taken into account. In other words, the most essential factor in determining whether or not a study is trustworthy is its credibility,

which is determined by how much trust or confidence the participants, researchers, and others have in the study's conclusions, data, interpretation, and procedures (Polit & Beck, 2014).

The instruments used for the current study were compatible with qualitative data collected, interpretation and conclusion of the findings and of the research population. The findings could also be generalized to other groups of rescued street children in Kinshasa and even DRC. The conclusions were only based on the study participants drawn from the three selected children's homes and not another population.

3.9.Data Collection Methods

Using mixed-methods convergent parallel design, the study used behavioural and emotional observations, interviews and questionnaires to collect both quantitative and qualitative data. PCL-Child Self-report was used to collect baseline data of the trauma levels. The quantitative data collected helped in the intervention planning. After each session, qualitative data was collected for follow-up during the intervention. Post intervention test was also done to collect quantitative data from all the three groups to establish the effectiveness of the intervention on the Psycho-trauma outcomes and draw conclusions based on all the relevant information to see which one worked better.

3.10. Data Analysis and Presentation

The statistical software for social sciences (SPSS) was utilized to analyse data in this study. After collecting data, it was coded before analysis and interpretation. The coding of data was done by assigning numbers to the names of participants and to the values in order to identify the gender, for example, "1" for male and "2" for female. This helped to categorize how many males and how many females participated in the study. The age brackets were also coded, for example, "1" was used to represent age from 7 to 9, "2" for 10 to 12, "3" for 13 to 15 and "4" for 16 to 17 years. This was done by maintaining the same interval scale for each

set of age except for the last scale. Then for the "Yes and No" answers, number "1" was assigned for "Yes", and "2" for "No". In measuring trauma with PCL-5- Child Self-report, a 5-point Likert scale was used. In this case, 1 represented 'Not at all', 2 represented 'A little bit', 3 represented 'Moderately', 4 represented 'Quite a bit' and 5 represented 'Extremely high'. In other words, 4 and 5 stood for the higher level of trauma, 3 medium, 2 low and 1 for no trauma. After coding, the researcher used SPSS programme to perform data cleaning to check for errors or missing values. After data cleaning, data analysis was done.

The analysis of Variance (ANOVA) and Pearson Correlation were used for the quantitative data, to ascertain the relationship between child-friendly approaches and psycho-trauma outcomes among rescued street children in selected children's homes. The qualitative data was analysed and organized into themes based on the study objectives. The results of the study were presented using tables, charts and graphs.

3.11. Limitations and Anticipated Constraints

One of the study limitations was the restriction implemented because of the Covid-19 situation that created a situation of uncertainty about the future. Despite of this, the study was carried out.

3.12. Ethical Considerations

Before going to the field, an authorization letter for research was given to the researcher by the Department of Counselling Psychology at the Catholic University of Eastern Africa (CUEA). This letter was presented to the Directors of the selected Homes in Kinshasa, DRC, together with the Police Clearance and the Welfare and Child Protection Certificate of the researcher.

Before embarking on the study, the researcher explained clearly and fully the objective and the benefits of the study to the research participants to obtain their informed signed consent.

No one was coerced or influenced to participate in the study. Furthermore, participants were informed that they were free to withdraw from the study without any consequences might they feel to do so. The researcher was sensitive all along and after the research to the ethical issues of confidentiality and privacy of the research participants. Knowing that the study dealt with emotional and behavioural disturbances, a psychological debriefing was done before, during and after the data collection to accompany and to help the participants learn how to cope with their feelings and return to normalcy. Traumatic experience and history of violence makes street children fearful and suspicious hence need a trustworthy relationship. Those who experienced betrayal in the past find it difficult to trust other people (Erikson, 1980). Therefore, the researcher ensured that all the participants were protected from any emotional or physical harm. This included not being judgemental and keeping unconditional positive regard towards the children to build a trustful and warm relationship during and after the study. The researcher also ensured that the collected data was used only for the purpose of the current study. All the documentations were kept private and safe, without revealing any name of the participants instead codes and pseudonyms were used on the questionnaires and all the documents, including in the final report, which is intended to be a public document.

CHAPTER FOUR

DATA ANALYSIS, PRESENTATION AND DISCUSSION

4.1.Introduction

The research objectives were: to describe the psycho-trauma outcomes among rescued street children, to determine the influence of music and dance on psycho-trauma among rescued street children, to identify the influence of storytelling on psycho-trauma among rescued street children and to examine the influence of meditation on psycho-trauma among rescued street children in selected children's homes in Kinshasa, DRC. This chapter presents the demographic information of participants that comprise of participation rate, participants' gender, age, religion, and education level.

In addition, this chapter presents the outcomes of data analysis which is subdivided into five subsections. The first subsection involves a general analysis of all the 124 rescued street children who were involved in the interventions where levels of trauma were measured before and after the treatment. The difference of the mean values is also discussed as revealed by the results of a t-test.

The second subsection involves the analysis of a sub-sample of 46 children from Jeunes au Soleil Children's Home who were involved in music/dance intervention only. Their levels of trauma were measured before and after the treatment after which the difference in mean values is also discussed as revealed by a t-test.

The third part of data analysis targeted a sub-sample of 35 children from Les Enfants d'abord Children's Home who took part in storytelling intervention only. After measuring their trauma levels before and after the treatment, the mean difference established by a t-test is discussed.

The fourth section of data analysis focused on a sub-sample of 43 children from Banabakintu-Amour et Liberté Children's Home who participated in meditation intervention only. Their trauma levels before and after the treatment as well as their mean difference is discussed.

The fifth part of data analysis section in this chapter involves the control group that had 18 rescued street children who were never involved in any of the interventions. Their trauma levels were recorded at the begging of the study and at the end of it. Just like the other sub-samples, the difference in mean values at the beginning and at the end is discussed as revealed by the results of a t-test.

The last part presents the results of a two-factor ANOVA test where the factors used in the analysis were "trauma level before and after treatment" and the "type of intervention." Unlike the first part of the intervention where the types of interventions were not taken into account in the t-test, the ANOVA test sought to find out whether the sample means of the trauma levels before and after treatment were equal regardless of the intervention used.

DSM V clusters includes, cluster B Cluster that covers re-experiencing symptoms, which are repeated disturbing memories, dreams of the traumatic event, flashbacks, physical reactions and prolonged psychological distress. Avoidance symptoms are included in Cluster C, such as distressing memories, thoughts, feelings or external reminders of the event. Cluster D (negative cognitions and mood) include sentiments like a lack of interest in objects or activities from the past, a feeling of being cut off from others, difficulty recalling the traumatic incident, difficulty sleeping, and a tendency to get agitated easily. Anxiety-inducing symptoms such as aggressiveness, hypervigilance, and antisocial behavior fall under Clusters E.

The interpretation of the average of the scores, according to the DSM V clusters, before or after the treatment, or the intervention, were supposed to indicates 1 for no trauma, 2 for minor trauma, 3 for mild trauma level, 4 for high trauma level and 5 for severe trauma level.

4.2 Demographic information of participants

In identifying the effects of child-friendly approaches on psycho-trauma outcomes among rescued street children, the demographics that the researcher considered as important for the selection criteria of the participants included gender, age, religion and education.

4.2.1 Participation Rate

After the baseline phase - which consisted of selection of 142 children who were newly admitted since one month in the homes and who received the PCL-5 Child Self Report questionnaire to screen the levels of trauma. The children who were selected from the intake forms presented high level of trauma. Out of the 142 targeted children, 124 of them (87.3%) accepted freely to participate in the intervention. The remaining 18 children (12.7%) who did not want to participate in the intervention, accepted freely to be in the control group. As the pie chart in Figure 1 shows, 46 rescued street children out of the 124 participants (representing 37%) were selected from Jeunes au Soleil Children's Home, 43 of them (representing 35%) were from Amour et Liberté Children's Home and the remaining 35 (representing 28% of the total) were from Les enfants d'abord Children's Home.

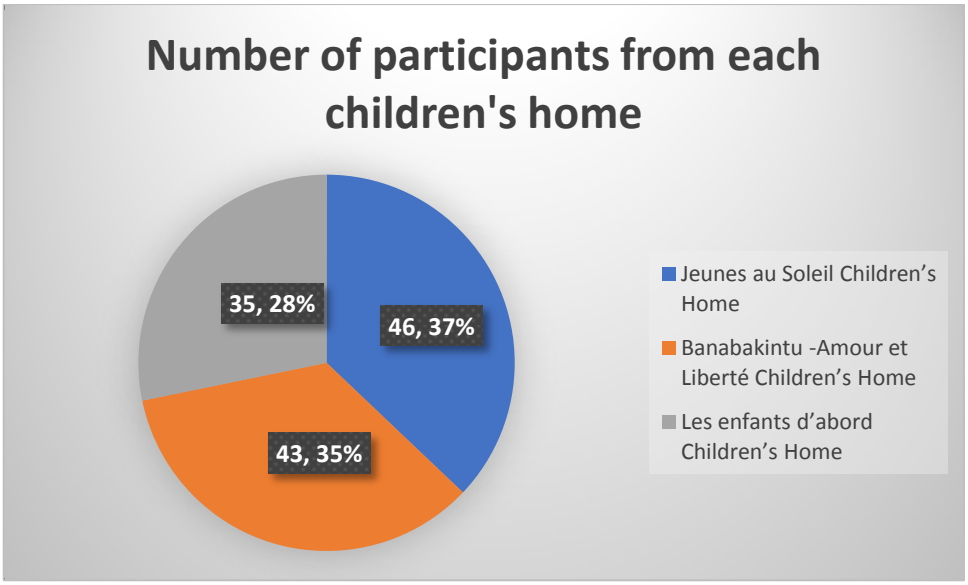


Figure 3: Number of Participants in the Intervention

(Source; Researcher, 2021)

4.2.2 Gender of Participants

Figure1 shows the gender of the rescued street children who received PCL-5 Child Self-report questionnaires at the baseline phase to screen the levels of trauma before the intervention. Out of the 142 targeted participants in the baseline phase, 74 of them were male (52%), while 68 were female (48%). Out of the 142 participants, 124 (87%) accepted freely to participate in the intervention. Out of these 124 participants, 63 (51%) were male and 61 (49%) were female. The 18 rescued street children who were targeted in the baseline phase but did not participate (13%) accepted to be in the control group of the intervention. They included 11 males (61%) and 7 females (39%).

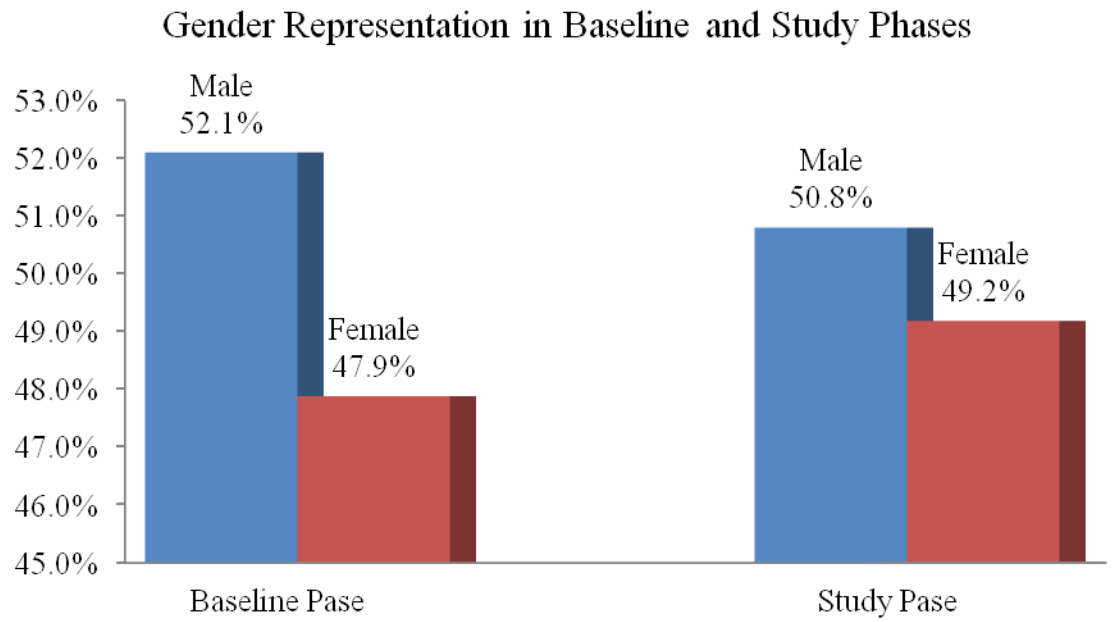


Figure 4: Number of Participants, in Terms of Gender

Source; Researcher, 2021

4.2.3 Age of the Participants

The study participants were categorized into four groups based on their ages. Since the minimum age was 7 years and the maximum age was 16 years, the first three groups had a class size of 2 while the fourth group's class size was 1. Most of the respondents were aged 9 years.

As shown in figure 3, 55 of the participants (44.4 % of the sample) were aged between 7 and 9. Those aged between 10 and 12 years were 43 (34.7%). Participants aged between 13 and 15 were 22 making (17.7%). Those between 16 and 17 were only 4 constituting 3.2%. This revealed that those children between 16 and 17 years old were less affected indicating that they can manage the psycho-trauma outcomes after one month in the homes.

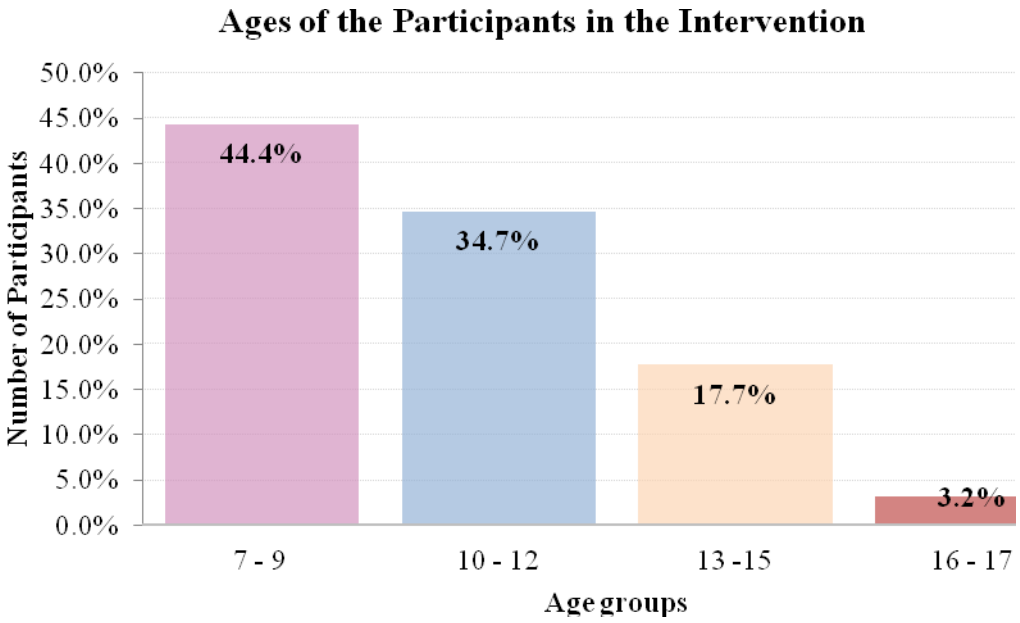


Figure 5: Ages of the Participants in the Intervention

(Source: Researcher, 2021)

4.2.4 Religion of the Participants

The religions of the participants were categorized into five: Catholic, Protestant, Muslim, None-religious and other religion. As indicated in figure 4, none of the participants was non-religious. Majority of the children (68%) were Catholics, 22% were Protestants, those belonging to other religions were 6% and Muslims were 4%.

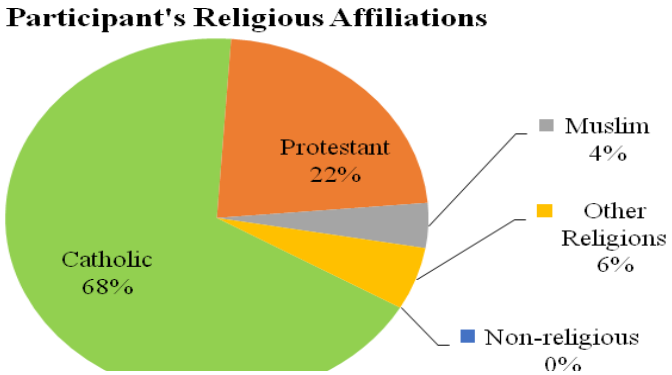


Figure 6: Religious affiliations of the Participants

(Source; Researcher; 2021)

4.2.5 Education Level of Participants

The participants' education level was categorized into three: Primary, Secondary and None at all. Those who indicated that they had attended secondary level were the least and primary level were the majority. As indicated in figure 5, majority of the participants (80 children) representing 64.5% of the sample size had primary educational even though none of them completed primary school education before going to the streets. In fact, most of them stopped at class one. Those children who have never been to school were 40 making 32.3% of the sample size. Only 4 children (3.2%) transitioned to secondary school before stopping in form 1 and migrating to the streets. This explains why majority of the participants could not read nor write. As a result, the instruments of the intervention were translated and explained in the local languages for easier understanding.

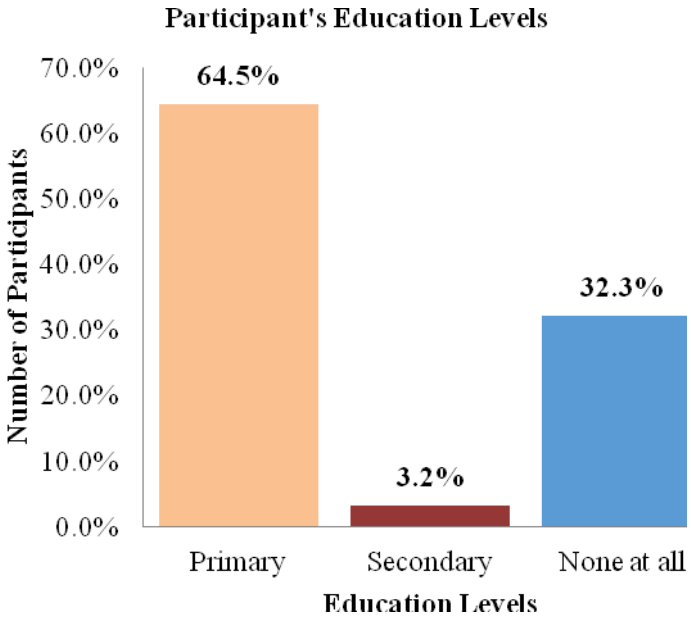


Figure 7: Education Levels of the Participants

(Source: Researcher, 2021)

4.3 Trauma symptoms among rescued street children living in children's homes

4.3.1 Trauma Symptoms before the intervention

The information summarized in table 1 indicates the psycho-trauma symptoms among rescued street children before the intervention.

	Cluster B	Cluster C	Cluster D	Cluster E
Mean	4.1613	4.2742	3.7883	4.3144
Standard Error	0.031	0.039	0.0319	0.0346
Standard Deviation	0.3447	0.4341	0.355	0.3858
Minimum	3	3	3.14	3
Maximum	4.8	5	4.57	5
Count (N)	124	124	124	124

Table 1: Trauma Symptoms before the Interventions

(Source: Researcher, 2021)

An examination of the symptoms of trauma according to the clusters showed that the highest level of 4.3145 was Cluster E symptoms, which include arousal symptoms such as aggressiveness, hyper-vigilance and antisocial behaviours. This was followed by Cluster C avoidance symptoms with a level of 4.2742. Those presenting Cluster B symptoms of re-experiencing came in the third position with 4.1613 and Cluster D comprising of negative cognitions and mood with a lot of feelings such as loss of interest in things or activities of the past, having difficulty relating to people, having difficulty recalling the painful experience event, sleep difficulties, feeling easily angry or irritated had a level of 3.7880. All the clusters were ranged from mild trauma level to severe trauma level.

The first observation is that all the rescued street children came from various traumatic experiences and developed similar symptoms. The most common symptoms for all participants were fear, sadness, hyper-vigilance and violence (verbal and physical). The findings of this study agree with Robinson et al. (2020) who observed that emotional and psychological trauma, especially for children was the result of any event that disrupts a child's sense of safety. Such events include neglect, physical, verbal and sexual abuse, an

unstable or unsafe environment, domestic violence, separation from a parent, serious illness, loss of loved ones and so on. Therefore, a child's normal response to these abnormal events are fear, anger, shock, denial, irritability, hyper-vigilance, disbelief, confusion, difficulty concentrating, mood swings, anxiety, shame, guilt and self-blame, isolation or withdrawing from others, sadness and hopelessness.

In yet another study, Morrison (2017) examined the symptoms or outcomes of trauma experienced by children. The study showed that there were different types of trauma with a variety of symptoms or outcomes, such as feelings of loss, anxiety, fear, depression, anger, confusion, displacement among others. This was observed in the current study by the participants' feelings at the time of administering the intervention especially during mood ticking, feeling chat and sharing before and after every session. The following are experiences of two participants, respondent 4 who is a 12-year old girl and respondent 12 who is a 10-year old boy:

> The first day when we started, in responding to the questions, I was feeling very sad thinking of my life. Many negative thoughts came in my mind. Examining my entire life was like looking at a mirror and this made me to cry. I was very young (5 years old) when my mother, my younger brother and I moved to the street. I was always beaten. I had unimaginable fear, my heart was always pounding and I thought anything could happen to me at any time. I never experienced love. Since I moved to this children's home, I always avoid talking of my experience because it always makes me to feel as if I am still living it. When the night comes, I fear. I also experience nightmares that make me shout when I am sleeping. However, I said to myself that this is my chance and I should focus on shaping myself to the person I would like to become tomorrow. I have to forget my past life, thank God

for this opportunity and do my best even though it is not easy to forget (respondent 4, 12th November 2021).

I am a 10 years old boy. I have been living in the street since I was 4 years old. After my mum died, my aunt chased my older brother and I away from her home. I was trained to steal fruits and bread to survive. Then after some years, I could fight and beat other children, I became aggressive with all the bad behaviours of the street that I cannot mention, but I know you are aware of them already. We were living with great fear. I was and always on guard watching for the Police or the Gang. It was a terrible experience. Since we started these meetings, I have been thinking of my past, the way I feel and my emotions. I can say that I was always sad at first besides being excited about what will happen. Every day my feelings and emotions were changing, from sadness to happiness, from hopeless to hope and trust. I believe in myself. I have confidence and I know that tomorrow I will become a better person, so that I can help others. I just want to be focused in the present moment without thinking about the past always. God loves me (respondent 12, 27th November 2021).

4.3.2 Trauma Symptoms after the Intervention

Table 2 below shows a summary of trauma symptoms after the intervention.

	Cluster B	Cluster C	Cluster D	Cluster E
Mean	1.4516	1.4153	1.1523	1.4433
Standard Error	0.0232	0.0361	0.0127	0.0328
Standard Deviation	0.2587	0.4018	0.1409	0.3655
Minimum	1	1	1	1
Maximum	2.2	2.5	1.57	2.33
Count (N)	124	124	124	124

Table 2: Trauma Symptoms after the Interventions

Looking at the symptoms of trauma among rescued street children, it was revealed that after the intervention, the trauma level for all the clusters showed no presence of trauma. This was

evident based on the mean values of trauma levels where Clusters B, E, C and D had 1.4516, 1.4435, 1.4153 and 1.1521 respectively.

Results from this study are consistent with those from previous research. Morrison (2017) whose research sought to measure the symptoms of Trauma in children affected by acute trauma in Kamloops in Canada found out that these children had a variety of psycho-trauma outcomes that included feelings of loss, anxiety, fear, depression, anger, confusion, displacement among others. Similar to Morrison's findings, the current study revealed the benefits of art therapy if administered to the traumatized children. However, the current research findings negate Morrison's findings that the researcher must focus on working individually with children and not as a group in order for the therapy to succeed. Although the current study involved different groups of children, improvement in the trauma symptoms was recorded as indicated in table 2.

4.3.3 Trauma Symptom Changes

Table 3 shows the changes of trauma symptoms before and after the intervention.

t-Test: Paired Two Sample for Means

	Cluster B		Cluster C		Cluster D		Cluster E	
	Before	After	Before	After	Before	After	Before	After
Mean	4.161	1.452	4.274	1.415	3.788	1.152	4.314	1.443
Variance	0.119	0.067	0.188	0.162	0.126	0.0198	0.1488	0.135
Observations	124	124	124	124	124	124	124	124
P(T<=t) two-tail		0		0		0		0
t Critical two-tail		1.9794		1.9794		1.9794		1.9794

Table 3: changes of trauma symptoms after the intervention

As indicated in table 3, the mean value of trauma level for cluster B without any intervention (M = 4.161, SD = 0.3447) was significantly more than the mean value of trauma level after intervention (M = 1.452, SD = 0.2587), (t (52) = 4.8, p < .001). Similar reduction in trauma levels was recorded in clusters C, D and E. After the intervention, most of the participants

reported that they slept well, the fear they had of the caregivers had reduced and the verbal and physical violence against one another in the home had also reduced.

Most of participants reported that the anger against their family members had reduced and they were ready and willing to forgive because they had discovered that they are able to work hard for their future being focused in present moment.

In line with previous research, this study's findings are in line with Christenbery's (2015) who discovered that there was improvement among traumatized children who participate in the study that was carried out in the USA. In yet another study that was conducted in Sweden, Rudstam et al. (2017) showed that there were changes in the heartbeat rates, anxiety and fear from the baseline stage up to post intervention stage. Positive changes were recorded in the scores of all the trauma measurements used in their study. Similar revelations were evident in the current study as demonstrated in the following narration of a 10-year old boy who participated in the study.

> These days have been nice for me. I feel like I am a different person. Presently, I can enjoy the company of my brothers and sisters here at the Centre. I am at peace in my heart. I do not fear anymore. When I go to bed, I sleep at once till morning. I even find it difficult to wake up. The days of peace have helped us to love one another. I have learned to forgive my enemies. My first enemy was my mother whom I blamed for bringing me into this world. I always asked myself why I was born. I now understand that God has a plan for me and I forgave my mother. If I see her today, I would greet her. Marking my feelings and emotions every day was amazing and it helped me to learn that I needed to change the negative feelings and emotions that do not help me to be happy and to grow. Instead, I chose the positive feelings and emotions in order to grow and enjoy life. I wish I could continue with the exercise.

4.4 Influence of Music and Dance on Psycho-trauma Outcomes among Rescued Street Children in Selected Children's Homes in Kinshasa, DRC

4.4.1 Trauma Level before Music/Dance Intervention

Music and Dance interpretation were administered to the rescued street children at Jeunes au Soleil Children's Home as treatment of Psycho-trauma outcomes. The participants in the Music intervention were 46 children. Before the treatment was administered, the levels of trauma among rescued street children were measured. In this case, trauma levels were screened according to the clusters before the participants received the treatment. Table 3 of descriptive statistics presents data of pre-treatment trauma levels.

	Cluster B	Cluster C	Cluster D	Cluster E
Mean	4.3217	4.3152	4.0096	4.4776
Standard Error	0.0381	0.0546	0.0361	0.0461
Standard Deviation	0.2581	0.3706	0.2447	0.3126
Minimum	3.8	3.5	3.57	3.67
Maximum	4.8	5	4.43	5
Count	46	46	46	46

Table 4: Trauma level before Music Intervention

Source; Researcher; 2021

As demonstrated in table 3, Cluster E that comprise of which are arousal symptoms had the highest level of Trauma symptoms at a mean of 4.4776. In fact, majority of the children recorded high scores of symptoms such as hyper-vigilance, physical and oral aggressive behaviors, feeling jumpy, having difficulty concentrating and other antisocial behaviours. Cluster B that was characterized by repeated disturbing memories and dreams related to the traumatic events had the second highest mean value of trauma level of 4.3217. Participants in this category experienced symptoms such as flashbacks, nightmares, physical reactions and prolonged psychological distress. Cluster C had the third highest trauma level of 4.3152 as measured using avoidance symptoms. Cluster D was the forth in number and it comprised of

negative thoughts and mood swinging, which includes feelings like lack of interest in things or activities from the past, feeling isolated or cut off from others, difficulty recalling the horrific incident, sleep difficulties and being prone to becoming angry or irritated.

Majority of the children indicated that they had never experienced love in their own families. Instead, they revealed that people who should love and protect them abused them. That explained why they had feelings of hatred and anger towards their family members and their abusers. This, according to Fraley (2010), can be understood by the fact that children are detached from people who are supposed to love and care for them but instead mistreat them forcing such victims to migrate to the streets in search of security, protection and survival. Such behaviour is an instinctive response to the perceived threat of losing the survival advantages that accompany being cared for, being loved and being provided with all the needs in a child's own family environment. This is demonstrated in the following narration of two boys: respondent 9 (14 years old) and respondent 22 (13 years old)

> This first question makes me see my past life like in a mirror… I never like to talk of it, but I will tell you. Since I was 6 years old, my father was abusing me. He was violent and drunk. I was 8 years old when my mother died and my younger brother and I escaped and went to our aunty who lived very far from our home. Things never changed much as the same abusive acts continued. I could be beaten to near-death. At times we spend several days without food even though we were doing all the donkey work in that family. It was too much to bear and that is when we decided to accompany a friend and escape to live in the streets. I cannot say how it was for me living on the streets for almost 6 years. I have been here for two months already and I never like to talk about my past. I have to say the truth; I hate my father and all family members. When something reminds me of the past, it

> makes me feel wish that I was dead. I will never forgive them… Those questions were good; they made me to reflect (respondent 9).
>
> You know, in the street one should be strong because you have to be alert and vigilant always. You have to fight for everything failure to which you will suffer. In the beginning, it was not easy for me. After other street children trained me, I managed to survive. Here at Jeunes au Soleil Children's Home, I forget sometime and react badly even while eating, but I come back to my senses and remind myself that I am no longer on the street to fight since the centre takes care of us. I do not know what my future will be. I'm just here. I will do my best. I always scream at night whenever I dream about being involved in street fight or someone trying to kill me. Once I wake up from my nightmare, I feel my heart pumping as if it is coming out of my chest. It is not easy (respondent 22).

After screening the Trauma levels with this variety of symptoms, the intervention started as planned for the group with music, songs and dance interpretation. Instead of one session per week, two sessions were held per week because the children were very committed and everybody was participating. The intervention lasted for two months instead of one month to let the participants grow. Sometimes, the sessions were lasting more than two hours. At the beginning and at the end of each session, participants ticked on the feelings and emotions chat to control their mood. The following is a comment from one of the participants.

> At the beginning, I felt like I was wasting my time. Usually, we play football when people come to visit us. However, as soon as we started to tick and explain the way we were feeling, I thought things were serious that day. I ticked that I was confused and at the end, I was happy and I ticked how I was feeling. It was such a wonderful day for me. I was excited about what would happen in the following

days. Every day it was a surprise to me and I am very happy. Playing the dice of peace was also exciting. Furthermore, it was exciting to see what will come out and try to live together with others. We have enjoyed these days. I am learning a lot such as to forgive, to love each other and to play together. I feel more relaxed and I can sleep well… (Respondent 6, 11 years old).

4.4.2 Trauma Level after Music intervention

After two months of music intervention, PCL-5 Child Self-report was used to measure the trauma level and ascertain any improvement on the Psycho-trauma outcomes. Table 6 below presents the average levels of trauma symptoms after intervention.

	Cluster B	Cluster C	Cluster D	Cluster E
Mean	1.5043	1.337	1.1524	1.4128
Standard Error	0.0397	0.0562	0.0207	0.05
Standard Deviation	0.2691	0.3809	0.1407	0.3391
Minimum	1	1	1	1
Maximum	2.2	2.5	1.43	2.33
Count	46	46	46	46

Table 5: Level of Trauma Symptoms after Music Intervention

According to the results presented in table 5, the mean values show absence of trauma in all the clusters. However, the mean values vary across the clusters. From the highest mean value to the lowest, clusters B, E, C, and D had mean values of 1.5043, 1.413, 1.337 and 1.1522 respectively. The maximum score of 2.5 was in cluster C, which include minor avoidance symptoms that disappear with time. This was followed by Cluster E with a maximum score of 2.33 that show minor arousal symptoms. Cluster B had maximum score of 2.2 indicating minimal re-experiencing symptoms. In all the process, the dice of peace supported the treatment in teaching some socio-emotional skills, such as forgiveness, resilience, love of others, self-esteem, acceptance, togetherness and awareness. Such skills are expected to help the participants to be focused at any particular time besides improving not only the quality of the interaction with one another as a group but also their relationship with the caregivers.

Such healthy relationship is expected to promote a peaceful life in the home, which will ensure that the minor symptoms disappear over time.

According to Shenk et al. (2014) who conducted a study about child maltreatment and posttraumatic stress disorder symptoms in the United State of America, a sample of 110 girls from 14 to 19 years old participated in the study. Their study findings showed that children with Post-Traumatic Stress Disorder's symptoms who had the ability to remember and cope with feelings, thoughts and emotions related to traumatic events with awareness and acceptance were less likely to heal over time. Such symptoms include avoidance, aggressiveness, loneliness and fear, which demonstrate that maltreated children avoid painful events. This assertion is demonstrated in the following testimony of a 10-year old participant of the current study.

> I can say that I understand why I was behaving the way I did. Living in the street was a terrible experience. Even here in the Home, it was not easy at the beginning. Sometimes I felt like escaping, but my brothers kept on encouraging me to keep on trying. Since we started these activities, I was just following what we were supposed to do. Now I realized how they have helped me. The fact of recalling my past was painful but helpful because it made me aware and aroused my conscience of what I should do to live well with everybody. The dice of peace is a nice instrument that taught us many things. I always do my relaxation exercise every day before I sleep and this gives me a sound sleep. I know that life is full of surprises but at least I have learned how and what to do. Something is still disturbing me… but I believe it will gradually end with time, I am not worried anymore. I thank God… (Respondent 7, 10 years old).

Indeed, the findings of the current study are in line with those of Sheik et al. (2016) on Psycho-Trauma among Children and Adolescents in Kaduna, Nigeria. According to their

study, low prevalence of psychological distress symptoms in children such as fear, anxiety, sadness, loneliness and isolation disappear with time when children live with parents or in a safe environment.

4.4.3 Trauma Changes after Music Intervention

T-tests were used to compare pre- and post-music intervention trauma levels. The t-test results are summarized in Table 6. T-tests were used to determine whether or not there was a statistically significant difference in the mean trauma scores before and after music intervention. The hypothesis was ruled out since p-value of 0.0000 was so small compared to the threshold of 0.05. Indicating that there would be a statistically significant difference, change of the mean from 4.2809 before the intervention to 1.3515 after the intervention (see table 6).

t-Test: Paired Two Sample for Means

	Before	*After*
Mean	4.2809	1.3515
Observations	46	46
P(T<=t) two-tail	0.0000	
t Critical two-tail	2.0141	

Table 6: Changes after Music Intervention
Source; Researcher; 2021

The first consideration that the findings of this study highlighted is that, the choice of songs is important when using music as a therapy while working with traumatized children. Joyful songs helped in reducing psycho-trauma symptoms, anxiety, difficulty of concentration, sadness and physical reactions such as heartbeats, sweating, agitation and other negative feelings and emotions. As a result, joyful songs increased positive emotions and feelings that are helpful for self-growth.

In addition, the performance of dance or bodily movements was important because it helped the children to relax and express all what their words could not express. It was observed that

the children were greatly trying to bring out all what they had within, such as aggressiveness, anger and hyper-activity. This affirmed the American Dance Therapy Association (ADTA) (2014) statement which pointed out that music associated with dance/movement therapy integrates emotions, feelings and thoughts because the body, the spirit and the mind are linked. Consequently, this promotes healing and wellbeing.

Researchers in this study also found a correlation between the emotional effects on young and older persons with various symptoms of post-traumatic stress disorder (PTSD) of listening to happy and sad Israeli national patriotic songs on Israel's Independence Day. Their study in Israel found that pleasant emotions were linked to cheerful national music and a significant reduction in symptoms of PTSD. Sad national songs, on the other hand, elicited more negative feelings and worsened the effects of trauma. As two study participants describe their experiences, the current study's findings are consistent with those of ADTA) (2014) and Bensimon et al. (2016).

> I really enjoyed the songs especially those that were making us to relax. I almost slept while relaxing before the activity of today. In the morning I was quite a bit sad and agitated because of what happened between mama Mary (not the real name) and I. Many thoughts came in my mind and I could no longer concentrate in anything… I even ticked in my feelings and emotions chart mood that I was nervous, sad and anxious, but when we started the relaxation with the song, "Child of Light", I felt like crying for the joy and peace that I experienced after a few minute. When the song said, "make me a child again" I thought it was saying to me and I said yes I should be like a child without negative thoughts and feelings… I relaxed and I felt to sleep. At the end, my heart was calm, I felt peace and joy and the negative thoughts disappeared… (respondent 18, 10 years old).

> I enjoyed streetlight song because it tells the story of Charles, a young man. After it was explained to me, it reminded me about my own story. Even though it is about different scenarios, it made me to recall the bad things that happened to me. However, when we were performing or interpreting the musical thinking of our story, I felt as if I was taking every bad experience out of me so that I could breathe well. That made me to feel good. The songs were nice. What streetlight says is true in that you are made for love and nothing is better than changing your heart. When we play the dice and try to live the phrase that comes, we really learn to love and play with others. I feel that I am no longer alone; we are together living the same experience in this home. We are really enjoying the activities (respondent 33, 11 years old).

The findings of the current study agree with Shack (2017) who conducted a study on music therapy and posttraumatic stress among American Adults aged between 18 and 65 years and who were sexually abused during war. After measuring the symptoms of posttraumatic stress before and after the music therapy intervention to address symptoms, Shack (2017) found out that there was improvement on the participants' feelings of self-worth. In addition, the participants' feeling of isolation reduced, their sleep quality improved and their anxiety symptoms declined. However, there was no change in depression and satisfaction in social relationship. This can be understood in the sense that Shack (2017) limited his study to music-listening without body movements. While such intervention was not bad, it was not as beneficial as the case where body movements would have been involved even when the participants were adults. In other words, music would be beneficial if it is accompanied by the body-movements because that would help to release the stress that accompanies depression and to relax the muscles especially in traumatized people. This, not only helps to reduce depression but also to change the quality of social relationships. During the interaction

with others in common activities such as music and dance as a therapy, the participants learn how to help, support, understand and forgive each other. They also learn how to believe in themselves and other socio-emotional skills that promote the quality of life. Consequently, their social relationships improve even outside the therapy session. That is what happened during the current intervention where dance and body movements were integrated into music as a therapy to help children who are full of vitality and hyperactive. The intervention helped the children to release the energy and to express what they could not communicate verbally. This promotes the quality of life and social relationships for their wellbeing. Stolk (2015) unearthed a similar outcome in his study that integrated drama and drawing in music as therapy with children in South Africa aged from 9 to 12 to address trauma symptoms. Unfortunately, his results were unsuccessful because he did not translate his tools into the local language before the intervention. In order to avoid such a mistake, the tools that were used in the current study were translated into local language and explained to the participants in the language that they understood best and this made it easier for them to understand and participate in the study.

4.5 Influence of Storytelling on Psycho-trauma Outcomes among Rescued Street Children in Selected Children's Homes in Kinshasa, DRC

4.5.1 Trauma Symptoms Level before the Storytelling Intervention

The second intervention that was used in addressing Psycho-trauma outcomes among street children in the current study was storytelling. 35 children of Les Enfants d'abord Children's Home, which is situated at Ngaba Municipality, received this treatment. Table 7 presents the descriptive statistics that summarize the trauma symptoms' levels before the storytelling intervention. Table 7 shows trauma symptoms level before the intervention.

	Cluster B	Cluster C	Cluster D	Cluster E
Mean	4.0743	4.2571	3.8817	4.1814
Standard Error	0.0651	0.0854	0.051	0.0674
Standard Deviation	0.3853	0.5054	0.3018	0.399
Minimum	3	3	3.29	3
Maximum	4.8	5	4.57	4.67
Sum	142.6	149	135.86	146.35
Count	35	35	35	35

Table 7: Trauma Symptoms Level before the Storytelling Intervention

(Source; Researcher; 2021)

Before the intervention was administered, trauma was screened according to the clusters. As indicated in table 7 above, participants in storytelling intervention had the highest mean level of cluster C symptoms at 4.2571, which are avoidance symptoms. This can be explained by the fact that traumatized children who have been abused physically or in another way avoid not only people and places or things that can remind them of the traumatic events, but also avoid thinking or talking about the traumatic experiences. The avoidance symptoms were followed by Cluster E or arousal symptoms at 4.1810 like lack of attention or concentration, hyper-vigilance or being always in alert to watch what goes on around. Clusters B (re-experiencing symptoms) and D (negative cognitions and mood with sleep disturbance symptoms) followed with mean values of (4.0743 and 3.8816 respectively.

Since majority of the participants had high avoidance symptoms, they could not open up easily and talk during the second session of the intervention. The researcher started with a short real story of a 7-years old child who was beaten to near-death by his father and was taken to his aunt's home for treatment. According to the story, the boy managed to heal and forgive his father after a few days. This story motivated the children to organize their own thoughts about their own traumatic stories.

After this short story, a spontaneous moment of discussion started, which helped the children to react by answering some questions to help them to explore their own traumatic experiences and their feelings, reactions and emotions about what happened to them. They narrated their

traumatic experiences. At that point, all the children were participating by sharing their stories in turns. While one of them was talking, the others were listening attentively.

This affirms the findings of Muhammed (2016), who did a study to analyze the influence of storytelling on the psychosocial development and well-being of vulnerable kids in Albania in whether by reading the story or watching a movie. According to his research, children's cognitive abilities, such like reasoning and paying attention, can be improved through the use of storytelling as a modern technique of accessing their inner lives. Using stories to motivate and participate in classroom or group activities was also beneficial. Mary and Isabelle (actually their real names) are participants in the current study, and their testimonies support this finding.

> The experience of that small boy who forgave his father helped and encouraged me to think of my own experience. I always said that I could never forgive my father for what he did to us, but I have discovered that I have that force within me. I can still forgive because not everything is lost in my life. I can start now a new life and focus on preparing my future. I have learned also through the stories of my friends here, that we can help each other to overcome difficulties and be strong to cope with life challenges even in adulthood (respondent 3, 14 years old)

> To reflect on my past story and on what I want to be tomorrow has helped me to discover that I have many talents and I can make them grow. I like to sing, to take care of others, to be together and enjoy nice things. Repeating within myself and aloud all the positive things that I have discovered in me has helped me to be aware of who I am. I always knew that I was nothing, and that my life has no sense. Today, I have discovered that being an image of God who is love I cannot be nothing. I just feel like flying like a bird. I am happy (respondent 15, 12 years old)

Storytelling as therapy helped in building self-esteem, resilience and other socio-emotional skills that contribute to self-growth, wellbeing and learning to cope with life adversities. Therefore, it helped in reducing psycho-trauma symptoms in children as Table 8 below shows.

4.5.2 Trauma Symptoms Level after Intervention

After storytelling intervention, trauma was measured to examine the changes in the outcomes. Table 8 shows that there is no presence of trauma among the research participants. Cluster D symptoms reduced to 1.2091, followed by Cluster E symptoms (1.2762), then Cluster B (1.44) and Cluster C (1.4571).

	Cluster B	Cluster C	Cluster D	Cluster E
Mean	1.44	1.4571	1.2091	1.2762
Standard Error	0.0408	0.0721	0.026	0.0555
Standard Deviation	0.2416	0.4265	0.1537	0.3283
Sample Variance	0.0584	0.1819	0.0236	0.1078
Minimum	1	1	1	1
Maximum	2	2.5	1.57	2
Count	35	35	35	35

Table 8: Trauma Symptoms Level after Storytelling Intervention

(Source: Researcher, 2021)

One of the characteristics of this group was that majority of the children had many negative thoughts and feelings about themselves and about the world around them. Moreover, they had mood swing problems and nightmares about the traumatic experiences. In observing them and listening to them, many said that they felt as if their future was already cut short. According to them, they were hopeless and easily irritated. Encouraging the children to repeat positive and encouraging words helped in changing negative thoughts and cognitions. The dice of peace helped to build their self-esteem and feelings of love for others hence reducing Cluster D trauma symptoms.

While working with traumatized youngsters in South Africa, Stolk (2015) found out that the children were better equipped to cope and be resilient when they were told a personal story by a therapist. Tests were undertaken to see if the means had changed significantly to warrant further investigation. Before and after the narrative intervention, the average value of trauma symptoms did not alter statistically in a significant way, according to the null hypothesis. The results are shown in Table 9.

4.5.3 Trauma Symptom Changes after Intervention

As indicated in table 9, the p-value of the t-test was 0.0000 (<0.05). As a result, the null hypothesis was rejected. In this case, it can be concluded that there was a statistically significant change of trauma symptoms from 4.0991 to 1.3451. This confirms the findings of the study carried out by Westrhenen et al. (2019) to address the symptoms of trauma, especially fear and anger, among South African children aged 6 to 12 years.

t-Test: Paired Two Sample for Means

	Avg Before	*Avg After*
Mean	4.0991	1.3451
Observations	35	35
P(T<=t) two-tail	0.0000	
t Critical two-tail	2.0322	

Table 9: Trauma Symptom Changes after Storytelling Intervention

Source; Researches; 202**1**

The results in table 9 shows that storytelling addressed and reduced negative emotions and thoughts associated with the trauma. Furthermore, it helped in building coping skills besides strengthening resilience, especially through interpersonal connections. These assertions are confirmed in the narration by one of the participants of the current study as follows.

> Since I came to this Centre, I was feeling loneliness and sad. Since they were laughing at me, I found it difficult to trust anyone and first, I'd better stay alone… Sometimes I felt like running away, but where would I go? I already understood

> that I could not go back to where I was. I just tried to remain. Mama Jane was trying to make feel at home, but no way, my bad feeling and thoughts continued. I know that I am not good and I do not have a future. These days I have seen that everybody is trying to live what we are learning. Listening to each other's stories made me understand that it was not easy for all of us. However, listening to the nice songs when we relaxed and thought about our stories helped me to reflect and focus only on good words that I was repeating. It was a good exercise, and I have learned a lot. I feel that something has changed in me. I feel that I am no longer alone again. Doing the activities together, playing together, trying to live according to the dice of peace helped us to learn how to live together loving and forgiving one other, and not to stay alone again… (Respondent 20, 9 years old)

This outcome makes sense in that the children's mood swing was the result of their thoughts, feelings and beliefs about themselves and the others, which are all connected to the traumatic experiences. Helping them to talk about it in telling their own story was the beginning of a healing process.

4.6 Influence of Meditation on Psycho-trauma Outcomes among Rescued Street Children in Children's Homes in Kinshasa, DRC

4.6.1 Trauma Level before Meditation Intervention

The third intervention that was used in this study to address the psycho-trauma outcomes among rescued street children in the third group was meditation. This group, which had 43 participants (N= 43), comprised of Banabakintu-Amour et Liberté Children's Home. Table 10 shows the symptoms before the intervention.

	Cluster B	Cluster C	Cluster D	Cluster E
Mean	4.0605	4.2442	3.4756	4.2481
Standard Error	0.0509	0.0673	0.0404	0.0598
Standard Deviation	0.3339	0.4415	0.2649	0.3922
Minimum	3.4	3.5	3.14	3.33
Maximum	4.8	5	4.14	5
Count	43	43	43	43

Table 10: Trauma Symptoms Level before Meditation Intervention

(Source; Researcher; 2021)

Before the intervention, Cluster E (arousal symptoms) had the highest mean level of trauma symptoms at 4.2481. Cluster C (avoidance symptoms) had the second highest level at 4.2442 while clusters B (re-experiencing symptoms) and D (negatives cognitions and mood) had 4.0605 and 3.4751 mean levels respectively. These statistics were indicative of the antisocial behaviours observed among the children in this specific group. Such behaviours included verbal or physical violence and provocation, hyper-activity, always on guard, intimidation of others, lack of concentration and noise making.

4.6.2 Trauma Level after Meditation Intervention

After the intervention, the trauma symptoms reduced significantly in all the clusters as shown in Table 11.

	Cluster B	Cluster C	Cluster D	Cluster E
Mean	1.4047	1.4651	1.1058	1.6128
Standard Error	0.0391	0.0609	0.0173	0.0543
Standard Deviation	0.2563	0.3993	0.1135	0.3562
Minimum	1	1	1	1
Maximum	2	2.5	1.43	2.33
Count	43	43	43	43

Table 11: Trauma Symptoms Level after Meditation Intervention

The findings of this study indicates absence of trauma after intervention. Clusters D, B, C, and E symptoms reduced to 1.1063, 1.4047, 1.4651, and 1.6124 respectively. This shows that meditation techniques that were used helped the participants to free their minds and be focused on what was going on at the time keeping quiet, only listening to the noises around

them and thinking. The use of two techniques, yoga and pranayama was included before meditation where they had to adopt a specific body posture. Having many negative thoughts and beliefs, the fact of repeating positive words in the silence of their hearts helped them to be focused on what they were thinking about and remain silent with high concentration level in order to think about their past and present experiences linked to their traumatic events. In addition, they also thought about their future.

The findings of this study are in line with those of Culver et al. (2015) who employed yoga and deep breathing as meditation approaches to treat children aged 7 to 17 years in Haitian orphanages with trauma and behavioral disorders. Their study revealed a decrease level of trauma in the severity of the symptoms. The finding in the current study that the negative cognitions and mood swing reduced significantly can be explained by the fact that the researcher introduced the ticking of the chat card of feelings and emotions before and after every session. This contributed and sustained the meditation intervention, which helped in changing their moods, thoughts and feelings. Similarly, the relaxation exercises were helpful to children since they assisted them to remain cool and focused. The ticking of the chat card of feelings and emotions also helped in reducing sleeping difficulties for most of them. These findings were affirmed by some participants' own admission as demonstrated below.

> I am 9 years old. After my father's death, his family took everything from our house and sold the house. We had nowhere to go. My aunt welcomed us for some days so that my mother could look for a house to rent. Since she could not find one, we went to stay in a church. Later we went to the streets when I was 6 years old. In the streets, we were always abused… One had to fight, to steal, to defend himself or herself. Then, my mother died. That is when they brought us here; my younger brother and I. If you fight here, they punish you so that you understand that you have to change. These activities have helped me to reflect on my bad behaviors. I want to change my

life so that I can become a better person. The songs were nice. In addition, playing the dice of peace everyday helps us to learn to live in peace with one another. I am happy (respondent 31).

I have watched my life these days like in a video. I never want to think or talk of my life because it is very sad. To live with people that you do not know is not easy. At least I have now a home. Even though I do not sleep well, I always have nightmares, and it makes me agitated during the day. However, I have learned many things so far with all the activities. I can manage to think of my experiences without crying or anger. Now I feel a lot of peace. I feel relaxed and I have confidence in me. I can still make it in life (respondent 10, 14 years old).

These two testimonies confirmed the findings by Bonnel (2016) who studied the impact of Yoga and mindfulness as techniques of meditation on children and youth who had traumatic experiences and were still suffering from the effects that trauma can have on their mind, spirit and body. The findings indicated that these techniques helped the participants to gain inner strengths, peace of mind and muscle relaxation. It also increased their self-confidence and self-esteem besides reducing trauma symptoms.

4.6.3 Trauma Symptom Changes after Meditation Intervention

Table 12 shows the changes in the symptoms after the intervention.

t-Test: Paired Two Sample for Means

	Before	*After*
Mean	4.0065	1.3977
Variance	0.0416	0.0110
Observations	43	43
P(T<=t) two-tail	0.0000	
t Critical two-tail	2.0181	

Table 12: Trauma Symptom Changes after Meditation Intervention

(Source: Researcher, 2021)

Looking at these statistics, there is a significant change (2.6088) in terms of symptoms comparing the averages before and after the intervention. Majority of the children indicated to have better sleep besides feeling more relaxed. As a result, they can concentrate on their daily activities. The relationships among them and that with the caregivers had improved. Some admitted to be aware of what was disturbing and impeding them from functioning well. In fact, some claimed that they already knew how to deal with the challenges having accepted themselves and their situation. They had to accept to live well with the others and encourage each other.

One of the participants gave this testimony:

> When I came here, they were telling me that I behave as if I was a small devil, and I believe to be a small devil. I was not able to sit quietly and pay attention to what we were doing. I really did not understand myself and what was going on in me. They even thought of taking me to see a priest or a pastor to pray for me but I refused. I was feeling bad… I was left alone because I could not relate or trust others. I was always sad and disturbed every time. I did not want to participate in this activity thinking that it was a prayer activity, but something told me in my heart to participate. From the first day, answering to question that were explained to us about why we had to do these activities with sister, I felt that something will change in me. When we were ticking every day in chat of "how are you feeling today", mine was always sad feelings in the beginning, and sister said that it is normal to feel the way I felt. I thought how come she did not say that I was bad? This changed me and I felt good, happy, with a little hope that I can change… Today I feel like I am another person. I am have power in me, I have many good things in me, I can still make it and become an important member of the society someday… even others tell me that

> I am now a good boy, that I am no longer a small devil that I was but a child of God, as we have been singing these days. Thank you (respondent 16, 9 years old).

This confession that John made is just one instance that confirms the statement of Sibinga et al. (2016) that meditation improves psychological wellbeing and reduces negative effects of stress among vulnerable individuals. Despite their overwhelming importance and use in our local cultures, few studies on Arts Therapy have been conducted. Arts Therapy is yet to gain ground in Africa as compared to other parts of the world where it is widely used as a professional field (Wangala, 2015).

4.7 Trauma Levels of the Control Group Difference at the beginning and End of the Research Project

4.7.1 Trauma Levels of Control Group at the Start and End of the Study

The control group comprised of 18 children who did not participate in the intervention. They only took part in the stage of measuring the trauma symptoms before the intervention. Then they also participated in a similar exercise at the end of the intervention to examine if they had any improvement despite the fact that they never participated in the intervention. They were however living together with the treatment group.

	trauma avg bef	*trauma avg aft*
Mean	4.173888889	3.322222222
Standard Error	0.085237611	0.114405412
Standard Deviation	0.361632555	0.485381058
Minimum	3.59	2.16
Maximum	4.74	4.1
Count	18	18

t-Test: Paired Two Sample for Means		
	trauma avg bef	*trauma avg aft*
Mean	4.1739	3.3222
Observations	18	18
P(T<=t) two-tail	0.0000	
t Critical two-tail	2.1098	

Table 13: Levels of Trauma for the Control Group

The results from the control group at the start of the study (M = 4.1739, SD = 0.3616) and that at the end of the study (M = 3.3222, SD = 0.4854) indicate that trauma levels slightly improved despite the fact that this group did not receive any treatment. This may be explained by the fact that members of the control group and those of the treatment group lived together. This explains why Kerr and Bowen (1988) emphasized on the interaction between family members. According to them, any change in one or more family members influence the whole family and can bring changes in other members (Bowen's Family System Theory). Rolando et al. (2020) made similar observation where they concurred with the argument that behaviour is learned through interaction within a given environment.

4.8 Similarity Outcomes between Music, Storytelling and Meditation as Trauma Intervention Approaches

Two ANOVA tests were conducted to compare the three approaches namely: meditation, storytelling and music or dance.

4.8.1 ANOVA Test Comparing the Three Groups before Intervention

The first ANOVA test was done to compare the means of trauma levels for the three groups before any intervention. The null hypothesis that was tested and the findings revealed that there is no significant difference between the three approaches before the interventions.

ANOVA test before intervention

SUMMARY

Groups	*Count*	*Sum*	*Average*	*Variance*
Story telling	35	143.47	4.10	0.06
Meditation	43	172.28	4.01	0.04
Music and dance	46	196.92	4.28	0.01

ANOVA

Source of Variation	*SS*	*df*	*MS*	*F*	*P-value*	*F crit*
Between Groups	1.73	2	0.87	25.03	0.00	3.07
Within Groups	4.19	121	0.03			
Total	5.92	123				

Table 14: ANOVA Test for Means of the three Approaches before Interventions

As table 14 indicates, we fail to reject the null hypothesis indicating that there was no significant difference in mean levels of trauma before the intervention [F (2, 121) = 25.03, p = 0.00] between the three types of interventions (storytelling, meditation, and music/dance. It means that all the participants had high levels of trauma at the start of the study where storytelling, meditation and music/dance had means of 4.10, 4.01 and 4.28 respectively.

4.8.2 ANOVA Test Comparing the three Groups before Intervention

The second ANOVA test was done to compare the means of trauma levels for the three groups after the intervention. The null hypothesis that was tested was: there is no significant difference between the three approaches after the interventions. The test results are presented in table 15.

ANOVA Test After Intervention

SUMMARY

Groups	*Count*	*Sum*	*Average*	*Variance*
Story telling	35	47.08	1.35	0.03
Meditation	43	60.1	1.40	0.01
Music and dance	46	62.17	1.35	0.02

ANOVA

Source of Variation	*SS*	*df*	*MS*	*F*	*P-value*	*F crit*
Between Groups	0.07	2	0.03	1.92	0.15	3.07
Within Groups	2.14	121	0.02			
Total	2.21	123				

Table 15: Table 16: ANOVA Test for Means of the three Approaches after Interventions

As shown in table 15 above, we reject the null hypothesis and conclude that there was a statistically significant difference in mean levels of trauma after the intervention [F (2, 121) = 1.92, p = 0.15] between the three types of interventions (storytelling, meditation and music/dance). This implies that trauma levels reduced significantly for all participants where music and dance had the highest mean reduction of 2.93 followed by storytelling with a mean value of 2.75 and the least was meditation with a reduction of mean level of trauma by 2.61.

In other words, the use of music and dance was the most effective approach. It means that all the participants had high levels of trauma at the start of the study where storytelling, meditation and music/ dance had means of 4.10, 4.01 and 4.28 respectively. As figure 8 indicates, the reduction was from high trauma levels of at least 4.01 before administering the treatment to minor level of utmost 1.4 after administering the treatment.

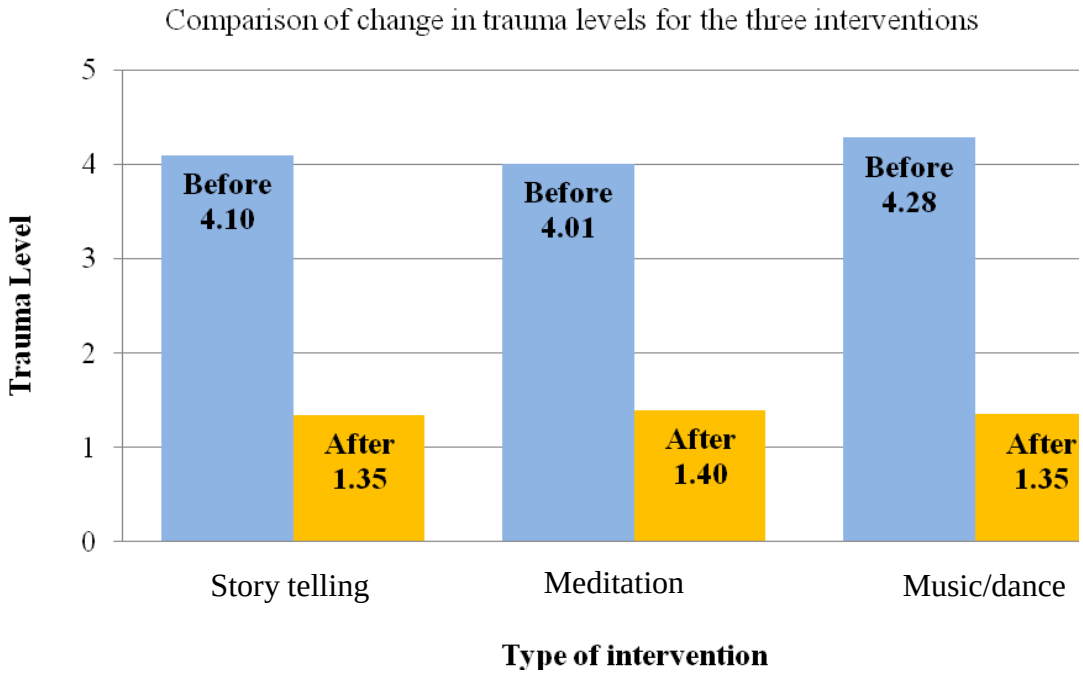


Figure 8: Change in Trauma Levels for the three Interventions

4.9 Summary and Conclusion

Street children in Kinshasa, the Democratic Republic of the Congo, who were rescued from the streets and placed in children's homes, showed less severe symptoms of trauma when treated using child-friendly approaches including music, storytelling and meditation. Music and dancing, in particular, have proved to have a good effect on the psychological well-being of street children who have been taken in by children's homes. Meditation also improved the psycho-trauma outcomes of rescued street children in the selected children's homes. Amongst rescued street children at the children's homes, storytelling was found effective to reduce

psycho-trauma outcomes. The researcher was surprised to find out that the level of trauma in the control group at the beginning of the investigation was lower than it was at the end of the study. Participants in the treatment and control groups interacted according to the researcher. Using music and dance-movement as a therapeutic tool, as well as storytelling and meditation, has shown promising results in trauma treatment.

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This chapter provides a summary of the study's key findings, conclusions and recommendation based on the objectives of the study.

5.2 Summary of Key Findings

Demographic Characteristics of Participants

The demographic factors of the participants that the researcher examined in this study were gender, age, religion and level of education. The minimum age of the participants was 7 years and the maximum age was 16 years. Most of the participants were aged 9 years. Majority of the participants (80 children) representing 64.5% of the sample size had primary educational level even though none of them completed primary school education before going to the streets.

Trauma symptoms among rescued street children

The study examined the psycho-trauma outcomes among rescued street children in three children's homes in Kinshasa, DRC, according to DSM children clusters. The findings revealed that before the intervention the trauma level for all the clusters without any intervention was significantly higher than the level of trauma after intervention. The most common symptoms for all participants were fear, avoidance, anxiety, anger, sadness, hyper-vigilance and violence (verbal and physical). After the intervention, all the symptoms reduced significantly.

Influence of Music and Dance on Psycho-trauma Outcomes

The study revealed that a combination of music and dance-movement was suitable to treat and reduce the symptoms of trauma among rescued street children. The findings of this study highlighted that, the choice of songs is important when using music as a therapy while

working with traumatized children. Joyful songs helped in reducing psycho-trauma symptoms and increasing positive emotions and feelings that are helpful for self-growth.

In addition, the performance of dance or bodily movements was important because it helped the children to relax and express all what their words could not express.

Influence of Storytelling on Psycho-trauma Outcomes

Additionally, the study established that storytelling was appropriate to treat psycho-trauma among rescued street children. The finding shows that storytelling addressed and reduced negative emotions and thoughts associated with the trauma. Furthermore, it helped in building coping skills besides strengthening resilience, especially through interpersonal connections.

Influence of Meditation on Psycho-trauma Outcomes

From the findings of the study, meditation was found to be effective in treating psycho-trauma among rescued street children. The meditation techniques that were used in this study helped the participants to free their minds and be focused. Repeating positive words in the silence of their hearts helped them to change the negative thoughts to positive ones and build self-esteem.

The fact that the negative cognitions and mood swing reduced significantly during meditation can be explained by the fact that the researcher introduced the ticking of the chat card of feelings and emotions before and after every session. This contributed and sustained the meditation intervention, which helped the participants in changing their moods, thoughts and feelings. Also to gain inner strengths, peace of mind and muscle relaxation. It also increased their self-confidence and self-esteem besides reducing trauma symptoms.

5.3 Conclusion

The study concludes that all the rescued street children from the three children's homes had passed through various traumatic experiences and developed similar symptoms. The most

common symptoms for all participants were fear, sadness, hyper-vigilance, avoidance and violence, which affected their behaviours and wellbeing. These findings confirm that these specific children faced many challenges by living on the street. Such challenges have made them to act and behave the way they do. Unless the traumatic experiences are addressed as soon as they are rescued and placed in the children's homes with child-friendly approaches, the levels of the street children rescue programs' success will remain minimal. Despite the use of music, dance, storytelling and meditation in African cultures, these child-friendly approaches are limited in the professional field of counselling. The study established that some strategies such as mood and feelings chat and the dice of peace as used in this study could accompany child-friendly approaches in treating traumatized children.

5.4 Recommendations

From the findings of this study, the following recommendations were drawn for the stakeholders including the governmental and non-governmental institutions:

- The government should support and accompany those institutions that are willingly to work for the wellbeing and protection of street children, by providing them with the necessary resources that would enable them to do their work well. This includes training professional counselling psychologists because the country endures many serious socio-economic and political problems.
- The study recommends that the non-governmental institutions working with street children should have a counselling psychologist, not only social workers, to follow the rescued street children and help them with child-friendly approaches as soon as they are rescued to address the psycho-trauma issues before they start other programs in children's homes.
- The study recommends and encourages the professionals working with traumatized children to focus not only on talk therapy while counselling children,

but to also use child-friendly approaches that are suitable for children in treating trauma symptoms in children.

- Social workers and caregivers should also be trained in counselling skills especially when working with traumatized children to compensate where counsellors cannot reach because there are many institutions but few counselling psychologists.

5.5 Areas for Further Research

The findings of this study revealed that art therapy, especially music and dance, storytelling and meditation have proved to be relevant in treating traumatized children. Yet these child-friendly approaches are not used in African professional field of counselling even though they are widely used in African socio-cultural context. This study recommends that the following studies be carried out:

- ✓ More studies to be conducted in other parts of DRC to capture the issue of cultural diversity in the second largest country in Africa. This is important to ensure that the governmental and non-governmental organizations formulate uniform programs and policies that address the specific needs of street children in each part of DRC.
- ✓ Further studies may also focus on child-friendly approaches and psycho-trauma outcomes among single parent children; or among refugee's children; among sexually abused children; among orphaned children.

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APPENDICES

Appendix I: Consent Form

Child's names: ……..

Code: ……..……..……

Age: …….……..……..

Caregiver's names: ……..…

Code: …….……..

I am Sr Esperance Fidelia Mupungu Kilanda, a postgraduate student pursuing a Master's Degree in Counselling Psychology at the Catholic University of Eastern Africa. I am carrying out this study on the effect of Child-friendly Approaches on Psycho-trauma outcomes among rescued street children living in the children's Home.

I kindly request you to participate in this research. I ensure you that all the information shared during this research will be kept confidential and secure, and will be used only for the purpose of this study; you can feel free to answer all the questions during this study.

You are requested to sign the form.

Participant's signature: ……. Date: ……

(The caregiver)

Researcher's signature: …… Date: …….

Thank you!

Appendix II: Questionnaire for Respondents

I. Identification of Participant

Name:

……

Code:

……

Date:

……

Gender: M ☐ F ☐

Age: 7-9 10-12 13-15 16

Religion: Catholic ☐ Protestant ☐ Muslim ☐ None ☐ Other ☐

Educational level: None at all ☐ Primary ☐ Secondary ☐

PCL-5-Child Self-report (Source: VA – National Center for PTSD)

(EVENT) (DATE)

	Below is a list of problems and complaints that people sometimes have in response to stressful life experiences. Please read each one carefully, then circle one of the numbers to the right to indicate how much you have been **bothered** by that problem **in the past month**.	Not at all	A little bit	Moderately	Quite a bit	Extremely
1	Repeated disturbing *memories, thoughts, or images* of a stressful experience from the past?	1	2	3	4	5
2	Repeated, disturbing *dreams* of the stressful experience?	1	2	3	4	5
3	Suddenly *acting* or *feeling* as if the stressful experience *were happening again* (as if you were reliving it)?	1	2	3	4	5
4	Feeling *very upset* when *something reminded* you of the stressful experience?	1	2	3	4	5
5	Having *physical reactions* (e.g., heart pounding, trouble breathing, or sweating) when *something reminded* you of the stressful experience?	1	2	3	4	5
6	Avoiding *thinking about* or *talking about* the stressful experience or avoiding *having feelings* related to it?	1	2	3	4	5
7	Avoiding *activities* or *situations* because they remind you of the stressful experience?	1	2	3	4	5
8	Trouble *remembering important parts* of the stressful experience?	1	2	3	4	5
9	Loss of *interest in things* that you *used to enjoy*?	1	2	3	4	5
10	Feeling *distant* or *cut off* from other people?	1	2	3	4	5
11	Feeling *emotionally numb* or being unable to have loving feelings for those close to you?	1	2	3	4	5
12	Feeling as if your *future* will somehow be *cut short*?	1	2	3	4	5
13	Trouble *falling* or *staying asleep*?	1	2	3	4	5
14	Feeling *irritable* or having *angry outbursts*?	1	2	3	4	5
15	Having *difficulty concentrating*?	1	2	3	4	5
16	Being *"super alert"* or watchful or *on guard*?	1	2	3	4	5
17	Feeling *jumpy* or *easily startled*?	1	2	3	4	5

Appendix III: Feelings Chart

Observe and Tick all the Images that express your Feelings



Appendix VI: Letter of Authorization to use the PCL5-Child Self-report

NCPTSD Assessment Instrument Request

Balch, Heather G. <heather.balch@va.gov>

À :fide.maria@yahoo.fr mar. 20 avr. à 20:59

Greetings, and thank you for your assessment instrument request.

You may access National Center for PTSD assessment measures by following the link below:

http://www.ptsd.va.gov/professional/assessment/documents/ptsd_trauma_assessments.asp

These assessment tools were created by government employees and therefore are not copyrighted. In accordance with the American Psychological Association's ethical guidelines, these instruments are intended for use by qualified health professionals with advanced graduate training in psycho-diagnostic assessment.

Please let us know if you have any difficulties downloading these instruments. Also, no thank you email is necessary.

Sincerely,

National Center for PTSD Staff

Subscribe to the PTSD Monthly Update

https://www.ptsd.va.gov/publications/subscribe.asp

Appendix V: Map of the Research Area



Appendix VI: Letter from the Catholic University of Eastern Africa (CUEA)

THE CATHOLIC UNIVERSITY OF EASTERN AFRICA

Faculty of Arts and Social Sciences

Department of Counseling Psychology

Our Ref: CUEA/DVC-ACAD/FASSc/Psychology/NACOSTI/009/September 2021

Date: 9th September 2021

TO WHOM IT MAY CONCERN

Dear Sir/Madam

RE: MUPUNGU KILANDA ESPERANCE REG.NO. 1037700

I am writing to introduce to you **Mupungu Kilanda Esperance** who is a final year Master's Degree student at The Catholic University of Eastern Africa, Nairobi – Kenya, and to request you to assist her to accomplish her academic research requirements.

Esperance's Master's Degree specialization is in Counseling Psychology. She has completed all course work requirements for this programme. However, every student in the programme is required to conduct research and write a report/thesis submitted during the final years of studies.

Accordingly, her research topic has been approved. She will conduct research on the following topic:

"Child-Friendly Approaches and Psychotrauma Outcomes among Rescued Street Children in Selected Children's Homes in Kinshasa, Democratic Republic of Congo."

Thanking you in advance for any assistance you give to Esperance .

Sincerely,

CATHOLIC UNIVERSITY OF EASTERN AFRICA FACULTY OF ARTS & SOCIAL SCIENCES 09 SEP 2021 DEPT OF COUNSELLING PSYCHOLOGY P.O. BOX 62157 - 00200, NAIROBI

Dr. Stephen Asatsa,
HOD. COUNSELLING PSYCHOLOGY.

THE CATHOLIC UNIVERSITY OF EASTERN AFRICA (CUEA) P.O. BOX 62157 00200 Nairobi – KENYA
Tel: 020-2525811-5, 8890023-4, Fax: 8891084, Email: psychology@cuea.edu, Website: www.cuea.edu
Founded in 1984 by AMECEA (Association of the Member Episcopal Conference in Eastern Africa)

Appendix VII: Intervention's Plan

This intervention intended to target 150 traumatized rescued street children, between the ages of 7 and 17 years, living in three selected children's homes, in which 50 participants for each group. They participated in 5 sessions of 2 hours each.

In the first phase, before the intervention, the researcher made a baseline study to select from the intake forms, those children who have been in the Homes for one month. Then, screened the trauma levels using PCL5-Child Self-report, as an interview since they were children.

The second phase implemented child-friendly approaches, and lasted one month. Each of the three groups received a different type of intervention. Group A may received Music and Dance-Movements Intervention. Group B worked with Storytelling Intervention, and the Intervention of Group C Meditation Intervention.

The first session: gathered all the 50 children of each children's home together for a debriefing on what the intervention is about, in order to establish a relationship of trust and create a safe environment. During this first session, the researcher presented and explain the informed consent and the caregiver signed for the children. The group rules were settled in this first session, by the children in dialogue with the researcher, written on a big poster and placed in the hall. However, before and after each session the researcher used mood-images card to address the children's emotions and feelings. The cards were presented and explained by the researcher, and then each child received a copy each session to tick when she/he was asked.

The tables bellow show in details how the weekly sessions unfolded for each group, from session 2 up to the end of the Intervention with the Post-Intervention Test, which was the re-administering of the PCL5-Child Self-report to all the groups. This served to screen the trauma levels and to see if there was any change in the psycho-trauma outcomes, comparing

to the beginning of the Interventions. It also allowed the researcher to compare the results of all the groups and to analyse which intervention was the most effective in addressing psycho-trauma outcomes in the selected rescued street children in selected Children.

GROUP A – MUSIC AND DANCE-MOVEMENTS		
Week/Session	**Activity**	**Timing**
Week 1/Session 2	**Introduction**: The researcher first created a safe environment and trust with a short preselected song that was sung by the children together with the researcher ("If you are happy and you know clap your hands…") (5 minutes). Then the researcher divided the children in 5 small groups of 10, (the children will count from one to five (5 minutes). All the number 1 formed a group, the same with number 2 up to 5). Each group sat together in a circle in the hall. Each group had one researcher's assistant. The groups remained the same throughout the whole Intervention. The children in the groups present themselves with their names. There was a brainstorming of the group rules affixed in the wall by the researcher (30 minutes). Then the researcher explored the emotions and feelings of the children with mood-images chart (each child may have a copy to tick). The researcher asked the children to change the position and seat in 5 lines of 10 children each (30 minutes) **Debriefing**: The researcher will debrief about stressful life events, the feelings, thoughts, beliefs and behaviours that can be experienced after a traumatic event (10 minutes).	2 hours

	Relaxation exercise: breathing in and out, with slow music of the first preselected song (Gen Verde – "Child Of Light" – Official lyric Video – can be seen also on You Tube) accompanied by the researcher's talk (5 minutes). **Exploration:** the researcher invite the children to explore their traumatic past events (accompanied by the Gen Verde music, "Child Of Light" and the researcher's talk). Also, their feelings about the events, the unfinished business and all the blocks to energy in their body (15 minutes).	
	Debriefing and sharing in the small groups, helped by the researcher's assistant, on how they were feeling in the beginning, during and after recalling the memories of the traumatic events (20 minutes).	
	End of the session: Psycho-education by the researcher to help the children to reduce uncomfortable feelings, thoughts and emotions aroused, such as shame, fear, anxiety, guilty, self-blame, sadness and so on. Relaxation exercise and breathing, accompanied by the researcher's talk and slow music (Gen Verde – "Child Of Light") to help the children to come back to normal. Presentation of mood-images card to address their feelings and emotions at the end of the session, and sharing on how they are feeling. Singing together: "If you are happy…". Greetings and good-bye (20 minutes).	
Week2/Session 3	**Introduction:** The researcher invite everybody may stand in a big circle. After greetings and singing together (If you are	

	happy…) to prepare the atmosphere. Then, everybody may move and stand in front of the big poster of the group rules and evaluate if they are put into practice. Then, the children may be asked to seat in five lines of 10 children each (15 minutes). **Debriefing**: The researcher may debrief on the last session. the invite the children to explore their feelings in the present moment (ticking on the mood-images of feelings and emotions). Debriefing, by the researcher, on the importance of being focused in the "here and now" experience. Then, relaxation exercise with slow music (Gen Verde – Child Of Light) accompanied by the researcher's talk, to help them to observe any block to the energy in some parts of their body (15 minutes).	
	Performance: After the relaxation, everybody may stand up. The second preselected music and dance-movements: a video of Gen Rosso – Streetlight Musical – found also in You Tube – will be put on. Firstly, the researcher's assistants may perform the movements while the children observe (10 minutes). Then, each assistant may move aside in the big hall with his group and help them to practice the movements (20 minutes). After that, all will make a short break (10 minutes). Then, each one return to his place, all the chairs are stacked. The children may stand in 5 lines of 10 each. The song will play, and everybody may perform the movements as explained and learned. While accompanied by the researcher's talk and comments, they may continue to explore, silently in their hearts, the "here and now" feelings, thoughts and	

	beliefs, helped by the body movements of the musical (20 minutes)	
	Debriefing: After the dance, each child return to his place with his chair, as arranged in the beginning, in 5 lines of 10 each. Relaxation exercise (breathing in and out) accompanied by a slow music accompanied by the researcher's talk (the same music as at the beginning) (5 minutes). Presentation of the feeling and emotion images, each one may tick how he is feeling in the present moment after the dance, and then share, on the feelings and if some blocks to the energy have been released (15 minutes).	
	End of the session: Psycho-education by the researcher to help the children to reduce uncomfortable feelings, thoughts and emotions aroused to help the children to remain focused on the present moment. Play song "If you are happy…". Greetings and good-bye (15 minutes).	
Week3/Session 4	**Introduction**: The children are seated in the hall in 5 small groups of 10 each with a researcher's assistant (10 minutes). **Debriefing** (by the researcher) of the last session, screening of the children's feelings, emotions and thoughts in the present moment with mood-images to tick; sharing on how they are feeling in the present moment and what are their dreams for the future. Some relaxation exercises (breathing in and out) accompanied by a slow music (Night with many stars – found also in You Tube) and the counsellor's talk (20 minutes)	

	Psycho-education: Each one has been created for a purpose, how to achieve one's goals (knowing your strengths and weaknesses, being focused and positive) (20 minutes).	
	Performance: After the psycho-education, all the chairs will stacked together in the hall, by everybody together. The children are arranged in 5 lines of 10 each. Then, the researcher will explain what may be done in this session: The Musical "Streetlight" of Gen Rosso (part 2) will help the children to focus and think on their dreams and how to achieve them if given all the means and favourable conditions in the future. Helped by the researcher's assistants, everybody may follow the musical and dance while reflecting on the future (20 minutes). After the dance, each one return to his seat as in the beginning in small groups. A relaxation exercise may be done to cool down (10 minutes).	
	Debriefing: After the relaxation exercise, the researcher will dialogue with the children on how they are feeling and what they have been reflecting on (20 minutes). **Psycho-education:** The researcher may teach the children some coping skills, such as resilience to cope with the adversities of life, and some socio-emotional skills. She will use for this the "Dice of Peace", which has six sides with short phrases on each side, that they may toss every morning and put into practice the phrase that may appear on the top side of the Dice. **Explanation** on the "Dice of peace": The researcher may present	

	the Dice and ask the children to read, one after the other, what is written on each of the six sides of the Dice. The researcher will explain that every morning after the prayer, when they are together, one of them would throw the Dice and read to everybody the slogan on the side which will be on top. The researcher may illustrate with examples how they can put into practice each phrase concretely in the present moment. After the explanation, one child may be invited to toss the Dice and then read the phrase. This may be a homework for the whole week until the next session. The children will keep the Dice in their Children's Home. the six sides are: 1. I am the first to love 2. We forgive each other 3. We love each other 4. We help each other 5. I listen to the other 6. I play with everybody (15 minutes).	
	End of the session: Presentation of mood images in their groups to explore their feelings and emotions. Each one may tick and share. Play slow music ("Night with many stars") to relax and come back to normal. Last song: "If you are happy… stand, turn around, jumps…". Greetings and Good-bye (15 minutes).	
Week4/Session 5	**Introduction**: Song "if you are happy…" to invite all the children to take a seat as per lines. This is the last session to evaluate what have been done during the previous intervention	2 hours

	sessions (10 minutes). **Debriefing**: All together, may recall the group rules, one by one, and evaluate and share how they have tried to follow them. They may also share about their feelings, emotions in the present moment using the same mood images to see the changes. They may recapitulate what they have enjoyed most during the intervention and what they have learned (30 minutes). **Relaxation** music (Mountain Dreams – found also on You Tube) (10 minutes). After the relaxation exercise, the researcher will invite the children to fill and answer the questions of the PCL5-Child Self-report test. This is to screen their trauma levels after the intervention (30 minutes). The results will be compared with the results of the same test done during the first session and to see the level improvements at the end of the Intervention. The researcher may say a word of encouragement and thanks words may be said to all the children for their commitment, and to the Children's Home for making the research possible. Final snack, a family photo and Good-bye (40 minutes).	

GROUP B – STORYTELLING		
Week/Session	**Activity**	**Timing**
Week 1/Session 2	**Introduction**: The researcher may creating an atmosphere of trust with a short preselected song: "If you are happy and you know clap your hands" (5 minutes). The researcher will divide	2 hours

	the children in 5 small groups of 10, seating in a circle in the hall. Each group may have one researcher's assistant. The groups may remain the same throughout the whole Intervention. The children in the groups present themselves with their names. There will be a brainstorming of the group rules affixed in the wall by the researcher. The researcher will invite the children to explore their emotions and feelings with mood images chart (each child may have a copy to tick) (20 minutes). **Debriefing**: about stressful life events, the feelings, thoughts, beliefs and behaviours that can be experienced after a traumatic event (by the researcher) (15 minutes).	
	Relaxation exercise: breathing in and out, with slow music of the first preselected song (Gen Verde – Child Of Light – Official lyric Video – can be seen also on You Tube) accompanied by the counsellor's talk (5 minutes); **Exploration:** Helped by the researcher's words, the children will have to think about their past traumatic events, what happened, what were their reactions and feelings about the events. They may explore and express all the feelings, emotions, thoughts and beliefs about these events and also those which may arise in the present moment. They may also explore the unfinished business and all the blocks of energy in their body (20 minutes).	
	Debriefing: After the exploration of the traumatic history, the researcher may explain to the children that it is normal to feel the way they feel. And invite them to tell their personal history about	

	their past traumatic experiences. Talking about it may help them to feel good. The researcher's assistant, in each group, may make sure everybody share after on how she is feeling after recalling the memories of the past traumatic events (20 minutes).	
	Debriefing: Psycho-education on the traumatic events shared by each child. The researcher explain and invite the children to focus on what they can control, their feelings, reactions and emotions, and let go what they cannot control, the traumatic events and situations (20 minutes). **End of the session**: relaxation exercise (breathing in and out), with slow music (Gen Verde – Child Of Light), to reduce uncomfortable feelings, thoughts and emotions aroused, such as anger, shame, fear, anxiety, guilty, self-blame, sadness and so on. To help the children to come back into normal. Presentation of mood images to address their feelings and emotions in the present moment, and sharing on how they are feeling here and now after the session. Song: "if you are happy…". Greetings and good-bye (15 minutes).	
Week2/Session 3	**Introduction:** After greetings, everybody may remain standing while singing (if you are happy…) to prepare the atmosphere. Then the children may have a seat, as usual, in five lines of 10 children each, and have a seat (15 minutes). **Debriefing**: The counsellor may debrief on the last session, inviting the children for a moment of sharing about their feelings in the present moment (ticking on the mood images of feelings	2 hours

	and emotions) (15 minutes). Then, each one may join her group for the relaxation exercise with slow music (Night with many stars – found also in You Tube). Accompanied by the counsellor's talk, the children may be guided to reflect about their experience in the present moment since they are in the Children's Home (15 minutes).	
	Then, helped by the counsellor-assistant, each one will tell her story, what is happening now, what is her experience here and now (in the Children's Home), how is it for them to be in the children's Home, what are their feelings and thoughts about their experience. The counsellor my pass in each group for few minutes to supervise (30 minutes).	
	Debriefing: After the personal storytelling, a break may be observed. Then each child return to his place with his chair, as arranged in the beginning, in 5 lines of 10 each. The researcher will debrief (Psycho-education model) on how to be focused on the here and now experience (10 minutes). Then a relaxation exercise may follow (breathing in and out) (the same music of the beginning: "Night with many stars" – found also in You Tube) to help the children to relax. After on, will be the presentation of the feeling and emotion images, each one may tick how she is feeling in the present moment and share it to the whole group (10 minutes).	
	End of the session: Recapitulation (psycho-education) on the here and now experience, how they may help and encourage each	

	other in accomplishing their everyday tasks. The researcher may teach them some socio-emotional skills with a "Dice of peace", which has six sides with short phrases in each side, that they may toss every morning and put into practice the phrase that may come out (10 minutes).	
	Explanation on the "Dice of peace": The counsellor may present the cube and ask the children to read, one after the other, what is written in each face of the six sides of the cube. The counsellor explain that every morning after the prayer, when they are all together, one of them would toss the Dice and read to everybody what will come out. The researcher may illustrate with examples how they would live each phrase concretely in the present moment. After the explanation, one child may be called to toss the Dice and read the phrase. This may be a homework for the whole week until the next session. The children will keep the Dice in their Children's Home. the six sides are: 1. I am the first to love 2. We forgive each other 3. We love each other 4. We help each other 5. I listen to the other 6. I play with everybody Play song "If you are happy…" Greetings and good-bye. End.	
Week3/Session 4	**Introduction**: The children are standing in a big circle in the hall (or outside) while singing (if you are happy…) (5 minutes).	

	After the song, the children are invited to have a seat in small groups, as usual, for some relaxation exercise with slow music accompanied by the counsellor's talk to help them to be focused (10 minutes). **Debriefing**: The researcher will debrief on the last session. Then invite the children to share about their feelings, emotions and thoughts, after ticking on the mood-card images (15 minutes). The researcher explain to the children (Psycho-education model) about a person's dream for the future, that everyone has been created for a purpose, and should to achieve it. The counsellor may help them to explore their strengths and weaknesses, their dreams, what they may like to become in the future and what to do, how to do to be focused and positive. (20 minutes).	
	After the debriefing, will follow a relaxation exercises (breathing in and out) accompanied by a slow music (Night with many stars – found also in You Tube) and the counsellor's talk, to guide the children to reflect on their future. What are their dreams and their strengths. How they may achieve their goals (15 minutes). Then, the children are divided in their previous groups. The counsellor invite the children to tell their stories, focusing on the future, on whom they may want to become, their dreams, and what they should do here and now to achieve their goals (30 minutes).	
	Psycho-education: After the personal storytelling, the counsellor may help the children to learn some coping skills (socio-	30 minutes

	emotional skills), to build self-esteem, to learn self-control, to express their feelings. Also, to ask for help when it is difficult, to listen and understand the others, how to solve small conflicts among them in the Children's Home, to be focused in the awareness of what they should do here and now, and how they should do it to prepare their future (30 minutes).	
	After on, all the chairs are remove. Everybody stand in a big circle singing ("if you are happy and you know"…) with movements (10 minutes).	
	End of the session: Everybody return in her group. Presentation of mood images to explore their feelings and emotions in the present moment and they may explain why they are feeling the way they feel. Each one may tick and explain (30 minutes). **Relaxation exercise:** Play slow music (Night with many stars) to relax and come back to normal. Before the final greetings, the cube of peace may be thrown, read and explain how to put it into practice. Done by a child (20 minutes). Greetings and Good-bye.	
Week4/Session 5	**Introduction**: Song "If you are happy…" to call all the children to have a seat as per lines. This is the last session to evaluate what have been done during the intervention sessions (10 minutes). **Debriefing**: All together, may recall the group rules, one by one, and evaluate how they have tried to live them and share. They may also share about their feelings, emotions in the present	2 hours

	moment using the same mood images to see the changes. They may recap what they have enjoyed most, and what they have learned during the intervention (30 minutes). **Relaxation** music accompanied by the counsellor's talk (Mountain Dreams – found also on You Tube) (10 minutes). After the relaxation exercise, PCL5-Child Self-report test may be administered to screen the trauma levels after the intervention (30 minutes). The results may be compared, from the beginning to the end to see the improvements. Thanks giving and encouragement words may be said by the counsellor to all the children for their commitment, and to the Children's Home for making the research possible. The children may also share their impressions about the intervention. Final snack, a family photo and Good-bye (40 minutes).	

GROUP C – MEDITATION		
Week/Session	**Activity**	**Timing**
Week 1/Session 2	**Introduction**: Creating a safe environment and trust (with a short preselected song: "if you are happy and you know clap your hands, jump a bit, turn around, dance a bit…"). Then the children may be divided the children in 5 small groups of 10, seating in small circles in the hall. Each group may have one counsellor assistant; telling each one's names in the groups; brainstorming	2 hours

	of the group rules written with big characters and pasted in the hall; exploring their emotions and feelings, in the present moment, with images (each child may have a copy to tick). **Debriefing**: about stressful life events, the feelings, thoughts, beliefs and behaviours that can be experienced after a traumatic event (by the counsellor) and how they may affect one's present experience. Then follow the explanation of the intervention (Meditation), how it may be done, with slow music to help them to reflect on the past, but to focus in the present moment and reflect on the future (30 minutes)	
	Relaxation exercise: breathing in and out, with slow music of the first preselected song (Gen Verde – Child Of Light – Official lyric Video – can be seen also on You Tube) accompanied by the counsellor's talk (5 minutes). **Exploration** of the traumatic past events (accompanied by the researcher's talk and the music), to reflect on their traumatic events, and their relationship with their family members linked to the traumatic events experienced on the past, being aware of all their body reactions in the here and now process. They may notify if there is any pain or tension in one part of the body. They may notify the heart bit rate and the breathing, all the bodily sensations, all the emotions and feelings that arise in the present moment (20 minutes). The counsellor may be passing in all the groups to observe.	
	Debriefing: on how one may feel or react when recalling a	

	stressful event (sad, angry, like you want to cry, fearful, and so on. all those feelings are normal for the abnormal traumatic events experienced). Then, the children are invited to share (in their small groups), helped by the counsellor-assistants, and the mood-images, on how they were feeling in the beginning, during and after recalling the memories of the past traumatic events (30 minutes). After the sharing, everybody stand holding one another's hand. They may learn a small song ("the love of god is big like this, is big like this, and is big like this. It is for me, it is for you, alleluia"). The children sing with movements and turning around (15 minutes). **Psycho-education**: to help the children to learn to change the negative feelings and thoughts in positive ones. Each one may found 5 positive things that she likes to do, and 5 positive words that are her strengths. They may repeat those words in short phrases several times. Starting within their hearts, then with words slowly, then aloud. Guided by the counsellor's talk to help the children to emphasise in each positive phrase that they are repeating in the present moment, such as: I am strong; I am capable; I can make it; I am lovely; I help others; I forgive others; I believe in me; I am kind, I am unique, and so on (30 minutes).	
	End of the session: After the Psycho-education, all the children	

	may return to their seats for a relaxation exercise with slow music, accompanied by the counsellor's talk (Gen Verde – Child Of Light) to help them to come back into normal. Also, to reduce uncomfortable feelings, thoughts and emotions if they still come in memories, such as shame, fear, anxiety, guilty, self-blame, sadness and so on, and remain focused on the positive words that they have been repeating. Then, presentation of mood images to tick how they are feeling at the end of the session, and share. Song: "if you are happy…". Greetings and good-bye. (20 minutes).	
Week2/Session 3	**Introduction:** Everybody may stand in a big circle. After greetings and song with hand-movements, ("The love of god is big like this, is big like this, and is big like this. It is for me, it is for you, alleluia"), to prepare the environment, the children may be arranged in five lines of 10 children each, and have a seat (15 minutes). **Debriefing**: on the last session about the positive words (phrases), the children may be invited to share on how are they feeling in the present moment (ticking on the mood images of feelings and emotions). Debriefing on the importance to be focused in the here and now experience. Then, relaxation exercise with slow music (Gen Verde – Child Of Light) accompanied by the counsellor's talk, to prepare the children for the meditation (10 minutes).	2 hours

	Meditation: After the relaxation, the children are invited to remain focused in the here and now experience while the counsellor may change the music song (Night with many stars – found also in You Tube). Guided by the counsellor's words, the children may reflect on their experience in the present moment since they are in Children's Home. While reflecting, they may listen also to their body reactions, to notify any block of energy or pain, the heart bit in the present moment (15 minutes). After the meditation, helped by the counsellor's talk, the children may come back to normal, relax a bit, and there will be a moment of sharing about how was the meditation moment and what it is their experience (20 minutes). After the sharing, a break may be observed (10 minutes). Then everybody will return in his place, song (The love of God is big…).	1 hour
	Debriefing: After the song, the children will relax (5 minutes) in silence. A debriefing about the importance of living the present moment will be done, reminding the children to repeat their positive phrases. Then, the counsellor may present the mood-images and each one may tick how he is feeling in the present moment, then share. (15 minutes).	
	End of the session: after the sharing, will be a song (If you are happy…). Then the closing words of the counsellor thanking everybody for his participation. Greetings and good-bye (10 minutes)	

Week3/Session 4	**Introduction**: After the greetings and welcoming, all the participants will stand a big circle, a song with hand-movements may be played (If you are happy…). Then, the children will be seated in the hall in 5 small groups of 10 each with a counsellor-assistant for a moment of sharing about the last session. each one will tick how is feeling in the present moment, his mood-images paper, and say aloud (17 minutes). **Debriefing** (by the counsellor) of the last session, which was focused in meditating about their experience in the present moment, and explain how this fourth session will be done, how they may focus in meditating about their dreams, what they would like to become in the future (20 minutes). The children are invited to observe a moment of silence to relax, to prepare them for the meditation, listening to all the noises around, while breathing in and out guided by the counsellor's talk (3 minutes). Meditation: accompanied by a slow music (Night with many stars – found also in You Tube) and the counsellor's talk, the children will meditate and reflect on their future, their dreams, what they would like to become. They may be guided to dream that they already big doing and living the way they would like it to happen in the future (20 minutes). A moment of sharing will be observe, after relaxing at the end of the meditation (20 minutes). **Psycho-education:** After they are relax, everybody will stand in	2 hours

	the big circle, singing (The love of God with movements). Then, the counsellor will explain how each one has been created for a purpose, how to achieve one's goals (know your strengths and weaknesses, be focused and positive in the present moment). They may learn some coping skills such as being focused, being resilient. They may learn how to think positively about themselves, knowing their strengths and weaknesses, how to focus on what they can control, how to encourage each other and work together to help each other and so on. The "cube of peace", done by the counsellor, which has six faces with short phrases in each face, that they may be playing every morning and put into practice the phrase that may come out. This may be explained to help them in learning socio-emotional skills (20 minutes). Explanation on the "Cube of peace": The counsellor may present the cube and ask the children to read, one after the other, what is written in each face of the six faces of the cube. The counsellor explain that every morning after the prayer, all together, one of them would throw the cube and read to everybody what will come out. The counsellor may explain with examples how they would live each phrase concretely in the present moment. After the explanation, one child may be called to throw the cube and read the phrase. This may be a homework for the whole week until the next session. The children will keep the cube in the Home. 1. I am the first to love	

	2. We forgive each other 3. We love each other 4. We help each other 5. I listen to the other 6. I play with everybody	
	End of the session: Presentation of mood-images, in their groups, to explore their feelings and emotions. Each one may tick and share. Closing words of the counsellor to encourage the children to be focused and to not forget the cube of peace to be played every morning and live accordingly. One child will be invited to throw the cube of peace and read the phrase to be put into practice from that moment. Last song: "if you are happy… stand, turn around, jumps…" Greetings and Good-bye (20 minutes).	
Week4/Session 5	**Introduction**: Song "if you are happy…" to call all the children to have a seat as per lines. The counsellor may explain that this may be the last session to evaluate what have been done during the intervention sessions (10 minutes). **Debriefing**: All together, may recall the group rules, one by one, and evaluate how they have tried to live them and share. They may also share about their feelings, emotions in the present moment using the same mood images to see the changes. The counsellor may recap what was done in each session. They may recap what they have enjoyed most during the intervention and what they have learned (30 minutes).	2 hours

	Relaxation music (Mountain Dreams – found also on You Tube) (10 minutes). A break may be observe (10 minutes). After the relaxation exercise, PCL5-Child Self-report test may be administered to screen the trauma levels after the intervention (30 minutes). The results may be compared, from the beginning to the end to see the improvements (by the counsellor after on) Thanks giving and encouragement words may be said to all the children for their commitment, and to the Children's Home for making the research possible. Final snack, a family photo and Good-bye (40 minutes).	