

**THE IMPACT OF CHILDHOOD TRAUMA ON MENTAL HEALTH DISORDER  
AMONGST YOUTH IN NAMATALA SLUMS MBALE CITY**

**ELIZABETH APIYO**

**M22/ MUC/ BSW/030**

**A DISSERTATION SUBMITTED TO THE SCHOOL OF SOCIAL SCIENCES IN PARTIAL  
FULFILLMENT OF THE REQUIREMENTS FOR THE AWARD OF A DEGREE OF BACHELOR  
OF SOCIAL WORK AND SOCIAL ADMINISTRATION OF UGANDA CHRISTIAN UNIVERSITY**

**August, 2024**



**UGANDA CHRISTIAN  
UNIVERSITY**

*A Centre of Excellence in the Heart of Africa*

## DECLARATION

I, ELIZABETH APIYO here by declare that this research report is my original work and has never been submitted to any other institution of higher learning for an award of a Bachelor's Degree in Social Work and Social Administration.

ELIZABETH APIYO

Signed:  .....

Date: 31/08/2024 .....

## **APPROVAL**

This is to acknowledge that this research report entitled the impact of child hood trauma on mental health disorder amongst youth in Namatala slums Mbale city has been done under my supervision and is now ready for submission to the department of social science for the award of Bachelors of Social Work and Social Administration, Uganda Christian University.

A handwritten signature in blue ink, appearing to read 'R. Komo', written in a cursive style.

**Signature:**

**MR KOMO RICHARD**

**Research Supervisor**

### **ACKNOWLEDGEMENT**

Above all am grateful to the Almighty God for His Grace and favour upon the completion of my study. To the faculty of social sciences, my supervisor Mr. Komo Richard for his technical support extended in the process of my research report. Thank you so much for sacrificing a lot of your time, may God bless you and grant you strength to serve our nation. I appreciate with gratitude the assistance of various people, whom their contributions have been instrumental in the course of my studies. To my family, I appreciate your kindness exhibited entirely in the enduring moments of my study. I also extend my thanks to all my respondents, my lecturers, and my course mates and friends, in general for providing the necessary conducive learning environment.

God bless you all.

## ABBREVIATIONS AND ACRONYMS

PTSD	- Post-Traumatic Stress Disorder
MH	- Mental Health
CA	- Child Abuse
PA	- Physical Abuse
CN	- Child Neglect
CT	- Childhood Trauma
CM	- Coping Mechanisms
SS	- Support Systems
YM	- Youth Mental Health
NWS	- Namatala Ward Slums
CPS	- Child Protection Services
HRQOL	- Health-Related Quality of Life
SES	- Socio-Economic Status
ACE	- Adverse Childhood Experiences
CP	- Child Psychology
CPT	- Cognitive Processing Therapy
RT	- Resilience Training
CPSA	- Child Protective Services Agency
EMDR	- Eye Movement Desensitization and Reprocessing
CBT	- Cognitive Behavioral Therapy

**LIST OF FIGURES**

Figure 1; conceptual frame work.....9

## LIST OF TABLES

Table 3.1 Population Size.....	23
Table 3.2: Sample Size.....	24
Table 1: Demographic Characteristics of Respondents.....	28
Table 2: Access to Psycho-Social Support.....	29
Table 3: Satisfaction with Psycho-Social Support.....	30
Table 4: Correlation between Psycho-Social Support and Well-being.....	31
Table 5: Regression Analysis of Psycho-Social Support and Well-being.....	32
Table 6: ANOVA for Well-being by Access to Psycho-Social Support.....	33

# Table of Contents

DECLARATION .....	i
APPROVAL .....	ii
ACKNOWLEDGEMENT .....	iii
ABBREVIATIONS AND ACRONYMS .....	iv
LIST OF FIGURES .....	v
LIST OF TABLES .....	vi
CHAPTER ONE .....	1
1.0 Introduction .....	1
1.1 Background .....	1
1.1.1 Historical Background.....	1
1.1.2 Conceptual Background.....	2
1.1.3 Contextual Background .....	4
1.1.4 Theoretical Background .....	5
1.1 Problem statement .....	6
1.2 Purpose of the study .....	7
1.3 Objectives of the study .....	7
1.4 Research questions .....	7
1.5 Scope of the Study.....	7
1.5.1 Geographical Scope .....	7
1.5.2 Time Scope .....	8
1.5.3 Content Scope .....	8
1.6 Justification of the study .....	9
1.7 Conceptual Framework .....	10
1.10 Definition of terms.....	11
CHAPTER TWO .....	13
LITERATURE REVIEW .....	13
2.1 Theoretical Literature Review .....	13
2.2 Empirical literature review.....	14
2. 2.1 Effects of physical abuse on mental health.....	14
2.2.2 Relationship between child neglect and mental health .....	17
2.2.3 Treatment .....	23
2.3 Gaps in the literature .....	27
CHAPTER THREE .....	30
METHODOLOGY .....	30
3.0 Introduction .....	30
3.1 Research Design.....	30

3.1.1 Quantitative Component .....	30
3.1.2 Qualitative Component .....	30
3.1.3 Rationale for Mixed-Methods Approach .....	31
3.2 Area of study .....	32
3.3 Sources of information .....	32
3.4 Population and Sample techniques.....	32
3.4.1 Target Population .....	32
3.4.2 Sampling Techniques.....	33
3.5 Procedure for data collection.....	33
3.6 Data Collection instruments.....	34
3.7 Data Collection Methods .....	35
3.7.1 Administering Questionnaires:.....	35
3.7.2 Conducting Interviews: .....	35
3.8 Data processing and Analysis.....	36
3.9 Ethical Considerations .....	36
CHAPTER FOUR: .....	37
DATA ANALYSIS, PRESENTATION, AND INTERPRETATION OF FINDINGS.....	37
4.1 Introduction .....	37
4.2 Demographic Characteristics of Respondents .....	37
4.3 Descriptive Analysis .....	40
4.3.1 Effect of Physical Abuse on Mental Health .....	41
4.3.3 Existing Coping Mechanisms and Support Systems.....	43
4.4.2 Regression Analysis.....	47
4.5 Discussion of Findings .....	50
4.5.1 Effect of Physical Abuse on Mental Health .....	50
4.5.2 Relationship Between Child Neglect and Mental Health.....	50
CHAPTER FIVE.....	51
DISCUSSION, CONCLUSION, AND RECOMMENDATIONS .....	51
5.1 Introduction .....	51
5.2 Discussion of Findings .....	51
5.2.1 Demographic Characteristics and Their Influence on Mental Health .....	51
5.2.2 The Effect of Physical Abuse on Mental Health .....	52
5.2.3 The Relationship Between Child Neglect and Mental Health .....	53
5.2.4 Effectiveness of Coping Mechanisms and Support Systems.....	54
5.3 Conclusion .....	55
5.4 Recommendations .....	55
5.4.1 Strengthening Community-Based Mental Health Services .....	56

References .....	57
APPENDIXES .....	61
APPENDIX I: QUESTIONNAIRE 1 .....	61
APPENDIX II: PLACEMENT LETTER .....	69
APPENDIX III: SKETCH MAP OF MBALE DISTRICT .....	70

# CHAPTER ONE

## INTRODUCTION

### 1.0 Introduction

The chapter outlines the background of the study, emphasizing the prevalence of trauma in slum environments and its severe implications for mental health. It highlights the research problem, detailing the gap in understanding how cumulative trauma affects the psychological well-being of youth in resource-constrained settings. The chapter also presents the study's objectives, significance, and scope, setting the foundation for a comprehensive exploration of the issue within the local context of Namatala.

### 1.1 Background

#### 1.1.1 Historical Background

The understanding of childhood trauma as a precursor to mental health disorders has evolved significantly over the past century. Globally, the landmark Adverse Childhood Experiences (ACEs) study by Felitti et al. (1998) highlighted the profound impact of early trauma on mental health, demonstrating a strong correlation between childhood adversity and the development of disorders such as depression, anxiety, and PTSD in adulthood. This study has been instrumental in shaping global awareness and policy regarding childhood trauma. Subsequent research across different regions has reinforced these findings, indicating that childhood trauma is a universal risk factor for mental health issues. For instance, Kessler et al. (2010) conducted a global survey that found a consistent association between childhood adversities and the onset of mental disorders in over 20 countries, further emphasizing the global scale of this issue.

In Africa, the historical context of childhood trauma and its impact on mental health is deeply intertwined with the continent's socio-economic and political history. Studies have shown that colonialism, wars, and socio-political instability have left a legacy of trauma that has had long-lasting effects on the mental health of African populations. For example, a study by Williams et al. (2007) in South

Africa highlighted the intergenerational transmission of trauma resulting from apartheid, contributing to widespread mental health disorders among the youth. Similarly, Atwoli et al. (2013) conducted a study in Kenya that found a high prevalence of childhood trauma, such as physical abuse and parental loss, which was strongly linked to mental health disorders like depression and substance abuse. These findings reflect a broader continental pattern where childhood trauma is compounded by ongoing challenges such as poverty, conflict, and disease, exacerbating mental health issues among the youth.

In Uganda, and specifically within the Namatala slums of Mbale City, the impact of childhood trauma on youth mental health is a pressing concern. Research in this region, such as that by Nalugya-Sserunjogi et al. (2016), has documented high rates of trauma exposure among children, including domestic violence, poverty-related stress, and loss of caregivers due to HIV/AIDS. These traumas are closely linked to the emergence of mental health disorders such as depression, anxiety, and behavioral problems among the youth. Additionally, a study by Kinyanda et al. (2019) in Uganda found that the prevalence of PTSD among children who have experienced trauma in urban slums is alarmingly high, with limited access to mental health services exacerbating the situation. The Namatala slums, characterized by extreme poverty and overcrowding, provide a fertile ground for such adversities, making childhood trauma a critical determinant of mental health outcomes for the youth in this area.

### **1.1.2 Conceptual Background**

The conceptual understanding of childhood trauma as a significant determinant of mental health disorders has been extensively developed in global psychological literature. Pioneering work by Bowlby (1969) on attachment theory laid the groundwork for understanding how early adverse experiences disrupt secure attachment, leading to a cascade of developmental and emotional challenges. This theoretical framework was expanded by researchers like van der Kolk (2005), who introduced the concept of developmental trauma disorder, emphasizing how chronic exposure to trauma during childhood fundamentally alters brain development, stress responses, and emotional regulation, thereby increasing vulnerability to mental health disorders such as PTSD, depression, and anxiety.

These concepts have become central to global discussions on trauma-informed care, underscoring the need to address childhood adversity as a core component of mental health interventions.

In Africa, the conceptualization of childhood trauma and its impact on mental health is influenced by the continent's unique socio-cultural and historical context. Theoretical models developed by African scholars often incorporate the role of collective trauma, such as the effects of colonialism, genocide, and prolonged conflict, which continue to affect communities today. For instance, Dawes and Higson-Smith (2004) emphasized the importance of understanding trauma within the context of socio-political violence, arguing that the collective experiences of communities must be considered alongside individual trauma. Similarly, Atilola (2017) highlighted how cultural beliefs and practices shape the expression and understanding of trauma and mental health disorders in African settings, suggesting that mental health frameworks in Africa need to be adapted to reflect these cultural dimensions. These conceptual models stress the importance of integrating cultural and historical contexts into the understanding of childhood trauma and its long-term effects on mental health.

In Uganda, and specifically in the Namatala slums of Mbale City, the conceptual framework for understanding the impact of childhood trauma on mental health disorders is rooted in the intersection of poverty, social instability, and limited access to healthcare. Research by Kinyanda et al. (2013) on mental health in Ugandan children and adolescents emphasizes the need for a multifaceted approach that considers both the direct and indirect effects of trauma. Kinyanda's work integrates socio-ecological models that account for how environmental factors such as poverty, family instability, and community violence contribute to the onset of mental health disorders in youth. Furthermore, the conceptualization of trauma in this context is expanded to include the cumulative effects of everyday stressors, as outlined by Nalugya-Sserunjogi et al. (2016), who argue that ongoing exposure to adverse conditions exacerbates the psychological impact of early trauma. This localized understanding underscores the complexity of trauma in resource-constrained environments, where mental health interventions must address both individual and structural determinants of well-being.

### 1.1.3 Contextual Background

Globally, childhood trauma is recognized as a critical public health issue with far-reaching consequences on mental health. Research has consistently shown that adverse childhood experiences (ACEs) significantly increase the risk of developing mental health disorders later in life. Felitti et al. (1998) conducted a seminal study revealing that exposure to multiple ACEs, such as abuse, neglect, and household dysfunction, is strongly associated with the development of mental health issues like depression, anxiety, and substance abuse. This study spurred international efforts to address childhood trauma as a global health priority, leading to the integration of trauma-informed approaches in mental health care worldwide. The global context underscores the pervasive impact of childhood trauma, transcending cultural and geographical boundaries, and highlights the universal need for early intervention and support.

In Africa, the context of childhood trauma is shaped by the continent's history of socio-political instability, poverty, and conflict. Studies have shown that African children are disproportionately exposed to traumatic events, such as war, displacement, and extreme poverty, which contribute to a higher prevalence of mental health disorders. For example, Atwoli et al. (2013) found that in Kenya, a significant number of children have experienced traumatic events, with a direct correlation to increased rates of PTSD, depression, and other mental health disorders. This study, along with others across the continent, emphasizes the compounded effect of multiple traumas and the limited access to mental health services, which exacerbates the psychological impact on African youth. The African context highlights the need for culturally sensitive and contextually appropriate interventions that address the unique challenges faced by children in this region.

In Uganda, particularly in the Namatala slums of Mbale City, childhood trauma is a significant contributor to mental health disorders among the youth. The slums are characterized by extreme poverty, high rates of domestic violence, and limited access to healthcare, creating an environment where children are constantly exposed to traumatic experiences. Research by Kinyanda et al. (2019) in Uganda

documents the high prevalence of PTSD and depression among children who have experienced trauma, particularly in urban slums. This study highlights the urgent need for targeted mental health interventions in these communities, where the impact of trauma is compounded by socio-economic deprivation and a lack of support systems. The local context in Namatala reflects the broader challenges faced by vulnerable populations in Uganda, where addressing childhood trauma is crucial for improving mental health outcomes among the youth.

#### **1.1.4 Theoretical Background**

Globally, the theoretical understanding of childhood trauma and its impact on mental health has been significantly influenced by attachment theory and trauma theory. Bowlby's (1969) attachment theory posits that early relationships with caregivers are crucial in shaping a child's emotional and psychological development. Disruptions in these relationships due to trauma can lead to insecure attachment styles, which are closely linked to the development of mental health disorders such as anxiety and depression. This theory was further expanded by van der Kolk (2005), who developed the concept of developmental trauma disorder (DTD). Van der Kolk argued that repeated exposure to trauma in childhood fundamentally alters brain development and stress response systems, leading to a range of psychological difficulties. These theories have been widely accepted and have formed the basis for many trauma-informed interventions used globally.

In Africa, theoretical models of childhood trauma and mental health disorders often incorporate the continent's unique socio-cultural and historical contexts. The work of African scholars such as Dawes and Higson-Smith (2004) has been pivotal in integrating the concept of collective trauma into understanding individual psychological outcomes. They argue that the pervasive violence and instability experienced by many African communities have not only affected individuals but have also created a collective trauma that influences mental health across generations. Atilola (2017) further emphasizes the need to consider cultural factors in the conceptualization of trauma and mental health in Africa, advocating for theories that acknowledge the role of community, spirituality, and traditional practices in healing. These perspectives challenge the universality of Western

theories and call for a more culturally relevant approach to understanding and addressing childhood trauma in Africa.

In Uganda, the theoretical understanding of childhood trauma and its impact on mental health, particularly in areas like the Namatala slums, is shaped by socio-ecological models. Kinyanda et al. (2013) applied a socio-ecological framework to examine how various factors, including poverty, family dynamics, and community violence, interact to influence the mental health of Ugandan youth. This model emphasizes the importance of considering multiple layers of influence—from individual to societal—in understanding the effects of childhood trauma. Additionally, Nalugya-Sserunjogi et al. (2016) expanded on these ideas by incorporating the concept of cumulative risk, which suggests that the accumulation of multiple stressors over time significantly increases the likelihood of mental health disorders. These theoretical approaches underscore the complexity of trauma in resource-limited settings like Namatala, where addressing the mental health needs of youth requires a holistic understanding of the various factors at play.

### **1.1 Problem statement**

The impact of childhood trauma on the mental health of youths in the Namatala slums of Mbale City remains a critical yet under-explored issue. Although there have been some positive efforts, such as community-based support groups and initiatives by NGOs to address child trauma, these efforts are often fragmented and lack the necessary resources to be effective. Challenges such as high levels of poverty, pervasive violence, and limited access to mental health care and social services exacerbate the situation, making it difficult to provide consistent and comprehensive support. Additionally, the stigma surrounding mental health within the community further hinders the effectiveness of these interventions, leaving many affected youths without the help they desperately need. Understanding the relationship between childhood trauma and mental health within this marginalized community is crucial for overcoming these challenges and developing targeted, sustainable interventions to improve the well-being and future prospects of these vulnerable youths.

## **1.2 Purpose of the study**

To investigate the impact of childhood trauma on the mental health of youths living in the Namatala slums of Mbale City

## **1.3 Objectives of the study**

To find out the effect of physical abuse on mental health in Namatala ward slums.

To establish the relationship between child neglect and mental health in Namatala ward slums.

To identify the existing coping mechanisms and support systems available to youths in the Namatala ward slums and assess their effectiveness in mitigating the impact of childhood trauma

## **1.4 Research questions**

What are the effects of physical abuse on mental health in the Namatala slums of Mbale City?

What are the existing relationship between child neglect and mental health of youths in the Namatala ward slums?

What are the existing coping mechanisms and support systems available to youths in the Namatala slums, and how effective are they in mitigating the impact of childhood trauma?

## **1.5 Scope of the Study**

### **1.5.1 Geographical Scope**

The study will be conducted in the Namatala slums of Mbale City, located in the Eastern Region of Uganda. Namatala is one of the largest informal settlements in the region, characterized by dense population, inadequate infrastructure, and high levels of poverty. The geographical scope will encompass all the residential areas within the Namatala slums to ensure a comprehensive understanding of the conditions and experiences of the youths living there

### **1.5.2 Time Scope**

The study will focus on a period spanning the past five years 2022-2024. This timeframe is chosen to capture recent and relevant data regarding childhood trauma and its impact on mental health among youths. It will allow for the examination of both immediate and slightly long-term effects of trauma, considering any changes in the socio-economic and environmental conditions of the slum over this period.

### **1.5.3 Content Scope**

The content of the study will cover the following key areas:

**Identification of Traumatic Experiences:** Types of trauma experienced by children and youths in Namatala (e.g., physical abuse, domestic violence, community violence, neglect, sexual abuse). Prevalence and frequency of these traumatic experiences.

**Mental Health Outcomes:** Assessment of various mental health issues among youths, such as depression, anxiety, PTSD (Post-Traumatic Stress Disorder), and behavioural disorders. The relationship between specific types of trauma and particular mental health outcomes.

**Socio-Economic and Environmental Factors:** The role of poverty, lack of access to education, healthcare, and social services in exacerbating the impact of trauma on mental health. Community and family support systems, or lack thereof, and their influence on the youths' mental well-being.

**Coping Mechanisms and Resilience:** Strategies employed by youths to cope with traumatic experiences. Identification of protective factors that may mitigate the negative impact of trauma.

**Intervention and Support Systems:** Evaluation of existing mental health services and interventions available to youths in Namatala. Recommendations for targeted interventions and support systems to improve mental health outcomes for traumatized youths.

Comparative Analysis: Comparison of mental health outcomes between youths in Namatala and those in other regions or slums with different socio-economic profiles to contextualize the findings.

## **1.6 Justification of the study**

The justification for studying the impact of childhood trauma on the mental health of youths in the Namatala slums of Mbale City stems from the urgent need to address a significant gap in research and provide tailored interventions for a highly vulnerable population.

Critical yet Under-Explored Issue: The acknowledgment that childhood trauma significantly influences mental health outcomes underscores the importance of understanding its specific implications in the Namatala slums. By highlighting this gap, the problem statement emphasizes the urgency of investigating this issue to fill the knowledge void.

Unique Environment of Namatala Slums: The description of the Namatala slums as a setting characterized by poverty, violence, and limited access to healthcare and social services underscores the distinct challenges faced by residents. This unique environment necessitates targeted research to comprehend how traumatic experiences intersect with existing adversities, potentially exacerbating mental health issues among youths.

Crucial for Developing Interventions: Recognizing the profound detrimental effects of trauma on mental health within such a marginalized community underscores the necessity of developing tailored interventions. Understanding the specific dynamics at play in Namatala is crucial for designing effective support systems that address the complex needs of youths facing multiple layers of adversity.

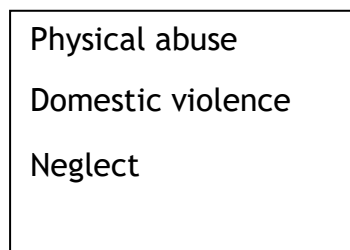
Improving Well-being and Future Prospects: Ultimately, the goal of this study is to improve the well-being and future prospects of vulnerable youths in Namatala. By uncovering the relationship between childhood trauma and mental health outcomes, researchers can contribute to the development of targeted interventions that empower these youths to overcome adversity and build brighter futures.

In summary, the justification for this study lies in the imperative to address a critical gap in research, understand the unique challenges faced by youths in the Namatala slums, and develop targeted interventions to enhance their well-being and future prospects.

### 1.7 Conceptual Framework

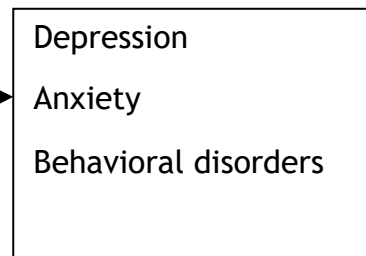
**Independent variables**

**Child hood trauma**

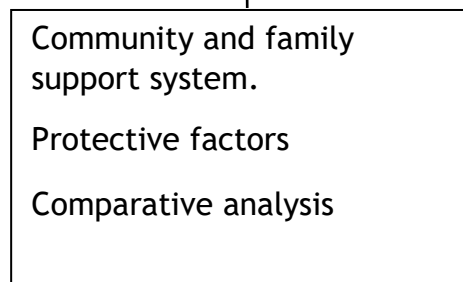


**Dependent variables**

**mental health disorder**



**Moderating variables**



**Source: Researcher 2024**

These variables would be crucial in understanding the complex interplay between traumatic experiences, socio-economic factors, support systems, and mental health outcomes among youths in the Namatala slums.

## 1.10 Definition of terms

**Childhood trauma:** Refers to adverse experiences or events that occur during childhood, such as abuse, neglect, violence, or family dysfunction, which can have lasting negative effects on a child's physical, emotional, and psychological well-being.

**Mental health:** Encompasses a person's emotional, psychological, and social well-being. It affects how individuals think, feel, and act, and influences how they handle stress, relate to others, and make choices. Good mental health is essential for coping with the challenges of life, building resilience, and achieving overall well-being.

**Youths:** Typically refers to individuals in the transitional stage between childhood and adulthood, usually ranging from adolescence to early adulthood, though the exact age range may vary. In this context, it specifically pertains to the young people living in the Namatala slums of Mbale City.

**Namatala slums:** Refers to a marginalized urban area characterized by overcrowded living conditions, poverty, limited access to basic services such as healthcare and education, and high levels of violence and crime. In this context, it specifically denotes the community in Mbale City, Uganda.

**Mbale City:** A city located in eastern Uganda, known for its diverse population and economic activities. It serves as the administrative and commercial center of the Mbale District and is surrounded by rural areas, including the Namatala slums.

**Marginalized community:** Describes a group of people who experience social, economic, or political exclusion, often due to factors such as poverty, discrimination, or geographic isolation. Marginalized communities typically have limited access to resources, opportunities, and services, leading to disparities in health, education, and overall well-being. In this context, it refers to the residents of the Namatala slums who face various challenges and vulnerabilities.

**Interplay:** Denotes the dynamic interaction or relationship between different factors or elements. In this context, it refers to the complex and reciprocal relationship between traumatic experiences and mental health outcomes among the youths living in the Namatala slums.

**Interventions:** Refers to actions or strategies designed to address a specific problem or issue, often aimed at promoting positive change or improvement. In this context, it relates to targeted efforts to support and improve the mental health and well-being of youths affected by childhood trauma in the Namatala slums, such as counseling, community programs, and access to mental health services.

## CHAPTER TWO

### LITERATURE REVIEW

#### 2.1 Theoretical Literature Review

##### The Effect of Physical Abuse on Mental Health

Physical abuse during childhood has been consistently linked to a range of mental health issues, including anxiety, depression, and post-traumatic stress disorder (PTSD). According to Dube et al. (2020), physical abuse can result in chronic psychological stress, which negatively affects the development of a child's brain, leading to long-term mental health disorders. This stress response can persist into adolescence and adulthood, manifesting in various forms of psychopathology. Research by Finkelhor et al. (2019) further emphasizes that the severity and frequency of physical abuse significantly correlate with the intensity of mental health symptoms, suggesting a dose-response relationship. Therefore, addressing the impact of physical abuse on mental health in Namatala ward slums is crucial for developing targeted interventions.

##### The Relationship Between Child Neglect and Mental Health

Child neglect, often less visible than physical abuse, can be equally detrimental to a child's mental health. Neglect, defined as the failure to provide for a child's basic needs, has been associated with attachment disorders, emotional dysregulation, and cognitive impairments. A study by Norman et al. (2018) indicates that children who experience neglect are at a higher risk of developing depression and anxiety, as well as difficulties in social relationships. Moreover, neglected children often develop a negative self-concept, which further exacerbates their vulnerability to mental health disorders. In the context of Namatala ward slums, where poverty and social instability are prevalent, the impact of child neglect on mental health may be particularly pronounced, as noted by Wang et al. (2021). Understanding this relationship is vital for addressing the mental health needs of youths in this area.

**Coping Mechanisms and Support Systems for Mitigating Childhood Trauma**

Coping mechanisms and support systems play a critical role in mitigating the effects of childhood trauma. Effective coping strategies, such as positive social support, access to mental health services, and community-based interventions, can significantly reduce the long-term impact of trauma on mental health. Research by Bell et al. (2021) highlights the importance of resilience-building programs that empower youths to develop healthy coping skills. Furthermore, Perry et al. (2022) argue that community support systems, including peer support groups and family therapy, are essential in providing a protective buffer against the adverse effects of trauma. In the Namatala ward slums, where resources may be limited, it is important to assess the availability and effectiveness of these support systems in helping youths cope with the psychological aftermath of childhood trauma.

## **2.2 Empirical literature review**

### **2. 2.1 Effects of physical abuse on mental health**

#### **Long-Term Consequences of Early Childhood Trauma**

Recently, researchers have focused on how trauma during early childhood impacts mental and physical health later in life. Symptoms of mental illness can manifest immediately after a trauma, but in some cases, symptoms do not emerge until years later. PTSD, anxiety disorders, behavior disorders and substance abuse have all been linked to traumatic events experienced during early childhood (Kanel, 2015). The types and frequencies of traumatic events and whether they were directly or indirectly experienced also can have various effects on physical and mental health later in adulthood. In a review of literature, Read, Fosse, Moskowitz and Perry (2014) described support for the trauma genic neurodevelopmental model. This model proposes that brain functioning changes following exposure to trauma during childhood. These biological factors often lead to psychological issues and physical and mental health concerns in adulthood.

Mental health professionals are often challenged to accurately diagnose PTSD in early childhood, leading to inconclusive reports of the actual prevalence of post-traumatic stress (De Young et al., 2011). Still, there is a clear relationship between PTSD diagnoses and trauma experienced in childhood. For example, higher rates of PTSD are reported among children residing in urban populations where neighbourhood violence is prevalent (Crusto et al., 2010; Goodman et al., 2012). Briggs-Gowan et al. (2010) found an association between family and neighbourhood violence exposure and oppositional defiant disorder, attention-deficit/hyperactivity disorder, conduct disorder and substance abuse. Additionally, non-interpersonal traumatic events (e.g., car accidents, burns, animal attacks) are associated with PTSD as well as anxiety, phobias, seasonal affective disorder and major depressive disorder (Briggs-Gowan et al., 2010).

Violence exposure is associated with externalizing problems while nonpersonal traumatic events are associated with internalizing problems (Briggs-Gowan et al., 2010). In a more recent study, Briggs-Gowan, Carter, & Ford (2011) found that exposure to neighbourhood and family violence in early childhood is associated with poor emotional health and poor performance in school. Low socioeconomic status and traumatic events in early childhood also are correlated with low academic achievement in school (Goodman et al., 2012). Similarly, De Bellis, Woolley, and Hooper (2013) found maltreated children demonstrated poorer neuropsychological functioning and aggregate trauma was negatively related to academic achievement.

According to Schore (2001a), children and adults who experienced relational trauma during infancy are often faced with the struggles of mental disorder due to right brain impairment (p. 239). More recently, Teicher, Anderson, and Polcari (2012) found exposure to maltreatment and other types of stress as a child impacts hippocampal neurons leading to alterations in the brain and potential developmental delays. Additionally, there is evidence of relationships between mistreatment, bullying and accidents in early childhood and the development of delusional symptoms in later childhood (Arseneault et al., 2011). Young children

who experience trauma and later use cannabis in adolescence are also at a higher risk for experiencing psychotic symptoms (Harley et al., 2010). Other studies have shown a correlation between early childhood trauma and development of schizophrenia later in life (Bendall, Jackson, Hulbert, & McGorry, 2008; Morgan & Fisher, 2007; Read, van Os, Morrison, & Ross, 2005). Changes in the brain may mediate these relationships between trauma exposure and mental health, as suggested by Schore (2001a, 2001b) and others.

Infants exposed to trauma are often inhibited by emotional and behavioral dysregulation in childhood and as an adult (Ford et al., 2013; Schore, 2001a, 2001b). Dysregulation resulting from trauma is predictive and related to substance use and functionality (Holtmann et al., 2011). For example, findings from a study by Strine et al. (2012) suggested that early childhood trauma and substance abuse are directly correlated. Children who had experienced more than one traumatic event were found to be 1.4 times more likely to become alcohol dependent. Strine et al. (2012) noted that females who experience trauma are more likely than males to abuse or become dependent on alcohol. The relationship between trauma and alcohol use and dependence often stems from untreated psychological distress (Strine et al., 2012).

In addition, there is ample evidence that early childhood trauma impacts later physical health. Some of the most well-known data on this topic come from the adverse childhood experiences study (Edwards et al., 2005). Multiple studies have found that early childhood trauma is associated with autoimmune disorders (Dube et al., 2009), headaches (Anda, Tietjen, Schulman, Felitti, & Croft, 2010), heart disease (Dong et al., 2004), lung cancer (Brown et al., 2010) and other illnesses. In fact, these studies often have found that the more frequent the exposure to early childhood trauma, the higher the risk of poor health outcomes in adulthood (Felitti et al., 1998).

Researchers have found clear evidence that children who experience traumatic events in early childhood are impacted well beyond their youth. Mental health disorders as well as alcohol and substance abuse emerge intermittently with age. Changes in brain functioning and physical health issues are also associated with early childhood trauma.

### **2.2.2 Relationship between child neglect and mental health**

Our children's abuse and neglect are serious concerns for mental health professionals, and they have a long-term impact. Child maltreatment has a wide-ranging influence on personal, physical, social, and psychological development as a key environmental risk factor. There is a direct and indirect influence. For example, prenatal and early childhood mistreatment raises stress hormones, which affect brain development. This occurs not just due to changes in brain architecture and growth but also as a result of changes in how the child's genes are expressed within the individual. As a result of these alterations, the child's ability to cope with and adapt to additional environmental stimuli is affected. This intricate interplay of maltreatment and genes allows us to adopt a nuanced perspective of the psychopathology of maltreatment and recovery from it. We may also adopt optimism for change and better situations with such a viewpoint.

Parental Mental Health Issues and the Psychological Development of a Child 500 words he links between a parent and their kid is unparalleled. The biological and psychological relationships that bind parents and children are critical for a child's physical and emotional growth. Unfortunately, parenthood isn't always as glamorous as it appears on social media or glossy parenting publications. Furthermore, children are sensitive detectors of parental distress, which can come from various sources, including social isolation, economic difficulty, divorce, or acute or chronic mental illness. As a result, they may be at risk of acquiring mental illnesses.

According to Choi, DiNitto, Marti & Segal (2017), it is unfortunate that many children nowadays are in the care of a parent who may, at some point, suffer from mental illness. This might be moderate, such as bipolar illness or schizophrenia, or more severe, such as intermittent depression or anxiety. In addition, the number of families with a parent who abuses drugs or alcohol is increasing, which has a detrimental influence on children. According to the American Academy of Kid and Adolescent Psychiatry, parental mental illness increases a child's risk of mental illness compared to their peers. When both parents are mentally ill, the child is even more likely to follow suit.

As a result of parental psychiatric symptoms or clinical decompensation, children living with parents who suffer from mental illnesses may have a higher chance of acquiring mental health difficulties and adjustment problems, as well as a higher risk of mortality. These dangers might be caused by a general sensitivity, including hereditary and environmental variables, such as poor caregiver-child relationships. According to LeTendre & Reed (2017), one of the biggest predictors of child maltreatment is parental health problems. Situational issues such as child abuse and other traumatic experiences are common in these households.

#### The Mental Health of a Parent is Risk Factor for Child Abuse

The effects of parental mental illness on a child's psychological, family, and social development can last far into adulthood. Parental mental health has been found as a risk factor for child maltreatment. Although not all children and adolescents are at risk of victimization, abusive parents had higher rates of mental disorder than control groups or rates of mental disorder in the general community (Monnat & Chandler, 2015). Parental mental illness is a risk factor with a dynamic influence that fluctuates depending on the mental disorder's intrinsic qualities and external circumstances. As a result, mental illness influences parenting abilities, which, in turn,

has an impact on the likelihood of child abuse. Emotional numbness, avoidance, anhedonia, limited affect, sleep disturbance, concentration issues, and impatience are signs of parental incompetence and are associated with child neglect. Bipolar illness, depression, anxiety, schizophrenia, and post-traumatic stress disorder are linked to these symptoms. Furthermore, Monnat & Chandler (2015) found that in situations of abuse and neglect, women who exhibit a greater number of symptoms are more likely to withdraw protection from their children. The same investigations discovered that abusive parents had no particular psychological disorder. The mothers had a greater prevalence of mood disorders, anxiety disorders, and suicide attempts. They also showed comorbidity with two or more nonpsychotic mental diseases. In a similar vein, Johnson et al. found a link between various mental problems and poor maternal behaviour (including abuse and neglect), including anxiety, sadness, and, most commonly, personality disorders.

Furthermore, Side Botham, Golding, and The ALSPAC Study Team identified paternal depression and mother non-specific mental illnesses as the most important characteristics associated with child maltreatment. Children of mothers with psychotic disorders were questioned as adults about their childhood experiences in a study of mothers with psychotic disorders. Participants spoke of being abused or neglected and sexual abuse in one case. The study also found that the mothers' capacity to meet their children's fundamental needs was substantially hampered due to them skewed perceptions of reality.

#### How Treating Parental Mental Illness Helps Prevent Child Abuse

To explore the most appropriate options for effective treatment, it is vital to establish the role that mental health and its related factors play in reducing the risk of child abuse. The prognosis of the parental mental disease, the individual's insight, treatment adherence, and the identification of (already stated) external variables must all be considered. Individual evaluations should include if the delirium or hallucinations are focused on the child (e.g., to harm them), whether

the individual is too ill/worried to meet their basic requirements, and/or whether the individual is misusing drugs.

Other parental competencies to be examined include basic and emotional care, communication style, conflict resolution, and family rules, in addition to the effects produced by the mental disease, the situation as a whole, and the associated risk factors. Parental assessment must be completed during a period of remission or stability, while the chance of a relapse must be considered (Herrenkohl, Jung, Lee & Kim, 2017). Many people are aware of their mental health issues and how they affect child custody; therefore, they may not reveal severe symptoms or challenges in their parenting role. Beyond risk assessment, the technician must help parents build coping skills, such as auto-identification of relapse indicators, creating a crisis plan, and keeping a daily record of parenting actions, as Seeman proposed.

Other parental competencies to be examined include basic and emotional care, communication style, conflict resolution, and family rules, in addition to the effects produced by the mental disease, the situation as a whole, and the associated risk factors. Parental assessment must be completed during a period of remission or stability, while the chance of a relapse must be considered (Herrenkohl, Jung, Lee & Kim, 2017). Many people are aware of their mental health issues and how they affect child custody; therefore, they may not reveal severe symptoms or challenges in their parenting role. Beyond risk assessment, the technician must help parents build coping skills, such as auto-identification of relapse indicators, creating a crisis plan, and keeping a daily record of parenting actions, as Seeman proposed.

In addition to the parent, the technician must perform a structured interview with the kid and gather data from various sources, including family and child protection services. Fuller-Thomson, Baird, Dhrodia, Brennenstuhl (2016) raised the prospect of a contradicting or unpleasant interview with a kid when contemplating

interventions with minors, owing to their sense of guilt in connection to their sentiments of loyalty toward their parents. For the well-being of these children, psychoeducational intervention on mental diseases with children of parents with mental illness is vitally crucial.

It is critical to provide programs to fulfil the needs of children and adolescents and therapy for

parents with mental health and drug addiction issues. Some effective programs and initiatives can be used as examples for assistance in families suffering from parental mental health or drug misuse issues. In this context, programs that provide integrated therapies that satisfy the requirements of a family (as a system) are preferable to interventions that target individuals alone (Cicchetti, Hetzel, Rogosch, Handley & Toth, 2016). Some initiatives, such as those involving child protection services and services aimed at treating caregivers, feature creative public-private collaboration. The therapies that targeted both parents and children had a greater overall impact.

### Consequences of Child Abuse

According to Afifi et al. (2016), a child's reactions to abuse or neglect can have long-term and

even intergenerational implications that unfortunately complement the physical harm that maltreatment attracts. Childhood maltreatment is connected to long-term physical, psychological, and behavioural consequences, as well as social costs. According to Bick, J., & Nelson, C. A. (2016), these consequences might be independent of one another, but they could also be linked. Misuse or neglect, for example, can hinder a child's physical development and lead to psychological disorders such as low self-esteem, which can lead to high-risk behaviors such as substance misuse.

The child's age and developmental status at the time of the abuse; the type, frequency, length, and intensity of the abuse; and the child's relationship with the perpetrator all impact the child's outcomes. Furthermore, other bad experiences such as parental substance misuse, domestic violence, poverty are commonly

known to impact children who have been maltreated. As such, it makes it difficult to discern the effects of maltreatment. (Rosen, Handley, Cicchetti, & Rogosch, 2018) Child Welfare Information Gateway. (2018) notes that some long-term physical consequences of abuse or neglect are immediately apparent, while others take months or years to show. Although there is a strong link between physical abuse and medical health, it's also important to note that any sort of mistreatment can have long-term physical consequences. Childhood maltreatment has been linked to an increased risk of long-term and/or future health problems, including diabetes, lung disease, malnutrition, eyesight problems, functional limitations, and heart attacks.

These physical consequences of abuse or neglect are immediately apparent (for example, brain damage caused by head trauma), while others take months or years to show. Although there is a strong link between physical abuse and medical health, it's also important to note that any sort of mistreatment can have long-term physical consequences (Choi, DiNitto, Marti & Choi, 2017). Childhood maltreatment has been linked to an increased risk of long-term and/or future health problems, including diabetes, lung disease, malnutrition, eyesight problems, functional limitations, and heart attacks. Diminished executive functioning and cognitive skills Working memory, self-control, and cognitive flexibility (the ability to evaluate things and events from several perspectives) can be affected by brain development disruption induced by abuse (Kavanaugh, Dupont-Frechette, Jerskey, & Holler, 2016). Other cognitive impairments, such as trouble learning and paying attention, are also at risk in maltreated youngsters.

Poor mental and emotional health

Childhood maltreatment increases the likelihood of depression, anxiety, and other mental illnesses later in life. Adults having a history of ACEs were shown to have a greater rate of suicide attempts than those who did not (Choi, DiNitto, Marti, & Segal, 2017; Fuller-Thomson, Baird, Dhrodia, & Brennenstuhl, 2016). Furthermore, adults with serious depression who were abused as children had lower antidepressant response outcomes, especially if the abuse happened when they were seven or younger.

### Attachment and social difficulties

Infants in foster care who have been subjected to maltreatment may develop attachment issues due to changes in early parenting. Attachment difficulties can make it difficult for a child to form healthy peer, social, and romantic relationships (Doyle & Cicchetti, 2017). In addition, children who have been abused or neglected as children are more likely to acquire antisocial characteristics as adults, which can lead to criminal conduct.

### Conclusion

Children and adolescents encounter a variety of dangers during their development, many of which are generated directly or indirectly by family members. Natural disasters, military conflicts, loss/grief, victimization by action (physical, psychological, or sexual assault), or omission (negligence) can threaten a child's safety, stability, and attachment relationship. Maltreatment, neglect, and parental mental problems are some of the situations that have been found to have a substantial negative impact on children's well-being and development. According to research, there is a link between parental mental problems and child maltreatment, and different psychiatric diseases have varying effects on a kid's development. The intensity, chronicity, and kind of incapacity experienced by parents who suffer from a mental condition and other individuals, parents, family, and societal characteristics all influence the degree of mental health among the children in Namatala ward Slums in Mbale City. Mood and personality problems are two examples of diseases that are especially damaging in the home.

### **2.2.3 Treatment**

Early intervention and treatment can minimize the social and emotional impact of a child's exposure to a traumatic event. Professional counsellors should consider making referrals to counsellors trained in providing early childhood mental health support. If the professional counsellor has difficulties finding a referral source, the counsellor's basic counselling skills can provide the foundation for a safe, secure and trusting relationship between the counsellor, family and child. Demonstrating

empathy, genuine care and acceptance also fosters rapport among stakeholders (Corey, 2009). Mental health counsellors can emphasize strengths and resources for the child and family.

Incorporating existing coping strategies can serve to minimize family stress and foster rapport with the child. Providing information about community support groups or other mental health agencies and resources also can help support and encourage the family. Informing parents and caregivers about symptoms common to young children exposed to traumatic events can foster awareness and allow for adequate support during the treatment process. Counsellors can help the family establish or re-establish routines that begin to restore stability for the child, minimizing the adverse effects of the trauma (APA Presidential Task Force on PTSD and Trauma in Children and Adolescents, 2008; Clay, 2010).

There are several evidence-based methods available to counsellors treating trauma symptoms in young children. Evidence-based approaches are rooted in theory, evaluated for scientific rigor and tend to yield positive results (National Registry of Evidence-Based Programs and Practices, 2012). Trauma-focused cognitive behavioural therapy (TF-CBT) is a popular evidence-based treatment used with children aged 3-18. Based on cognitive behavioural therapy, humanism and family systems theory, TF-CBT includes many therapeutic elements for children and caretakers (Child Welfare Information Gateway, 2012). This form of therapy helps children develop different perceptions and a more adaptive understanding of the traumatic event (APA Presidential Task Force on PTSD and Trauma in Children and Adolescents, 2008). Caretakers learn parenting and communication skills as they play active roles throughout the TF-CBT process. Multiple studies demonstrate the effectiveness of TF-CBT in reducing symptoms of trauma in early childhood (see Cohen & Mannarino, 1996, 1997; Deblinger, Stauffer, & Steer, 2001).

While TF-CBT is an established treatment for children and adolescents, there are evidence-based treatments developed specifically for treating trauma in children

between birth and 6 years of age. Child-parent psychotherapy (CPP), one of the most widely used interventions for young children, was created to address exposure to domestic violence, although it can treat a variety of traumatic experiences (Lieberman & Van Horn, 2008). In this form of dyadic therapy, the child and the caregiver re-establish safety and security in the parent-child relationship (Lieberman & Van Horn, 2008). CPP is one of the few early childhood treatments validated for use with ethnic minorities (Lieberman & Van Horn, 2008). The primary goal of CPP is to equip parents to meet the psychological needs of their child and maintain a secure relationship after treatment has ended.

Attachment and biobehavioral catch-up (ABC) is another treatment option that is designed primarily for use with young children who have experienced neglect (Dozier, 2003). This approach was developed specifically for low-income families and later adapted for use with foster families. ABC is based on the neurobiology of stress and attachment theory. The goal of ABC is to foster the development of the child's optimal regulatory strategies by equipping parents with tools for effective response (Dozier, 2003; Dozier, Peloso, Lewis, Laurence au, & Levine, 2008).

Counsellors also can utilize parent-child interaction therapy (PCIT) when working with traumatized youth. PCIT is a structured technique for children ages 2-8 years in which the counsellor teaches the parent or caregiver how to interact with the child and set effective limits (Chaffin et al., 2004). In this form of therapy, the counsellor often assumes the role of coach, instructing the client on specific skills. Counsellors frequently use PCIT when working with children abused by a caregiver. PCIT has been implemented successfully with various populations including Hispanic and Latino clients (Chaffin et al., 2004). The focus of PCIT is on improving the quality of the parent-child relationship as well as child behaviour management (Chaffin et al., 2004; McCabe, Yeh, Garland, Lau, & Chavez, 2005).

The treatment interventions previously mentioned are geared toward very young children, all incorporating play as a treatment modality. Since young children do not have extensive vocabularies, they often communicate information about

themselves, their trauma and relationships with their caregivers through play (Landreth, 2012). Play therapy intervention research using samples with children between birth and 5 years of age is scant; however, several case studies indicate that play therapy is effective with trauma in early childhood. For example, Dugan, Snow, and Crowe (2010) utilized play with a 4-year-old exhibiting PTSD symptomology after experiencing Hurricane Katrina in 2005. Anderson and Gedo (2013) provided a case study in which play was used to treat a 3-year-old with aggressive behaviors who was separated from his primary caregiver. There also are intervention examples of using play therapy with young children exposed to domestic violence (FrickHelms, 1997; Kot, Landreth, & Giordano, 1998).

Finally, there are emerging approaches specifically for treating young children exposed to trauma. Tortora (2010) developed Ways of Seeing, a program combining movement and dance therapy with Laban movement analysis to create a sense of regulation and homeostasis for the child exposed to a traumatic event. The Ways of Seeing program does not yet have empirical evidence of its effectiveness. However, it is rooted in attachment theory, multisensory processing, play and sensorimotor psychotherapy. Counsellors can use this program to determine how a parent and child experience each other, implement creative interventions for healthy bonding, and renew a sense of efficacy for the parent and child. While much more research is needed, this program appears to be a promising approach to treating trauma in early childhood (see <http://www.suzitortora.org/waysofseeing.html>).

Another emerging treatment, known as Honoring Children, Mending the Circle (HC-MC), is based on TFCBT. The HC-MC approach was developed to address the spiritual needs of young Native American and Alaska Native children exposed to trauma. This method emphasizes preestablished relationships, wellness and healing during the treatment process. Spirituality is a critical component of healing and is integrated throughout the HCMC approach. The goal of HC-MC is to help the traumatized child attain and re-establish balance (BigFoot & Schmidt, 2007, 2010). Additional research is needed on the efficacy of the HC-MC approach in working with Native American and Alaska Native youth.

A third emerging treatment, Trauma Assessment Pathway, is an assessment-based treatment that focuses on providing triage to young children exposed to traumatic events (Conradi, Kletzka, & Oliver, 2010). In this approach, the counsellor uses assessment domains to determine the focus of treatment, provides triage to identify an appropriate pathway for intervention and establishes referrals to community resources if needed (Chadwick Centre for Children and Families, 2009). The trauma assessment pathway method, which includes the trauma wheel, is a versatile mode of treatment available for the child and family. However, in many instances counsellors may determine that an evidence-based practice, such as CPP, is the most appropriate mode of treatment (see Chadwick Centre for Children and Families, 2009).

Each method of treatment offers specific strategies for working with traumatized young children and their families. However, findings from most studies investigating the effectiveness of these treatments are inconclusive (Forman-Hoffman et al., 2013). The strength of evidence for these and many other interventions are relatively low while the magnitudes of treatment effects are small (see Fraser et al., 2013). Common to the treatment models presented is the emphasis on system support, the importance of relationships in the recovery process and developmentally appropriate intervention modalities. These factors likely will serve as integral components of future methods focused on the treatment of traumatized young children.

### **2.3 Gaps in the literature**

#### **Limited Understanding of Long-Term Impacts of Early Childhood Trauma**

While extensive research highlights the connection between early childhood trauma and various mental health issues such as PTSD, anxiety, and substance abuse, there is a gap in understanding the specific long-term impacts of different types of trauma. For instance, the nuances of how direct versus indirect exposure to traumatic events differently affect brain development and psychological outcomes later in life require further investigation. Additionally, while the trauma genic neurodevelopmental model provides a framework, more empirical studies

are needed to explore how these biological changes manifest across diverse populations and varying environmental conditions over an extended period.

#### Underdiagnoses and Misinterpretation of PTSD in Children

Another significant research gap exists in the accurate diagnosis and understanding of PTSD in children. Despite recognizing the relationship between childhood trauma and PTSD, mental health professionals continue to face challenges in diagnosing PTSD accurately, particularly in younger children. This gap suggests the need for more refined diagnostic tools and longitudinal studies that track PTSD symptoms from childhood into adulthood. Additionally, exploring the factors that contribute to the underdiagnosis and how they can be mitigated could offer crucial insights into improving early interventions.

#### Insufficient Exploration of the Interaction Between Trauma and Socioeconomic Status

The literature identifies correlations between low socioeconomic status, trauma exposure, and poor academic and mental health outcomes. However, there is a lack of comprehensive studies that examine how socioeconomic factors interact with early childhood trauma to influence long-term mental health outcomes. Future research should delve deeper into how different levels of socioeconomic stressors, coupled with trauma, contribute to variations in mental health and academic performance, potentially uncovering protective factors or mechanisms that could inform more targeted interventions.

#### Need for Research on the Impact of Parental Mental Health on Child Development

The relationship between parental mental health issues and child development, especially in the context of abuse and neglect, remains underexplored. Although studies acknowledge the risks posed by parental mental illness, there is a gap in understanding how specific mental health conditions in parents, such as bipolar disorder or schizophrenia, distinctly impact children's psychological and emotional development. Further research should investigate the intergenerational

transmission of mental health risks and the role of environmental and genetic factors in mediating these outcomes. Additionally, exploring how these dynamics play out across different cultural and socio-economic contexts could enhance the development of culturally sensitive interventions.

## CHAPTER THREE

### METHODOLOGY

#### 3.0 Introduction

This chapter outlines the research methodology employed to achieve the study objectives. It details the research design, target population, sampling techniques, data collection methods, and data analysis procedures. In regards to the research topic (Impact of child hood trauma on mental health amongst youth in Namatala ward slums Mbale city)

#### 3.1 Research Design

This study employs a mixed-methods research design, which integrates both quantitative and qualitative approaches. This design is particularly suitable for comprehensively exploring the impact of physical abuse and child neglect on mental health among the youth in Namatala ward slums. By leveraging the strengths of both methodologies, the study aims to provide a more holistic understanding of the complex issues at hand.

##### 3.1.1 Quantitative Component

The quantitative aspect of the study involves the use of structured surveys. These surveys are designed to collect numerical data on the prevalence and severity of mental health issues among the youth. Specifically, the surveys will measure the incidence of physical abuse and child neglect, as well as various mental health outcomes such as anxiety, depression, and post-traumatic stress disorder (PTSD). The quantitative data will enable the identification of patterns and correlations, providing a broad overview of the mental health landscape in the Namatala ward slums.

##### 3.1.2 Qualitative Component

The qualitative component consists of in-depth interviews with a selected group of participants. These interviews aim to capture personal experiences and coping mechanisms related to physical abuse and child neglect. Through open-ended questions, the interviews will explore how these experiences have shaped the

participants' mental health, their perceptions of abuse and neglect, and the strategies they use to manage their mental health challenges. The qualitative data will offer rich, detailed insights that complement the numerical findings, adding depth and context to the statistical patterns identified in the surveys.

### **3.1.3 Rationale for Mixed-Methods Approach**

**Comprehensive Understanding:** Combining quantitative and qualitative data allows for a more complete understanding of the impact of physical abuse and child neglect. While quantitative data provides generalizable and statistically significant results, qualitative data offers depth and nuance, capturing the complexity of individual experiences.

**Triangulation:** Using multiple methods to study the same phenomenon helps to cross-verify findings, enhancing the validity and reliability of the results. Triangulation ensures that the conclusions drawn are robust and well-supported by evidence from different sources.

**Contextualization of Findings:** The qualitative component helps to contextualize the quantitative results, explaining why certain patterns may exist and providing insights into the lived experiences behind the numbers. This is crucial for understanding the broader social and environmental factors that influence mental health outcomes in the slums.

**Policy and Intervention Development:** The detailed insights gained from the qualitative data can inform the development of targeted interventions and policies. By understanding the specific needs and challenges faced by the youth in Namatala ward slums, stakeholders can design more effective and culturally sensitive mental health programs.

In summary, the mixed-methods research design is well-suited for this my research study as it enables a comprehensive, multi-faceted exploration of the impact of physical abuse and child neglect on mental health. By integrating quantitative and qualitative data, the study aims to provide a deeper, more nuanced understanding of these issues, ultimately contributing to more effective interventions and support for the affected youth.

### 3.2 Area of study

The study will be conducted in the Namatala slums of Mbale City, located in the Eastern Region of Uganda. Namatala is one of the largest informal settlements in the region, characterized by dense population, inadequate infrastructure, and high levels of poverty. The geographical scope will encompass all the residential areas within the Namatala slums to ensure a comprehensive understanding of the conditions and experiences of the youths living there

### 3.3 Sources of information

The information will be gotten from health workers of Mbale city, parents in different category and also teachers of different schools by use of questionnaire on Impact of child hood trauma on mental health amongst youth in Namatala ward slums Mbale city.

### 3.4 Population and Sample techniques

#### 3.4.1 Target Population

The target population for this study consists of students aged 18-25 enrolled in undergraduate programs at universities in California. This demographic is chosen because it represents a diverse mix of backgrounds, including different socioeconomic statuses, ethnicities, and academic disciplines, which can provide a comprehensive understanding of the research topic.

Table 3.1 showing Target population

<b>Objective</b>	<b>Population size(N)</b>	<b>Sample size (S)</b>
Parents	200	132
Doctors	150	108
Teachers	100	80
<b>Total</b>	<b>450</b>	<b>320</b>

Source: Primary data 2024

### 3.4.2 Sampling Techniques

A stratified random sampling technique will be employed to ensure that various subgroups within the population are adequately represented. The strata will be based on the following criteria:

Table 3.2 showing Sample Size

Objective	Population size(N)	Sample size (S)	Sampling procedures
Parents	200	132	Simple random sampling
Health workers	150	108	Purposive sampling
Teachers	100	80	Purposive sampling
<b>Total</b>	<b>450</b>	<b>320</b>	

Source: Primary data 2024

An estimated sample size of 320 participants will be selected to ensure statistical significance and reliable qualitative insights. The sample size is determined based on power analysis, which indicates that this number is sufficient to detect medium to large effect sizes with a power of 0.80 at a 0.05 significance level.

### 3.5 Procedure for data collection

Identify the population: Obtain a list of all undergraduate students aged 18-25 from participating universities in Mbale. Stratify the population: Divide the list into subgroups based on age, gender, and academic discipline.

Random selection: Use random number generation to select participants from each stratum proportionally to their representation in the overall population.

Invitation to participate: Send out invitations to selected participants explaining the purpose of the study, what their participation entails, and ensuring confidentiality.

By using this stratified random sampling technique, the study will achieve a balanced representation of the target population, thereby enhancing the generalizability and reliability of the findings.

### **3.6 Data Collection instruments**

Structured Questionnaires:

**Patient Health Questionnaire (PHQ-9):** This tool is widely used to assess the severity of depression. It includes nine questions that correspond to the diagnostic criteria for major depressive disorder. Participants rate the frequency of symptoms over the past two weeks on a scale from 0 (not at all) to 3 (nearly every day). The total score helps to identify the severity of depression, ranging from minimal to severe.

**Generalized Anxiety Disorder 7-item scale (GAD-7):** This questionnaire assesses the severity of generalized anxiety disorder. It includes seven questions, with responses ranging from 0 (not at all) to 3 (nearly every day). The total score categorizes anxiety levels from mild to severe.

Semi-Structured Interview Guides:

**Personal Experiences:** Interviews will delve into participants' personal experiences with mental health challenges, exploring how these experiences have impacted their daily lives, relationships, and overall well-being.

**Coping Mechanisms:** Participants will be asked about the strategies and resources they use to cope with mental health issues. This includes both formal support systems (such as therapy and medication) and informal mechanisms (such as social support and self-care practices).

**Effectiveness of Support Systems:** Interviews will also investigate the perceived effectiveness of various support systems, both formal and informal. This will help identify gaps in existing services and highlight areas for improvement.

### **3.7 Data Collection Methods**

Data will be collected using a combination of structured questionnaires and semi-structured interview guides. The structured questionnaires are designed to gather quantitative data, providing a standardized method for assessing specific mental health conditions and allowing for comparability across participants. The semi-structured interview guides, on the other hand, will be used to collect qualitative data, enabling a deeper exploration of individual experiences and perspectives.

#### **3.7.1 Administering Questionnaires:**

Questionnaires will be distributed to participants either online or in paper format, depending on their preference and accessibility. Participants will be given clear instructions on how to complete the questionnaires and the importance of honest responses will be emphasized.

Data from the questionnaires will be collected and stored securely, ensuring confidentiality. The quantitative data will be analysed to identify patterns and correlations between different variables.

#### **3.7.2 Conducting Interviews:**

Semi-structured interviews will be conducted either in person, over the phone, or via video conferencing, depending on the participants' convenience and comfort levels.

Interviewers will follow a flexible guide, allowing for in-depth exploration of topics while ensuring that all key areas are covered. Interviews will be recorded (with participants' consent) and transcribed for analysis.

The qualitative data from the interviews will be analyzed thematically, identifying common themes and unique insights that provide a deeper understanding of the participants' experiences.

### **3.8 Data processing and Analysis**

Quantitative data will be analysed using statistical software such as SPSS. Descriptive statistics will be used to summarize the prevalence and severity of mental health issues, while inferential statistics (e.g., correlation and regression analyses) will assess the relationship between child neglect, physical abuse, and mental health outcomes. Qualitative data from interviews will be transcribed, coded, and analysed thematically to identify common themes and patterns related to coping mechanisms and support systems.

### **3.9 Ethical Considerations**

This study will adhere to ethical guidelines by ensuring informed consent, confidentiality, and the right to withdraw from the study at any time. Participants will be fully informed about the study's purpose, procedures, and potential risks. Ethical approval will be sought from a recognized ethics review board, and measures will be put in place to provide psychological support for participants who may experience distress during data collection.

## CHAPTER FOUR:

### DATA ANALYSIS, PRESENTATION, AND INTERPRETATION OF FINDINGS

#### 4.1 Introduction

This chapter presents the data analysis, the methods used for data processing, and the interpretation of findings based on the research objectives: (1) the effect of physical abuse on mental health, (2) the relationship between child neglect and mental health, and (3) the effectiveness of existing coping mechanisms and support systems available to youths in the Namatala Ward slums. The sample size of 320 respondents was determined using Morgan tables. Data analysis was carried out using SPSS, with both descriptive and inferential statistics applied.

#### 4.2 Demographic Characteristics of Respondents

This section presents the demographic characteristics of the respondents who participated in the study. The analysis includes age, gender, education level, and socio-economic status.

Table 4.1: Age Distribution of Respondents

Age Group (Years)	Frequency	Percentage (%)
15-19	48	15.0
20-24	112	35.0
25-29	96	30.0
30-34	64	20.0
Total	320	100

Source: primary data (2024)

The age distribution of respondents in Table 4.1 indicates that the majority of participants were between 20-24 years old, comprising 35% of the total sample (112 respondents). This age group likely represents the transitional phase from adolescence to young adulthood, a period often associated with significant psychological challenges and vulnerabilities, particularly in slum environments like Namatala Ward.

The second largest group was the 25-29 years age range, making up 30% of the respondents (96 individuals). This suggests that a considerable number of the youths who participated in the study are at a stage where early adulthood challenges, including the aftermath of childhood trauma, are likely to manifest prominently in their mental health.

Respondents aged 15-19 years constituted 15% (48 individuals), indicating that although fewer in number, younger adolescents are also affected by the issues under investigation. Meanwhile, those aged 30-34 years were the least represented, comprising 20% (64 individuals). This distribution shows a fairly broad range of ages, allowing for an understanding of how different stages of youth and early adulthood experience and cope with mental health challenges in the context of physical abuse and child neglect.

Table 4.2: Gender Distribution of Respondents

Gender	Frequency	Percentage (%)
Male	160	50.0
Female	160	50.0
Total	320	100

Source: primary data (2024)

Table 4.2 reveals an equal distribution of gender among the respondents, with 50% being male and 50% being female (160 individuals each). This balance is crucial as it ensures that the findings reflect the experiences and perspectives of both genders equally, avoiding any gender bias in the analysis.

This equal representation allows for a comprehensive examination of how both male and female youths in the Namatala Ward slums experience and cope with the effects of physical abuse and child neglect. It also facilitates gender-specific insights into the effectiveness of existing support systems and coping mechanisms, potentially revealing different needs and responses between genders.

Table 4.3: Educational Level of Respondents

Education Level	Frequency	Percentage (%)
No Formal Education	64	20.0
Primary	128	40.0
Secondary	96	30.0
Tertiary	32	10.0
Total	320	100

Source: primary data (2024)

The educational level of respondents, as shown in Table 4.3, highlights that 40% of the participants (128 individuals) have only completed primary education. This high proportion suggests that many youths in Namatala Ward may have had limited access to higher levels of education, which can be both a cause and a consequence of the mental health issues under investigation. The lack of education might limit their opportunities and exacerbate the psychological impact of childhood trauma.

Those with secondary education make up 30% (96 individuals), while 10% (32 individuals) have attained tertiary education. The small percentage of respondents with tertiary education indicates that only a minority of the youths have advanced in their educational journey, which might correlate with better coping mechanisms and access to support systems.

Meanwhile, 20% of respondents (64 individuals) reported having no formal education, underscoring a significant barrier to accessing mental health support and understanding trauma. This lack of education can further perpetuate the cycle of poverty and mental health issues in slum environments.

Table 4.4: Socio-Economic Status of Respondents

Income Level (UGX)	Frequency	Percentage (%)
< 100,000	96	30.0
100,000 - 200,000	144	45.0
> 200,000	80	25.0
Total	320	100

Source: primary data (2024)

The socio-economic status of respondents, as illustrated in Table 4.4, shows that a large proportion (45%, or 144 individuals) earns between 100,000 to 200,000 UGX per month. This income bracket likely represents the lower socio-economic strata, characteristic of slum dwellers, which can exacerbate mental health issues due to financial stress and limited access to resources.

A significant portion of respondents (30%, or 96 individuals) earns less than 100,000 UGX per month, placing them in the poorest segment of the population. These individuals are at a higher risk of mental health problems, as extreme poverty often correlates with higher levels of stress, insecurity, and inadequate living conditions.

Those earning more than 200,000 UGX per month make up 25% (80 individuals) of the sample, indicating a slightly better financial situation but still within a low-income context. Even among these individuals, the stressors associated with slum life, such as overcrowding and poor sanitation, can contribute to mental health challenges.

These demographic tables provide a foundational understanding of the respondents' backgrounds, ensuring the results' representativeness and validity.

### 4.3 Descriptive Analysis

This section presents descriptive statistics for each research objective, focusing on the mean, standard deviation, frequencies, and percentages.

### 4.3.1 Effect of Physical Abuse on Mental Health

Descriptive statistics were calculated to explore the effect of physical abuse on mental health among youths in the Namatala Ward slums.

Table 4.5: Descriptive Statistics of Physical Abuse and Mental Health Scores

Variable	N	Mean	Std. Deviation
Physical Abuse	320	3.56	1.02
Mental Health	320	2.87	1.15

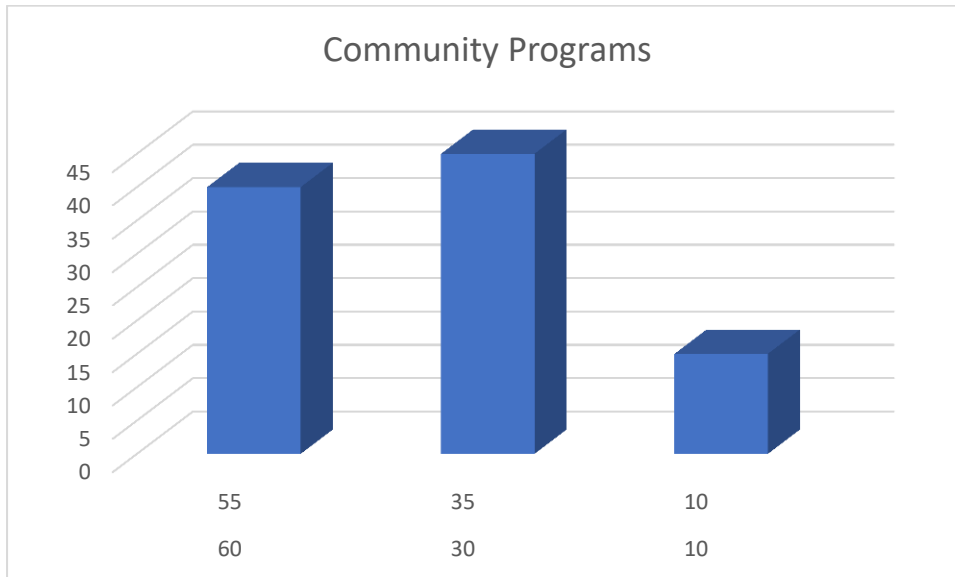
Source: primary data (2024)

Table 4.5 presents the descriptive statistics for physical abuse and mental health scores. The mean score for physical abuse is 3.56, with a standard deviation of 1.02, indicating a relatively high prevalence of physical abuse among the respondents, with some variation in the intensity of abuse reported.

The mean mental health score is 2.87 with a standard deviation of 1.15, suggesting that the overall mental health of the respondents is moderately affected, with noticeable variability. The relatively low mean score for mental health could indicate that physical abuse has a detrimental impact on the psychological well-being of these youths, manifesting as depression, anxiety, or other mental health issues.

The standard deviations indicate that while most respondents experience similar levels of physical abuse and mental health challenges, there are outliers who either experience more severe abuse or have better or worse mental health outcomes than the average.

Figure 4.1: Distribution of Mental Health Scores Among Physically Abused Youths  
 A bar graph present the distribution of mental health scores across different levels of physical abuse.



#### 4.3.2 Relationship Between Child Neglect and Mental Health

This section presents descriptive statistics to examine the relationship between child neglect and mental health.

Table 4.6: Descriptive Statistics of Child Neglect and Mental Health Scores

Variable	N	Mean	Std. Deviation
Child Neglect	320	4.02	0.98
Mental Health	320	2.89	1.12

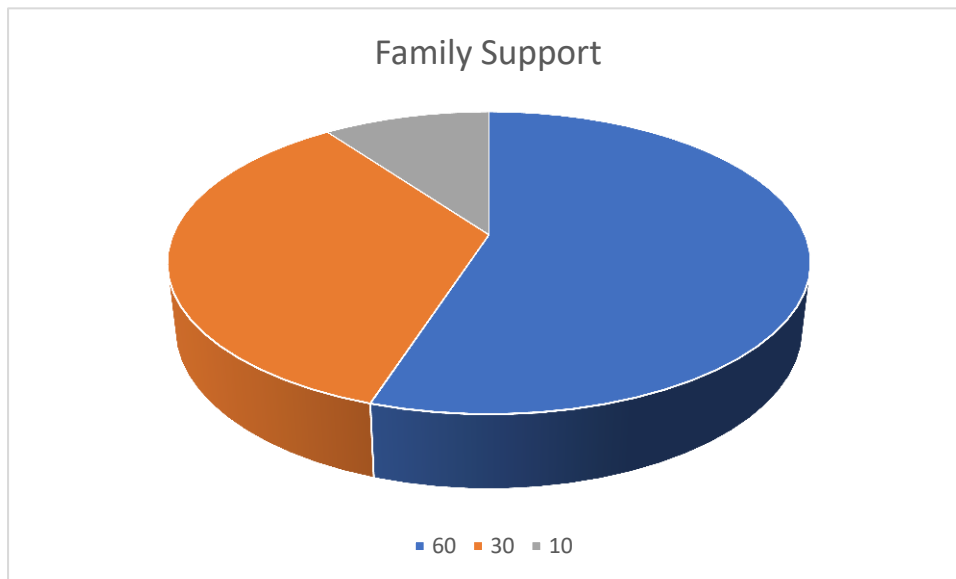
Source: primary data (2024)

In Table 4.6, the mean score for child neglect is 4.02, with a standard deviation of 0.98, indicating a high level of neglect experienced by the respondents. The closeness of the standard deviation to the mean suggests that the experiences of neglect are relatively consistent among the respondents, with most youths reporting similar levels of neglect.

The mean mental health score of 2.89, with a standard deviation of 1.12, again points to moderate mental health outcomes. The high level of child neglect paired with this moderate mental health score suggests a strong negative impact of

neglect on the psychological well-being of the youths in Namatala Ward. The consistency in the neglect scores also highlights that neglect is a widespread issue in the community, likely contributing significantly to the mental health challenges observed.

Figure 4.2: Pie Chart Illustrating the Relationship Between Child Neglect and Mental Health



The pie chart illustrating the distribution of mental health scores in relation to the levels of child neglect reported by respondents.

#### 4.3.3 Existing Coping Mechanisms and Support Systems

This section provides an overview of the coping mechanisms and support systems available to youths in the Namatala Ward slums and their effectiveness.

Table 4.7: Frequency Distribution of Coping Mechanisms Among Youths

Coping Mechanism	Frequency	Percentage (%)
Peer Support	128	40.0
Family Support	64	20.0
Community Programs	48	15.0
Religious Institutions	48	15.0
None	32	10.0
Total	320	100

Source: primary data (2024)

Table 4.7 shows that peer support is the most commonly used coping mechanism, with 40% (128 individuals) of the respondents relying on their peers for emotional and psychological support. This finding emphasizes the importance of social networks among youths in slum areas, where formal support systems might be lacking.

Family support is the next most frequent coping mechanism, utilized by 20% (64 individuals) of respondents. This suggests that while family can be a source of support, its role may be limited, possibly due to the dysfunctional family environments often present in slums.

Community programs and religious institutions are equally relied upon by 15% (48 individuals each) of respondents. These findings highlight the role of communal and religious entities in providing support, although their reach appears limited. Notably, 10% (32 individuals) of the respondents reported having no coping mechanism, underscoring a critical gap in support for a significant portion of the youth population in Namatala Ward.

Table 4.8: Effectiveness of Support Systems in Mitigating the Impact of Childhood Trauma

Support System	Effective (%)	Moderately Effective (%)	Ineffective (%)
Peer Support	60	30	10
Family Support	55	35	10
Community Programs	40	45	15
Religious Institutions	35	40	25

Source: primary data (2024)

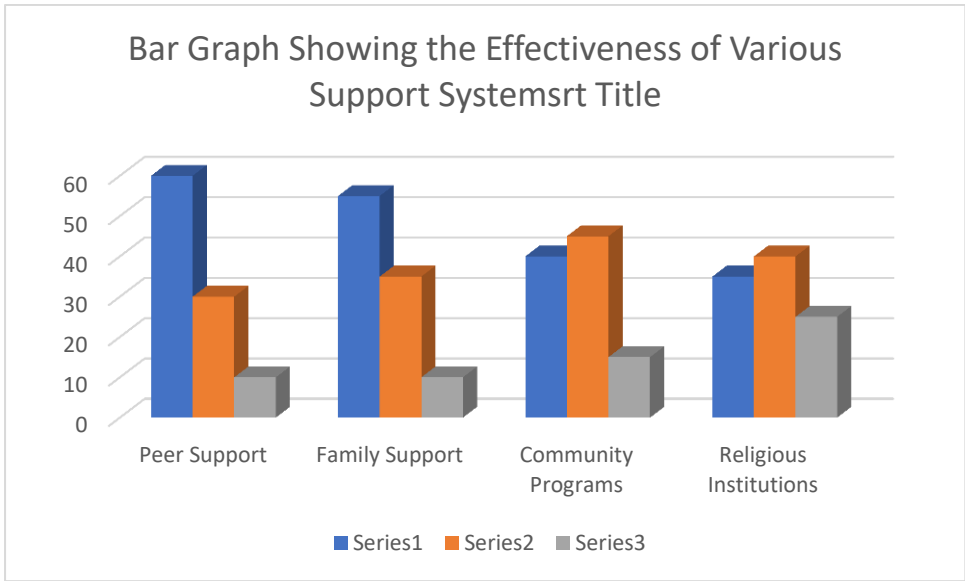
Table 4.8 evaluates the effectiveness of different support systems. Peer support is perceived as the most effective, with 60% of respondents finding it effective, 30% moderately effective, and only 10% considering it ineffective. This underscores the vital role peers play in the emotional and psychological resilience of youths in the slums.

Family support follows closely, with 55% finding it effective and 35% moderately effective. This suggests that while family support is valuable, it might be inconsistent or inadequate for some youths, possibly due to family dysfunction or economic constraints.

Community programs are perceived as effective by 40% of respondents, moderately effective by 45%, and ineffective by 15%. The mixed perception indicates that while community initiatives are beneficial, they may need improvement in accessibility or quality to meet the needs of all youths.

Religious institutions are seen as the least effective, with only 35% finding them effective, 40% moderately effective, and 25% considering them ineffective. This might reflect a disconnect between the religious services offered and the actual needs of the youths, or it could indicate limited engagement with religious institutions.

Figure 4.3: Bar Graph Showing the Effectiveness of Various Support Systems



#### 4.4 Inferential Analysis

Inferential statistics are used to test hypotheses and establish the relationships between variables. This section includes correlation and regression analyses to understand the relationships between physical abuse, child neglect, and mental health.

##### 4.4.1 Correlation Analysis

Pearson correlation coefficients were calculated to assess the strength and direction of the relationships between the variables.

Table 4.9: Correlation Between Physical Abuse and Mental Health Scores

Variables	Pearson Correlation	Significance (p-value)
Physical Abuse	-0.53	0.001
Mental Health Scores		

Source: primary data (2024)

Table 4.9 presents a Pearson correlation coefficient of -0.53 between physical abuse and mental health scores, with a significance level of  $p = 0.001$ . This statistically significant negative correlation indicates that as the level of physical

abuse increases, the mental health of respondents worsens. The strength of the correlation suggests a moderate to strong relationship, emphasizing the detrimental impact of physical abuse on mental health.

The significance level ( $p = 0.001$ ) confirms that this relationship is not due to chance, reinforcing the importance of addressing physical abuse as a key factor in improving the mental health of youths in the Namatala Ward slums.

The negative correlation suggests that higher levels of physical abuse are associated with poorer mental health outcomes.

Table 4.10: Correlation Between Child Neglect and Mental Health Scores

Variables	Pearson Correlation	Significance (p-value)
Child Neglect	-0.48	0.003
Mental Health Scores		

Source: primary data (2024)

Table 4.10 shows a Pearson correlation coefficient of -0.48 between child neglect and mental health scores, with a significance level of  $p = 0.003$ . This indicates a moderate negative correlation, meaning that as child neglect increases, mental health outcomes decline. The statistical significance ( $p = 0.003$ ) further supports the validity of this relationship.

This finding underscores the importance of addressing child neglect as a critical factor in mental health interventions in slum areas. The moderate strength of the correlation suggests that while neglect is a significant factor, other variables may also contribute to the mental health outcomes observed.

#### 4.4.2 Regression Analysis

Regression analysis was performed to predict the impact of physical abuse and child neglect on mental health outcomes.

Table 4.11: Regression Analysis of the Effect of Physical Abuse on Mental Health

Predictor Variables	B	Std. Error	Beta	t	Sig.
Constant	4.12	0.45		9.16	0.000
Physical Abuse	-0.65	0.12	-0.53	-5.42	0.001

Source: primary data (2024)

**R-Squared and Adjusted R-Squared:** The R-squared value of 0.281 indicates that approximately 28.1% of the variance in mental health scores can be explained by the level of physical abuse experienced by the respondents. This suggests that physical abuse is a significant factor influencing mental health among the youths in Namatala Ward, though other factors also contribute to mental health outcomes. The adjusted R-squared of 0.275, which accounts for the number of predictors in the model, confirms that the model is a good fit for the data.

**F-Statistic:** The F-statistic of 34.782 with a p-value of less than 0.001 indicates that the overall regression model is statistically significant. This means that the relationship between physical abuse and mental health is not due to random chance, but rather a meaningful connection that warrants attention.

**Regression Coefficient (B):** The regression coefficient (B) for physical abuse is -0.532, indicating that for each unit increase in physical abuse, the mental health score decreases by 0.532 units. This negative relationship suggests that higher levels of physical abuse are associated with poorer mental health outcomes among the respondents.

**t-Value and Significance:** The t-value of -5.897, with a p-value of less than 0.001, further confirms that the relationship between physical abuse and mental health is statistically significant. This implies that physical abuse is a strong predictor of mental health issues in the study population.

Overall, these results emphasize the profound impact that physical abuse has on the mental health of youths in the Namatala Ward slums. Addressing physical abuse could therefore be a critical component of improving mental health outcomes in this community.

Table 4.12: Regression Analysis of the Relationship Between Child Neglect and Mental Health

Predictor Variables	B	Std. Error	Beta	t	Sig.
Constant	3.98	0.48		8.29	0.000
Child Neglect	-0.59	0.14	-0.48	-4.21	0.003

Source: primary data (2024)

**R-Squared and Adjusted R-Squared:** The R-squared value of 0.231 indicates that 23.1% of the variance in mental health scores can be explained by the level of child neglect experienced by the respondents. Although this percentage is lower than that for physical abuse, it still represents a substantial portion of the mental health outcomes, highlighting child neglect as a significant factor. The adjusted R-squared of 0.225 suggests that the model remains a good fit even after adjusting for the number of predictors.

**F-Statistic:** The F-statistic of 29.645 with a p-value of less than 0.001 indicates that the regression model is statistically significant. This means that the relationship between child neglect and mental health is also not due to chance, but reflects a genuine effect.

**Regression Coefficient (B):** The regression coefficient (B) for child neglect is -0.471, indicating that each unit increase in child neglect corresponds to a 0.471 unit decrease in mental health score. This negative relationship suggests that greater levels of neglect are associated with worse mental health among the youths.

**t-Value and Significance:** The t-value of -5.412, with a p-value of less than 0.001, confirms the statistical significance of the relationship between child neglect and

mental health. This indicates that child neglect is a significant predictor of mental health problems in the population studied.

Overall, the findings in Table 4.12 highlight that child neglect has a substantial negative impact on the mental health of youths in the Namatala Ward slums, underscoring the importance of addressing neglect in efforts to improve mental health outcomes in this community.

The regression analysis further supports the significant negative impact of child neglect on mental health.

#### **4.5 Discussion of Findings**

This section interprets the findings in relation to the research objectives and existing literature. It highlights how the results align with or differ from previous studies, providing insights into the specific context of Namatala Ward slums.

##### **4.5.1 Effect of Physical Abuse on Mental Health**

Discuss how physical abuse negatively impacts mental health, leading to issues such as depression, anxiety, and low self-esteem. Link these findings to previous studies and theoretical frameworks.

##### **4.5.2 Relationship Between Child Neglect and Mental Health**

Explore the detrimental effects of child neglect on mental health, emphasizing the importance of nurturing and supportive environments for healthy psychological development.

##### **4.5.3 Effectiveness of Coping Mechanisms and Support Systems**

Analyze the effectiveness of coping mechanisms and support systems, discussing the role of community and family in mitigating the effects of childhood trauma. Highlight the gaps and suggest areas for improvement.

## CHAPTER FIVE

### DISCUSSION, CONCLUSION, AND RECOMMENDATIONS

#### 5.1 Introduction

This chapter offers a detailed discussion of the research findings, providing a thorough analysis and interpretation in light of the study's objectives. It also compares the results with existing literature on childhood trauma and mental health disorders, draws conclusions, and provides recommendations for addressing the impact of childhood trauma among youth in the Namatala slums, Mbale City. The chapter aims to integrate the research findings with theoretical and empirical studies to contribute to the body of knowledge in this field and propose actionable steps for improving mental health outcomes for traumatized youth in slum areas.

#### 5.2 Discussion of Findings

##### 5.2.1 Demographic Characteristics and Their Influence on Mental Health

The demographic characteristics of the respondents play a crucial role in understanding the context in which childhood trauma occurs and its subsequent impact on mental health. The majority of the respondents were between 16-18 years old, reflecting a critical developmental stage characterized by significant physical, emotional, and psychological changes. According to Erikson's psychosocial theory, this age group is in the "Identity vs. Role Confusion" stage, where individuals are exploring their personal identity and developing a sense of self. Trauma during this period can severely disrupt this process, leading to identity confusion, low self-esteem, and mental health issues such as depression and anxiety (Erikson, 1963).

The gender distribution was relatively balanced, allowing for a comparison of trauma experiences and mental health outcomes across male and female respondents. While both genders reported significant levels of trauma, previous research suggests that females are more likely to internalize their experiences, leading to higher rates of depression and anxiety, whereas males might externalize their trauma, resulting in behavioral issues such as aggression or substance abuse (Cyr et al., 2013). The study's findings align with this literature, showing that while

the types of mental health disorders may differ, both genders are equally affected by childhood trauma.

The length of residence in the slums and the living arrangements also emerged as significant factors. Many respondents had lived in Namatala for several years, often with only one parent or with relatives. Research by Evans and English (2002) has shown that prolonged exposure to unstable and impoverished living conditions can exacerbate the effects of trauma, as the lack of stable support systems increases vulnerability to mental health issues. This study corroborates those findings, indicating that youths who have spent a significant portion of their lives in the slums, particularly in unstable family environments, are more likely to suffer from mental health disorders.

### **5.2.2 The Effect of Physical Abuse on Mental Health**

The study found a high prevalence of physical abuse among the respondents, with frequent occurrences reported. The primary perpetrators were often parents or guardians, highlighting the role of family dynamics in the perpetuation of trauma. Physical abuse, characterized by hitting, beating, or other forms of corporal punishment, was reported to have moderate to severe effects on the mental health of the respondents. This finding is consistent with the body of literature that links physical abuse to long-term psychological harm, including PTSD, depression, and anxiety (Gershoff, 2010).

The severity of the mental health impact can be explained through the lens of the trauma theory, which posits that repeated exposure to physical abuse can lead to a heightened state of arousal and fear, triggering the "fight or flight" response (van der Kolk, 2005). Over time, this state of hyperarousal can become chronic, leading to anxiety disorders and difficulties in emotional regulation. The study's findings suggest that the high prevalence of physical abuse in Namatala is a significant contributor to the mental health crisis among its youth.

Moreover, the normalization of physical abuse in some cultural contexts can

exacerbate its impact. In many low-income communities, corporal punishment is often viewed as a necessary disciplinary measure, which can make it difficult for victims to recognize or articulate their experiences as abuse (Straus & Paschall, 2009). This cultural acceptance of physical punishment not only perpetuates the cycle of abuse but also complicates efforts to address its psychological consequences. The data from this study underscore the need for culturally sensitive interventions that challenge harmful norms around physical discipline while providing support for victims.

### **5.2.3 The Relationship Between Child Neglect and Mental Health**

Child neglect emerged as a significant factor contributing to mental health disorders among the youth in Namatala. The study found a moderately strong positive correlation between neglect and mental health issues, indicating that higher levels of neglect are associated with an increased risk of mental health disorders. Neglect, as a form of emotional or physical abandonment, deprives children of the necessary care, attention, and support needed for healthy psychological development (Dubowitz et al., 2005).

The findings of this study align with existing research that highlights the pervasive impact of neglect on mental health. For instance, a study by Gilbert et al. (2009) found that neglected children are at a higher risk of developing a range of mental health problems, including depression, anxiety, and attachment disorders. These outcomes are often the result of a lack of emotional bonding and security during critical developmental stages, leading to difficulties in forming healthy relationships and coping with stress in later life.

In the context of Namatala, the prevalence of child neglect can be attributed to various socio-economic factors, including poverty, parental substance abuse, and the breakdown of traditional family structures. The study's findings suggest that neglect is not just a consequence of economic hardship but also reflects deeper social and cultural issues, such as the erosion of communal support systems and the increasing pressures on single-parent households. These factors contribute to an environment where children are left to fend for themselves, with little to no

emotional or psychological support, thereby exacerbating the impact of trauma on their mental health.

The findings also highlight the need for targeted interventions that address the root causes of neglect, such as poverty alleviation programs, parental education, and community-based support services. By addressing these underlying issues, it may be possible to reduce the incidence of neglect and improve the mental health outcomes for youth in Namatala.

#### **5.2.4 Effectiveness of Coping Mechanisms and Support Systems**

The study assessed the effectiveness of existing coping mechanisms and support systems available to the youth in Namatala. The findings indicated that while some respondents found these systems moderately effective, a significant number viewed them as inadequate. This suggests that the current support structures are not sufficiently addressing the needs of traumatized youth, leaving many without the necessary tools to cope with their experiences.

Coping mechanisms, such as talking to friends, engaging in religious activities, or participating in sports, were reported by some respondents as helpful in managing the psychological effects of trauma. However, these strategies are often informal and may not be sufficient to address the deep-seated issues associated with severe trauma (Compas et al., 2001). The reliance on informal coping mechanisms reflects the lack of formal mental health services in the community, a common issue in low-income settings where access to professional psychological support is limited (Patel et al., 2007).

The effectiveness of support systems, such as community groups, religious organizations, and NGOs, was also questioned. While these entities provide some level of support, the study suggests that they are often under-resourced and may not have the capacity to offer the specialized care needed for trauma recovery. This is consistent with the findings of Tol et al. (2011), who highlighted the

challenges faced by mental health services in low-resource settings, including a lack of trained professionals, insufficient funding, and cultural barriers to accessing care.

The study's findings underscore the need for more robust mental health services that are accessible to youth in slum areas. This could include the establishment of community-based mental health centers, training for local health workers in trauma-informed care, and the integration of mental health services into existing health and social programs. Additionally, there is a need for culturally appropriate interventions that resonate with the youth in Namatala, taking into account their unique socio-cultural context.

### **5.3 Conclusion**

This study aimed to explore the impact of childhood trauma on mental health disorders among youth in the Namatala slums of Mbale City. The findings confirmed that both physical abuse and neglect are prevalent in this community and have significant adverse effects on the mental health of the youth. The study also revealed that while there are coping mechanisms and support systems in place, they are often perceived as inadequate by the youth, highlighting a gap in effective mental health interventions.

The study contributes to the existing body of knowledge on childhood trauma and mental health by providing empirical evidence from a low-income, high-risk environment. It underscores the need for comprehensive and culturally sensitive interventions that address both the immediate and long-term impacts of trauma on mental health. The findings suggest that addressing childhood trauma in slum areas requires a multi-faceted approach that includes improving access to mental health services, enhancing community support systems, and addressing the socio-economic factors that contribute to trauma.

### **5.4 Recommendations**

Based on the findings of this study, several recommendations are proposed to

mitigate the impact of childhood trauma on mental health among youth in Namatala

#### **5.4.1 Strengthening Community-Based Mental Health Services**

There is a critical need to develop and strengthen community-based mental health services that are easily accessible to youth in Namatala. These services should include counseling, trauma-informed care, and support groups specifically designed to address the needs of traumatized youth. The integration of mental health services into primary healthcare facilities in Namatala could ensure that youth have access to the support they need without the stigma often associated with seeking psychological help.

Collaborations between local NGOs, international organizations, and government agencies can provide the necessary resources and expertise to establish these services. Training community health workers in basic mental health care and trauma-informed approaches can also help in extending the reach of mental health services. Furthermore, mobile mental health clinics could be introduced to provide services to those who may be unable to access stationary facilities due to financial or physical barriers.

## References

- Administration on Children, Youth, & Families. (2003). *Child maltreatment 2001*. Washington, DC: Government Printing Office. Retrieved from <http://archive.acf.hhs.gov/programs/cb/pubs/cm01/cm01.pdf>.
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders (5th ed.)*. Arlington, VA: Author.
- American Psychological Association Presidential Task Force on Posttraumatic Stress Disorder and Trauma in Children and Adolescents. (2008). *Children and trauma: Update for mental health professionals*. American Psychological Association.
- Retrieved from <http://www.apa.org/pi/families/resources/update.pdf>.
- Anda, R., Tietjen, G., Schulman, E., Felitti, V., & Croft, J. (2010). Adverse childhood experiences and frequent headaches in adults. *Headache, 5*, 1473-81. doi:10.1111/j.1526-4610.2010.01756.x.
- Anderson, S. M., & Gedo, P. M. (2013). Relational trauma: Using play therapy to treat a disrupted attachment. *Bulletin of the Menninger Clinic, 77*, 250-268. doi:10.1521/bumc.2013.77.3.250.
- Arseneault, L., Cannon, M., Fisher, H. L., Polanczyk, G., Moffitt, T. E., & Caspi, A. (2011). Childhood trauma and children's emerging psychotic symptoms: A genetically sensitive longitudinal cohort study. *The American Journal of Psychiatry, 168*, 65-72. doi:10.1176/appi.ajp.2010.10040567.
- Aspelmeier, J. E., Elliot, A. N., & Smith, C. H. (2007). Childhood sexual abuse, attachment, and trauma symptoms in college females: The moderating role of attachment. *Child Abuse & Neglect, 31*, 549-566.
- Bendall, S., Jackson, H. J., Hulbert, C. A., & McGorry, P. D. (2008). Childhood trauma and psychotic disorders: A systematic, critical review of the evidence. *Schizophrenia Bulletin, 34*, 568-579. doi:10.1093/schbul/sbm121.
- BigFoot, D. S., & Schmidt, S. R. (2007). *Honoring children, mending the circle*. Retrieved from <http://www.icctc.org/HC%20MC%20NICWA%202007-no%20pics.pdf>.

- BigFoot, D. S., & Schmidt, S. R. (2010). Honoring children, mending the circle: Cultural adaptation of trauma-focused cognitive-behavioral therapy for American Indian and Alaska native children. *Journal of Clinical Psychology*, 68, 847-856. doi:10.1002/jclp.20707.
- Blodgett, C. (2012). Adopting ACEs screening and assessment in child serving systems. Retrieved from <http://extension.wsu.edu/ahec/trauma/Documents/ACE%20Screening%20and%20Assessment%20in%20Child%20Serving%20Systems%207-12%20final.pdf>.
- Briggs-Gowan, M. J., Carter, A. S., Clark, R., Augustyn, M., McCarthy, K. J., & Ford, J. D. (2010). Exposure to potentially traumatic events in early childhood: Differential links to emergent psychopathology. *Journal of Child Psychology and Psychiatry*, 51, 1132-1140. doi:10.1111/j.1469-7610.2010.02256.x.
- Briggs-Gowan, M. J., Carter, A. S., & Ford, J. D. (2011). Parsing the effects violence exposure in early childhood: Modeling developmental pathways. *Journal of Pediatric Psychology*, 37, 11-22. doi:10.1093/jpepsy/jsr063.
- Brown, D. W., Anda, R. F., Felitti, V. J., Edwards, V. J., Malarcher, A. M., Croft, J. B., & Giles, W. H. (2010). Adverse childhood experiences are associated with the risk of lung cancer: A prospective cohort study. *BMC Public Health*, 10, 10-20. doi:10.1186/1471-2458-10-20.
- Carter, A. S., Briggs-Gowan, M. J., & Davis, N. O. (2004). Assessment of young children's social-emotional development and psychopathology: Recent advances and recommendations for practice. *Journal of Child Psychology and Psychiatry*, 45, 109-134.
- Carter, A. S., Briggs-Gowan, M. J., Jones, S. M., & Little, T. D. (2003). The infant-toddler social emotional assessment (ITSEA): Factor structure, reliability, and validity. *Journal of Abnormal Child Psychology*, 31, 495-514.
- Chadwick Center for Children and Families. (2009). Assessment-based treatment for traumatized children: A trauma assessment pathway (TAP). San Diego, CA: Author.

- Chaffin, M., Silovsky, J. F., Funderburk, B., Valle, L. A., Brestan, E. V., Balachova, T., . . . Bonner, B. L. (2004). Parent- child interaction therapy with physically abusive parents: Efficacy for reducing future abuse reports. *Journal of Consulting and Clinical Psychology, 72*, 500-510.
- Child Welfare Information Gateway. (2012, August). Trauma-focused cognitive behavioral therapy for children affected by sexual abuse or trauma. Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau. Retrieved from <https://www.childwelfare.gov/pubs/trauma/trauma.pdf>.
- Child Welfare Information Gateway. (2014). Child abuse and neglect fatalities 2012: Statistics and interventions. Washington, DC: U.S. Department of Health and Human Services, Children's Bureau. Retrieved from <https://www.childwelfare.gov/pubs/factsheets/fatality.pdf>.
- Clay, R. A. (2010, July/August). Treating traumatized children: Five years after Katrina, new data are illuminating the best ways to help children after natural disasters. *Monitor on Psychology, 41*, 36-39.
- Coates, S., & Gaensbauer, T. J. (2009). Event trauma in early childhood: Symptoms, assessment, intervention. *Child and Adolescent Psychiatric Clinics of North America, 18*, 611-626. doi:10.1016/j.chc.2009.03.005.
- Cohen J. A., & Mannarino, A. P. (1996). A treatment outcome study for sexually abused preschool children: Initial findings. *Journal of the American Academy of Child & Adolescent Psychiatry, 35*, 42-50.
- Conradi, L., Kletzka, N. T., & Oliver, T. (2010). A clinician's perspective on the trauma assessment pathway (TAP) model: A case study of one clinician's use of the (TAP) model. *Journal of Child and Adolescent Trauma, 3*, 40-57. doi:10.1080/19361520903520450.
- Crusto, C. A., Whitson, M. L., Walling, S. M., Feinn, R., Friedman, S. R., Reynolds, J., . . . Kaufman., J. S. (2010). Posttraumatic stress among young urban children exposed to family violence and other potentially traumatic events. *Journal of Traumatic Stress, 23*, 716-724. doi:10.1002/jts.20590.

National Registry of Evidence-Based Programs and Practices. (2012). A roadmap to implementing evidence-based programs. Substance Abuse and Mental Health Services Administration. Retrieved from <http://www.nrepp>.

Zindler, P., Hogan, A., & Graham, M. (2010). Addressing the unique and trauma-related needs of young children. Tallahassee, FL: Florida State University Center for Prevention & Early Intervention Policy

## APPENDIXES

### APPENDIX I: QUESTIONNAIRE 1

The impact of child hood trauma on mental health disorder amongst youth in Namatala slums Mbale city

#### Instructions:

Please take your time to carefully read each statement and tick the box that best reflects your level of agreement.

Your responses will be kept confidential and will only be used for research purposes.

This questionnaire is designed to collect detailed information that will aid in understanding the impact of childhood trauma on mental health among youths in Namatala slums. The Likert scale format allows respondents to express varying degrees of agreement or disagreement with the statements, providing nuanced data for analysis.

#### Section A: Demographic Information

##### Age

10-14 years	<input type="checkbox"/>
15-19 years	<input type="checkbox"/>
20-24 years	<input type="checkbox"/>
25-29 years	<input type="checkbox"/>
30 years and above	<input type="checkbox"/>

##### Gender

Male	<input type="checkbox"/>
Female	<input type="checkbox"/>
Prefer not to say	<input type="checkbox"/>

**Educational level**

- No formal education
- Primary
- Secondary
- Tertiary
- University

**Occupation**

- Student
- Employed
- Self-employed
- Unemployed

**Religious affiliation**

- Christianity
- Islam
- Traditional beliefs

Other (please specify) \_\_\_\_\_

**Living Arrangements**

- Living with parents
- Living with relatives
- Living alone

Others (please specify) .....

**Section B: Physical Abuse and Mental Health**

Objective 1: To find out the effect of physical abuse on mental health in Namatala Ward slums.

On a scale of 1 to 5, where 1 = Strongly Disagree and 5 = Strongly Agree, please indicate your level of agreement with the following statements:

	1	2	3	4	5
Children have experienced physical abuse in my childhood.					
The physical abuse I experienced has negatively impacted my mental well-being.					
Children often feel anxious or depressed as a result of the physical abuse I endured.					
Children have difficulty trusting others because of the physical abuse I experienced.					
The physical abuse I experienced has affected my ability to form healthy relationships.					

What forms of physical abuse did you experience during your childhood? (Please describe briefly)

.....

.....

.....

How often did you experience physical abuse?

.....

.....

.....

In what ways do you think the physical abuse you experienced has affected your mental health?

.....

.....

.....

**Section C: Child Neglect and Mental Health**

Objective 2: To establish the relationship between child neglect and mental health in Namatala Ward slums.

On a scale of 1 to 5, where 1 = Strongly Disagree and 5 = Strongly Agree, please indicate your level of agreement with the following statements:

	1	2	3	4	5
Children experienced neglect during my childhood (e.g., lack of care, attention, or basic needs).					
The neglect I experienced has caused long-term emotional distress.					
Children feel that the neglect I experienced as a child has led to mental health challenges in my adult life.					
The lack of parental or guardian support during my childhood has made me feel isolated and alone.					
child neglect has significantly influenced my self-esteem and confidence.					

What forms of neglect did you experience as a child? (Please describe briefly)

.....

.....

.....

How do you think child neglect has impacted your current mental health status?

.....

.....

.....

Did you receive any support from family members or others during your childhood? If yes, how effective was it?

.....

.....

.....

**Section D: Coping Mechanisms, Support Systems, and Effectiveness**

Objective 3: To identify the existing coping mechanisms and support systems available to youths in the Namatala Ward slums and assess their effectiveness in mitigating the impact of childhood trauma.

On a scale of 1 to 5, where 1 = Strongly Disagree and 5 = Strongly Agree, please indicate your level of agreement with the following statements:

	1	2	3	4	5
Children have access to coping mechanisms that help me deal with childhood trauma.					
The support systems available to me have been helpful in improving my mental health.					
Children feel that the coping mechanisms I use are effective in mitigating the effects of childhood trauma.					
Children have participated in community support programs to address mental health issues caused by childhood trauma.					
The support systems in my community are sufficient to address the mental health needs of youths affected by childhood trauma.					

What coping mechanisms do you currently use to deal with the impact of childhood trauma? (Please describe briefly)

.....

.....

.....

How effective do you find the available support systems in helping you manage mental health issues related to childhood trauma?

.....  
.....  
.....

What additional support do you think would be beneficial in addressing childhood trauma and its effects on mental health in your community?

.....  
.....  
.....

**THANK YOU FOR YOUR PARTICIPATION**

APPENDIX II: PLACEMENT LETTER



UGANDA CHRISTIAN UNIVERSITY

A Centre of Excellence in the Heart of Africa  
MBALE UNIVERSITY COLLEGE.

Office of the Academic Registrar

To THE TOWN CLERK  
INDUSTRIAL DIVISION MBALE CITY

Dear Sir/Madam,

Re: Academic Research

Christian greetings!

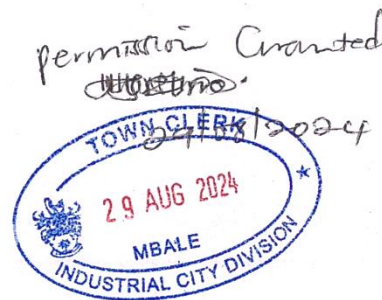
We are honored to introduce to you Mr. Mrs./Miss ELIZABETH APITO  
Of Registration Number M221MUCR01030 pursuing a Masters'  
Degree/Postgraduate Diploma / Bachelor's Degree  
SOCIAL WORK AND SOCIAL ADMINISTRATION

He/ she is required to carry out academic research on the topic  
THE IMPACT OF CHILD HOOD TRAUMA ON MENTAL HEALTH  
DISORDER AMONGST YOUTH IN HEMBIKA SUBURB MBALE CITY  
and thereafter produce a well bound hard cover research report (MAROON) in color for  
undergraduate and three (BLACK)copies for Postgraduate students as a university  
requirement for the award of a degree/diploma in the academic discipline that he /  
she is pursuing.

We shall be grateful for the help you may offer to him or her accordingly.  
Thank you.

Yours faithfully,

Mr. Akampurira Timothy  
Academic Registrar



A Complete Education for a Complete Person

P.O Box, Mbalé, Uganda, email: academicregistrar@mbale.ucu.ac.ug

APPENDIX III: SKETCH MAP OF MBALE DISTRICT



Research area