2022

The Experience of Providing Direct Care to Children Victims of Boko Haram Insurgencies in Nigeria

Felicia Etuke
Walden University

Walden University

College of Allied Health

This is to certify that the doctoral dissertation by

Felicia Etuke

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Review Committee
Dr. Kimberly McCann, Committee Chairperson, Psychology Faculty
Dr. Lucille Esralew, Committee Member, Psychology Faculty
Dr. Alethea Baker, University Reviewer, Psychology Faculty

Chief Academic Officer and Provost
Sue Subocz, Ph.D.

Walden University
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Abstract

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by

Felicia E. Etuke

PhD, Capella University, 2015

MA, Liberty University, 2009

BS, University of Calabar, Nigeria, 1994

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Clinical Psychology

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Abstract

The insurgency of terrorism leaves lasting economic, social, academics, spiritual, religious, and psychological effects, but often children's psychological welfare is neglected in the aftermath of terrorist attacks. Boko Haram's presence in Nigeria has left many children orphaned, displaced, and impoverished. Thus, there is a need to highlight the importance of the role that care providers play in securing the psychological health of the child victims of Boko Haram insurgency. This qualitative, phenomenological study explored the experiences of care providers to the child victims of Boko Haram insurgency in Nigeria. Compassion fatigue theory was used as a theoretical framework for the study to understand the participants' experiences in providing direct care to the minor victims of Boko Haram insurgency in Nigeria. Semistructured interviews were used to collect data from nine participants. Interviews were analyzed using Moustakas' modification of Van Kaam's process of analyzing phenomenological data through hand analysis. Results showed that prolonged exposure to narratives from minor victims of Boko Haram insurgencies led to vicarious trauma for the care providers. Based on the results, it is hoped that the work of mental health providers in Nigeria would be recognized nationally and globally and add evidence-based value to the care profession and literature leading to positive social change.

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Dedication

"This sickness will not end in death" (John 4:11, NIV).

I would like to dedicate my dissertation to my Jehovah Rophe (Rapha), the One who is able to heal all diseases. I want to testify that God still heals. When it was difficult to pick myself up and keep moving with the dissertation, He encouraged and strengthened me. Thank You, Father, for proving to me that You are a Promise Keeper. I remain eternally grateful to You!

I also dedicate this work to my family - my husband, Dr. Emmanuel Etuke, who is selfless in giving to humanity. Honey, you are my greatest cheerleader. You pushed me to pursue my second doctorate degree immediately after completing my first one. I am glad I listened to you! To our children, Oghenekaro and his precious wife, Mary, and Zoe, thank you for your continuous support and prayers and unconditionally accepting me. To my siblings, brother Obi Ina, Dr. Esther Ina-Egbe, Mrs. Grace Ndasi, Mrs. Mercy Nkyimbeng, and Mrs. Joy Ele Samuel, I remain grateful to you for your love, prayers, and support. To my in-laws, Mrs. Alice Etuke, Mr. Emmanuel Egbe, Dr. Takwi Nkyimbeng, Ma Comfort Ina, and my many nieces, nephews, cousins, aunts, and uncles, church family, friends, and colleagues, I am forever grateful to you. You prayed with and for me during very difficult times in my life without wavering.

Uncle Sam, I dedicate this doctoral degree to you. As painful as it is to remember that you are not here to witness the work you applauded, supported, and encouraged, with reverence to God, Who deemed it fit to call you Home at the time you departed, you will be forever missed. Adieu, Uncle Samuel Ele Asebe (1Thessalonians 4:13-18).

Acknowledgments

I would like to acknowledge and deeply thank my mentor and Committee Chair, Dr. Kimberly McCann, for believing in my ability to meet her high standards. Thank you for your encouragements through many telephone and conference calls, text messages, and emails. You genuinely pushed me to the finish line. Without your push, I do not believe that I could have been motivated to finish at the time I did. I am grateful!

To Dr. Lucy Esralew, thank you immensely for contributing positively to my academic journey. God handpicked you to be my methodologist and my committee member. Your gentle push and recommendations gave me the inspiration to keep going.

I want to deeply thank Dr. Alethea Baker, who served as my University Research Reviewer (URR) member. I appreciate your expedited review of my dissertation, and the guidance you provided me when I was still thinking about the topic. I still remember the discussions we had at the BAYRs in Minneapolis. I appreciate the wealth of knowledge you deposited in me.

Lastly, my deepest gratitude goes to the many unsung heroes who shared their experiences with me. No one can compensate you enough for the unconditional care you give to the vulnerable. Your work will not go unnoticed. I pray that God, who sees your work in secret, will reward you abundantly. Your work and consequent reward are heavenly.

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Chapter 1: Introduction to the Study

The current study was designed to explore and understand the lived experiences of care providers to the child victims of Boko Haram insurgency in Nigeria. The impact of terrorism on children and on the country of Nigeria has been well documented (Adepelumi, 2018; Amusan & Ejoke, 2017; Terwase et al., 2010) in addition to literature on the impact of violence on children globally (Burnett-Zeigler et al., 2012). In cases where the victims of crime have care providers, whether family, friends, or professionals, the impact of providing care to the victims takes a psychological toll on them (Shaw, 2014; Thomas, 2013). The psychological impact of caring for victims of violence on the providers has also been documented (Franza et al., 2020; Figley, 1995). However, there is a lack of knowledge about the lived experiences of care providers in Nigeria who provide services to the children victim of Boko Haram insurgency. The information gleaned from the study can lead to improving the country's perspective on mental health issues. This chapter provides the background literature on the phenomenon of the Boko Haram insurgency and its impact on the affected children. The research question that will guide the study will be stated as well as the nature of the study, theoretical foundation, significance of the study, and limitations.

Background

Boko Haram emerged in 2002 through Mohammed Yusuf's leadership in the northeastern part of Nigeria, specifically Maiduguri, Borno State. The Boko Haram insurgency (BHI) is believed to be the most destructive outbreak of violence in the country of Nigeria since the country's civil war (Abdulmalik et al., 2019). Initially, the

organization focused their objective on the advocacy of Islam in the Northern region of Nigeria and against bad governance (De Montclos, 2014). However, the organization extended their goal to fighting against Western education (McDonnell, 2017), viewing it as sinful. Consequently, the organization advocated for individuals to follow the Islamic way of life (Ojo, 2017). At the onset, the organization promoted financial empowerment and Islamic education for girls, which appealed to the community because many struggled with poverty, illiteracy, early marriage, and corruption (De Montclos, 2014). Consequently, the community saw the organization as an opportunity to secure their financial freedom (De Montclos, 2014). But Boko Haram became a militia organization due to their constant battles with the Nigerian government (Sergie & Johnson, 2015). Adebayo (2014) postulated that the killing of the organization's founder in 2009 by the Nigerian government resulted in the organization's engagement in wide radicalization. Though the presence of the organization was predominantly in the northeast of Nigeria, specifically in Borno, Adamawa, and Yobe States, the fear and effects of the BHI activities reverberate in many parts of Nigeria (Abdulmalik et al., 2019).

The insurgency by Boko Haram in northeast Nigeria resulted in many atrocities and human rights abuses (Abdulmalik et al., 2019). To date, hundreds of civilians, including female school children, have been killed or abducted by Boko Haram (Abdulmalik et al., 2019). In 2014, the organization abducted 276 schoolgirls from the Government Secondary School in Chibok, Borno State (Abdulmalik et al., 2019; Matfess, 2017; Mutanda, 2017). The consequences of these attacks have led to over 20,000 mortalities and 3.6 million people who were displaced from their homes and towns fled

to shelters elsewhere (Abdulmalik et al., 2019). In a study to determine the vulnerability of households and plan for humanitarian support, 17,534 households were found to be vulnerable to many risk factors, out of which 9,717 households were reported to have high levels of vulnerability among minors or children, while 6,930 households had children who were separated from their families (UNHCR, 2015). Further, 12,338 households also reported to have experienced sexual and gender-based violence (SGBV), such as sexual assault, early forced marriage, engagement in "survival sex" to barter for money, food, and other essential amenities (Abdulmalik et al., 2019; UNHCR, 2015).

Children living in the region have experienced severe trauma through the violent attacks of Boko Haram. Some children have experienced loss of parents and other family members, kidnappings, including abductions and forced marriages, and famines that have led to malnutrition (Abdulmalik et al., 2019). Many children were displaced from their families as a result of the insurgency. These internally displaced persons (IDPs) and families were placed in camps created by the Nigerian government across the country. Many of the IDPs can no longer return to their communities because of the ravages of the insurgency and insecurities (Abdulmalik et al., 2019). About 55% of the IDPs are said to be children, aged 18 years and under, while 53.6% of all IDPs are females (Abdulmalik et al., 2019).

Traumatic events such as terrorism, natural disasters, civil unrest, and wars affect over 1 billion children, with significant consequences to their physical and psychological well-being (Malekoff, 2008; Schiff et al., 2015). Children and adolescents below the age of 18 years have significant mental health distresses that include but are not limited to

depression, posttraumatic stress disorder (PTSD), sleep disorders, suicide ideations, high risk behaviors, attention difficulties, learning challenges, and chronic physiological issues (Burnett-Zeigler et al., 2012). Post-traumatic symptoms, functional impairment, and somatic complaints are common effects on those exposed to terrorism (Pat-Horenczyk et al., 2007) in addition to psychological distress, which has been reported as the most impactful (Summers & Winefield, 2009). In IDP camps, the prevalence of emotional disorders, suicidal ideation, and psychological distress were significantly high among the children victim of Boko Haram (Dahiru & Abdulmalik, 2017; Jidda et al., 2017; Terwase, et al., 2015). Inadequate support system and exposure to complex traumas among the victims are predictors of experiencing PTSD (Dahiru & Abdulmalik 2016).

The Nigerian federal government and certain states in the northeast have provided shelters or placements for the victims of Boko Haram. The local governments have identified these victims as internally displaced persons (IDPs) and have made provisions for them. Some have been placed with care providers in different parts of the country. Care providers are determined not only by the federal and state governments but also by traditional rulers in remote parts of the country. The most trusted care providers in remote areas are Muslim clergies (*Malamai*) because culturally, they are believed to possess spiritual powers. There is a cost of providing care to the minor victims of Boko Haram insurgencies. The psychological impact includes depression, anxiety, isolation, secondary trauma, and posttraumatic stress disorder (Harrison & Westwood, 2009; McCormack & Adams, 2016)

Problem Statement

Despite an overall decline in global terrorist activities, terrorism remains a security threat to a number of nations, particularly in West Africa and the Middle East (Dudar, 2018; Hjelmgaard, 2019; International Association for Counterterrorism & Security Professionals, 2018). Although the number of global terrorism-related deaths in 2018 declined by 15.2% (Institute for Economics & Peace [IEP], 2016), cases of terrorism remain frequent in some countries including the aforementioned. Specifically, those that have recorded high numbers of terrorism-related deaths include Afghanistan, Mali, and Nigeria, with an increase of 33% (IEP, 2016). More than 60% of all terrorist attacks and 80% of all lives lost to terrorism in 2013 occurred in just five countries: Pakistan, Afghanistan, Nigeria, and Syria (IEP, 2016). Terrorism in these countries has resulted in the loss of thousands of lives and billions of dollars every year (Abdulmalik et al., 2019). In particular, Nigeria has witnessed the rise of Boko Haram, a Nigerian-based radical Islamic group, in recent years. The group is committed to the teachings of the Prophet Mohammed and the doctrine of Jihad (Yusuf, 2013). Its radical ideologies have not only threatened national security but also terrorized the lives of many in Nigeria, including children.

The increase in violent attacks has heightened the psychological distress of Nigerians, especially those living in Boko Haram-controlled areas (Adepelumi, 2018). Studies have shown that the psychological impact of terrorism and natural disasters on individuals, including children, can be enormous (Adepelumi, 2018; Garbarino et al., 2015; World Federation for Mental Health, 2002). Although terrorism can and does

create a highly unstable and risky environment for children (Miller & Heldring, 2004; Pat-Horenczyk, 2007; Summers & Winefield, 2009), children are also confronted with the possibilities of emotional and sexual exploitation as a result of separation from their families, displacement, recruitment into terrorist groups, and educational deprivation (Kostelyn & Wessells, 2015). Psychologists have categorized the psychological effects of terrorism on children as acute stress disorder (ASD; Adepelumi, 2018) and post-traumatic stress disorder (PTSD; Adepelumi, 2018; Kostelyn & Wessells, 2015; Pine et al., 2005). However, a significant number of children with mental illness resulting from Boko Haram's attacks are undiagnosed and untreated (Adepelumi, 2018; Alozieuwa & Oyedele, 2017; Olaniyan & Asuelime, 2017; Onapajo, 2017).

Most often, the psychological well-being of care providers is neglected. Studies have indicated that care providers to victims of any trauma experience psychological trauma themselves from secondary exposure. Therapists and others who care for victims of trauma or sexual abuse have a high risk of experiencing vicarious traumatization (Culver et al., 2011). Care providers providing help to refugees and people displaced by terrorists also experience various other challenges and burdens (Branson, 2019). Given their close contact with affected persons, care providers are similarly exposed to extreme traumatic effects (Cohen & Collens; 2013; Manning-Jones et al., 2015; Michalopoulos & Aparicio, 2012), including PTSD, depression, and anxiety (Harrison & Westwood, 2009; McCormack & Adams, 2016). Based on the literature about the impact of secondary or vicarious traumatization on direct care providers (McCann & Pearlman, 1990; Michalopoulos & Aparicio, 2012), it is crucial to extend the research to care providers of

child victims of Boko Haram terrorist attacks in Nigeria. This study addressed the lived experience of the care providers of child victims of Boko Haram terrorist attacks through interviews.

Purpose of the Study

The purpose of this phenomenological qualitative study was to understand the lived experience of providing direct care to child victims of Boko Haram terrorist attacks in Nigeria. Phenomenological qualitative studies depict the lived experience of a phenomenon or concept of individuals (Moustakas, 1994). In this study, the participants were adult providers at different facilities who work directly with child victims of Boko Haram terrorist attacks.

Research Question

The research question was, "What is the lived experience of care providers who provide direct care to child victims of Boko Haram terrorist attacks in Nigeria?"

Theoretical Foundation

The theoretical orientation that guided this study was clinical trauma theory, specifically compassion fatigue as experienced by care providers. Compassion fatigue is described as the emotional exhaustions that care providers experience from working with their traumatized clients (Adams et al., 2006). The concept of compassion fatigue (CF) among care providers was first developed by Figley (1995) to shed light on trauma workers and mental health professionals and how they vicariously experience the traumatic effect of their clients. CF occurs when a care provider has a prolonged exposure to the traumatic experiences of their clients or others (Franza et al., 2020).

Secondary trauma stress or vicarious trauma coupled with burnout lead to compassion fatigue. However, because individuals possess an inherent ability to construct their own personal realities as they interact with their environment, they can easily adapt to their experiences of vicarious trauma. The compassion fatigue theoretical framework was used to understand and elucidate the experiences of providing direct care to the child victims of Boko Haram.

Nature of the Study

This study followed an interpretive, phenomenological design (Moustakas, 1994) to uncover participants' experiences of providing care to child victims of Boko Haram terrorist attacks in Nigeria. Qualitative research designs allowed the researcher to understand the subjects' experiences, feelings, perspectives, and perceptions of their experiences (Ravitch & Carl, 2016). Phenomenological research design was appropriate for this study because it highlighted participants' ability to describe what they perceive, sense, and know of their experiences of working with child victims of Boko Haram (Moustakas, 1994). One strength of phenomenology is its provision of an extensive and valuable description of the research participants' experiences, as well as the meanings of the phenomenon given by the participants. The study included interviews with direct care providers of child victims directly impacted by Boko Haram in their natural setting. Due to difficulties travelling to the remote parts of the country, the study was conducted exclusively with care providers in Abuja, the capital city. Interviews were conducted only with individuals who work directly with children affected by Boko Haram terrorist attacks.

Definitions

This section of the study will provide definitions of terms used throughout the study for further elucidation of each term.

Acute stress disorder: A condition that occurs within a month after an exposure to a tragedy or trauma (Balogun et al., 2018).

Bracketing: The process of eliminating or putting aside any preconceived or personal judgements of a phenomenon that may skew or taint a study (Moustakas, 1994).

Burnout: Refers to general exhaustion or lack of interest or motivation in relation to one's occupation.

Care providers: Individuals, not necessarily medical personnel, over age 18 that help or attend to the needs of people who are not independent (APA, 2020).

Caregiving: The concept of providing paid or unpaid mental and/or physical care to individuals who need it (Sheikh et al., 2016).

Cognitive impairment: Diminished ability to perceive new information, recall memories or remember new tasks or events (Isokpan & Durojaye, 2016).

Compassion fatigue: Also known as vicarious trauma, refers to the negative or less affect that people show or feel from prolonged exposure to trauma or prolonged exposure to a client's traumatic experience through their work (Ordway et al., 2020). Figley (1992) referred to compassion fatigue as the cost of caring.

Compassion Satisfaction: The term refers to personal feelings of satisfaction that a caregiver receives from working with trauma patients (Bride & Figley, 2007).

Countertransference: It is a phenomenon that is used in psychological interventions to transmit the psychologist's unconscious reactions or thoughts to the client (APA, 2020).

Health care providers: Professionals in the healthcare industry who are engaged in different health-related settings such as hospitals, mental health, clinics, rehabilitation centers and welfare centers (Nnam et al., 2020).

Post-traumatic stress disorder: This is a condition that is marked or characterized by a failure to recover from the effect of exposure to a life-threatening or debilitating event that initially gave rise to feelings of trauma (Ordway et al., 2020).

Protective factors: Strategies and attributes in individuals that help them deal effectively with tragedies or stressful events, and minimize negative outcomes (APA, 2020).

Psychoeducation: This is a psychological term used as therapeutic tool and treatment protocol to inform clients about a phenomenon with a focus to communicate vital information within the framework of cognitive behavioral therapy (Bäuml, et al., 2006).

Resilience: The ability to mentally adapt successfully to adversities or challenging situations. Victims of terrorism show resilience in the face of terrorist activities (Okome, 2017).

Secondary stress: Emotional intrusion that occurs due to repeated exposure to traumatic events or experiences, whether directly or indirectly affected (Abada et al., 2020).

Secondary traumatic stress: Emotional duress or pressure that ensues when care providers or individuals work firsthand with traumatized children, clients, or individuals. This is often observed in the medical field, including psychologists, physicians, and care providers (Ekhator-Mobayode & Abebe Asfaw, 2019).

Self-care: The ability for an individual to provide care or nurture to oneself through healthy activities without the aid others (APA, 2020).

Trauma: Exposure to life-threatening or fatal incidents, such as natural disasters (earthquake, flood, land sliding), exposure to violent acts such as a terrorist attack, robbery, kidnapping, sexual harassment, sexual abuse, sexual victimization, and road vehicle accidents (Shekwolo et al., 2017).

Vicarious traumatization: A concept that describes the effects of empathic engagement in working with victims or survivors of trauma and violence (Al-Mateen et al., 2014).

Assumptions

The primary goal of this study was to explore the lived experiences of care providers to minor victims of the Boko Haram insurgency in Nigeria, and through the providers' own description, identify the impact of their work with the vulnerable population on themselves. To be eligible to participant in the study, the participants would have worked directly with the minor population as care providers in the Nigerian setting and were over 20 years old at the time of the study. The first assumption was that each study participant would have provided direct services to the minor victims. The second assumption was that each service provision took place in Nigeria. The third

assumption was that children received services from the study participants. Lastly, the fourth assumption was that the participants were honest in their responses to the interview questions.

Scope and Delimitations

This research study was limited to the lived experiences of care providers to children victim of Boko Haram insurgency in Nigeria. Human subjects were recruited to participate in the study through purposeful sampling to ensure that they met the study criteria. Data collection was through individual interviews in an informal setting using semi-structured interview questions. The study was grounded by the compassion fatigue (Figley, 1995) theory, burnout, and vicarious models. The study excluded care providers who did not reside in Nigeria and who did not provide services to children victim of Boko Haram. Several methods including flyers and telephone calls were used in participant selection to access many participant pools to ensure transferability.

Limitations

The study addressed the experience of providing direct care to child victims of Boko Haram terrorist attacks in northeast Nigeria. The goal was to examine the therapeutic factors or services that helped care providers become resilient in their efforts to help survivors with their psychological struggles. One limitation of this research is generalization (Patton, 2002). Boko Haram terrorist activities are limited to six states in the northern parts of Nigeria the Hausa tribe; it is therefore not possible to generalize the findings of this study and apply them to cases in the rest of the country.

Another limitation is that because Nigeria is my birth country, the possibility of authorial subjectivity and bias exists. To address the limitation of subjectivity, I bracketed any prejudgments about Boko Haram terrorist attacks and activities in Nigeria (see Moustakas, 1994). According to Moustakas (1994), it is crucial for all phenomenological researchers to employ the process of epoché by setting aside their biases when engaged in research to ensure that the participants' lived experiences are adequately captured.

Significance of the Study

An extensive amount of research has pointed to the impact of vicarious traumatization on health care providers working with clients with trauma (Michalopoulos & Aparicio, 2012). However, there is a lack of research on the impact on the provider giving direct care to child victims of Boko Haram terrorist attacks in Nigeria. No investigative research has been conducted to understand the experiences of providing direct care to child victims of Boko Haram from a phenomenological research perspective (Adepelumi, 2018). The literature has demonstrated that direct exposure to traumatic materials of their clients' trauma psychologically impacts providers (Cohen & Collens, 2010; Kadambi & Ennis, 2008; McCann & Pearlman, 1990). It is therefore essential to understand whether providers of care to child survivors of Boko Haram undergo similar psychological effects in the context of their work. In understanding providers' perspectives of how direct care affects them in particular, the findings may help develop possible solutions and treatment interventions for policy makers and mental health providers in the interest of care providers.

Furthermore, this study can narrow the research gap in understanding the lived experiences of direct care providers to child victims of Boko Haram. The study may have implications for positive change both nationally and internationally. First, the findings may inform treatment providers of the consequences of secondary trauma due to working directly with victims. Second, the findings may help policy makers in Nigeria to develop inclusive programs and policies that are provider focused and directed.

Summary

This chapter introduced the research study by establishing the background of the impact of insurgency of Boko Haram on victims, especially children, in Nigeria. Children have been displaced, abducted, recruited by the organization, and they have been used as suicide bombers since the organization made its presence known in Nigeria. For many displaced children, the government and non-profit organizations have cared for them. The aim of the study was to understand the lived experiences of the care providers to the minor victims and the consequences of their caregiving. The chapter also introduced the theoretical underpinnings on which the study was grounded. The nature of the study was also discussed in this chapter. Chapter 2 will provide an in-depth review of the theoretical framework, the phenomenon of Boko Haram, and its impact on the minor victims and their care providers.

Chapter 2: Literature Review

Boko Haram insurgency in Nigeria has left a psychological impact on diverse populations, including the Nigerian government, parents, and children. A significant impact on children involves their mental health. For instance, assimilation of educational materials and poor school performance are predominant with child victims of terrorism (Bloom & Matfess, 2016). Most specifically, Nigerian children who were directly exposed to Boko Haram insurgency faced displacements, loss of family members and friends, and psychological distress (Terwase et al., 2015). These mental health issues include posttraumatic stress disorder (PTSD), anxiety, and acute stress disorder (Adepelumi, 2018; Kostelyn & Wessells, 2015). In addition to the undetected cases of mental health disorders in Nigerian children exposed to Boko Haram insurgency, the psychological well-being of their care providers is also neglected. An expansive body of literature has substantiated that care providers to victims of terrorism equally experience psychological challenges and trauma (Cohen & Collens, 2013; Manning-Jones et al., 2015; Michalopoulos & Aparicio, 2012), including PTSD, depression, and anxiety (Adepelumi, 2018; McCormack & Adams, 2016).

The purpose of this study was to understand the lived experiences of care providers or counselors while providing care to child victims of Boko Haram insurgency in Nigeria. Additionally, the study aimed to identify care providers' coping mechanisms and support programs or systems they employ to manage their own traumas. The study also identified some self-help evidence-based treatment modalities that promote healthy coping skills for care providers. The literature review confirmed that care providers to

trauma patients or clients experience secondary trauma that are as significant as their patients (Adepelumi, 2018; Figley, 2013). However, with effective diagnosis and early intervention and treatment of mental health issues in care providers, the vulnerability to and impact of trauma on care providers may be significantly reduced (Wheeler & Richards, 2007). There is a significant lack of trained professional therapists or psychologists in Nigeria and a lack of effective programs to address trauma-related issues. The gaps in research and treatment protocols specific to the Nigerian setting adds an additional burden for care providers to child victims of Boko Haram insurgency.

This chapter offers a review of literature, the literature search strategies, theoretical underpinnings of compassion fatigue, vicarious trauma, and burnout (Pearlman & Saakvitne, 1995), the psychological impact of Boko Haram insurgency on child victims and their care providers, and the barriers to mental health and self-care practices. The chapter will also outline the methods used in the retrieval of literature that relates to the psychological implication and consequences of vicarious trauma on care providers. The chapter will end with a summary of the literature review.

Literature Search Strategy

In conducting a literature search, an in-depth review of numerous studies of peer-reviewed journals was completed. Information used to develop this chapter was accessed in the Walden University libraries, Google Scholar, EBSCO Academic Search, ProQuest Central, PsycINFO, SocINDEX, PsycARTICLES, psychology books, and other public and non-profit organizations and government websites, such as the Human Rights Watch and the British Broadcasting Corporation. Additional sources of data included

psychology databases from the American Psychological Association periodicals, dissertation databases at Walden University library, and Z-Library. Z-Library is the largest electronic file-sharing library that hosts scholarly journals of more than eighty thousand journal articles. The terms and keywords used for the study included *Boko Haram, insurgency, compassion fatigue theory, burnout, vicarious trauma in understanding trauma among terror victims, psychological consequences of terrorism among children, care providers of Boko Haram's victims, terrorism in Nigeria, terrorism, resilience, impact, implications, consequences, posttraumatic disorder, acute stress disorder, distress, Nigeria,* and other related topics. The timeline used to search the various database was 2005 to 2021, for both past and recent or current research.

Theoretical Foundation

This study was theoretically guided by the compassion fatigue (CF, Figley, 1995), burnout, and vicarious trauma models (McCann & Pearlman, 1990). Research studies have focused attention on care providers and their emotional and sometimes, physical depletion, from their work with traumatized clients, often referred to as compassion fatigue (Figley, 1995). However, there is a still lack of study relative to formal caregiving to minor victims of Boko Haram and their emotional response to dealing or handling cases with the traumatized population care providers work with. The adverse effect of providing care to clients with a history of psychological trauma, such as terrorist attacks, displacements as a direct consequence of Boko Haram insurgency, sexual and physical abuse, or exposure to violence, is described under a variety of terms. These terms include compassion fatigue, vicarious traumatization, secondary traumatization (Adams et al.,

2006; Jordan, 2010), and burnout. The goal of this study was to explore the lived experiences of care providers who provide services directly to minor victims of Boko Haram insurgency in Nigeria and what practices they put in place for self-care. Consequently, the compassion fatigue, vicarious or secondary traumatization, and burnout model was the most appropriate theoretical orientation to employ in understanding the research question. These terms will be used interchangeably to describe the phenomenon.

Compassion Fatigue

CF has been used as a broad term comprising three significant components: vicarious trauma, secondary traumatic stress, and burnout (Ordway et al., 2020; Williamson et al., 2017). The three facets have been linked with suboptimal care services resulting from negative effects of "empathic engagement when working with victims of trauma and violence" (Al-Mateen et al., 2014, p. 90). Vicarious trauma is equally experienced by care providers when they begin to develop or report their own trauma-based symptoms as a result of their exposure to their clients' traumas (Ordway et al., 2020). Symptoms of vicarious trauma may resemble those of PTSD (Jordan, 2010). These include exhaustion, pessimism, irritability, anxiety, apathy, relationship issues, loss of autonomy and trust, and bodily complaints (Al-Mateen et al., 2014; Sabo, 2011). CF is one of the three primary classifications of a severe reaction that a professional or care provider experiences when exposed to the aftermath of traumatic events or crisis based on the care provider's work with their clients (Figley, 1995; Ordway et al., 2020). The reaction is defined as emotional and mental exhaustion and the "cost of caring" (Figley,

1992). This reaction stems from prolonged or repeated exposure to the traumatic experiences of others (Franza et al., 2020).

Providing therapeutic or psychosocial care to victims of trauma can be rewarding for the care providers, but at the same time, it can be stressful (Adams et al., 2006). Some care providers face some adverse psychological consequences, such as psychological distresses as a result of their interaction with their clients (Adepelumi, 2018; Terwase et al., 2015). CF is often experienced when a caregiving relationship based on empathy goes beyond the limit into a psychological response to trauma and stress, which progresses to the care provider's psychological, social, and physical exhaustion (Sessions et al., 2017). When care providers fail to remove themselves from their clients' conditions or develop balance with their job, they may feel overwhelmed and guilty, which then translates to trauma and depression (Bloom & Matfess, 2016; Garbarino et al., 2015). Due to CF, the care provider may experience reduced capacity or interest in being empathic or showing empathy as a consequent behavior or emotion resulting from repeated exposure to the traumatizing events (Sessions et al., 2017). Prolonged or repeated exposure to the narration of clients' trauma may lead to numerous psychological distresses such as sadness, avoidance, somatic symptoms, detachment, psychological distress, nightmares, grief, relational issues, and survivor or witness guilt (Sabo, 2011).

Research studies have also suggested that care providers not only experience compassion fatigue from their exposure to their clients' trauma, but that also some aspects of their life experiences may cause them to develop compassion fatigue (Adams et al., 2006). For example, the care provider's inability to develop good coping skills to

handle the demands of caring for the child victims of Boko Haram insurgency may influence the care provider's likelihood to develop compassion fatigue. The care provider's personal trauma history and lack of social support may also result to having compassion fatigue (Adams et al., 2006), which subsequently may lead to burnout.

Understanding compassion fatigue, STS, vicarious trauma, or burnout as a theoretical framework gives the care providers the foundation to deal with trauma among children effectively. Care providers working with stressed and traumatized clients are frequently exposed to stressful and emotional situations at a higher rate (Coetzee & Laschinger, 2017). The framework provides a rich insight into caregiving work, helping the professionals working with traumatized children balance their influence and overall well-being. Therefore, improving awareness and recognition of burnout, compassion fatigue, and STS helps reduce turnover rates, thereby increasing retention. The model can also facilitate the development of effective strategies or interventions towards decreasing burnout and compassion fatigue. Care providers should be trained on emotional intelligence and understanding of CF as it would empower their contribution to the children's well-being (Eseadi et al., 2016). Care providers, among other health care professionals, should adequately adopt and practice preventive measures that promote their self-well-being and self-care, improve patient experience, and optimize therapeutic alliance (Eseadi et al., 2016).

Literature Review

This section of Chapter 2 presents a review of the literature in relation to key variables of the research study. These include insurgency of Boko Haram, its history,

beliefs, and practices in Nigeria, the psychological implications of terrorist attacks on children in Nigeria, psychological implications and consequences of trauma on the care providers, and barriers to mental health in Nigeria for care providers.

The Insurgency of Boko Haram: History, Beliefs, and Practices in Nigeria

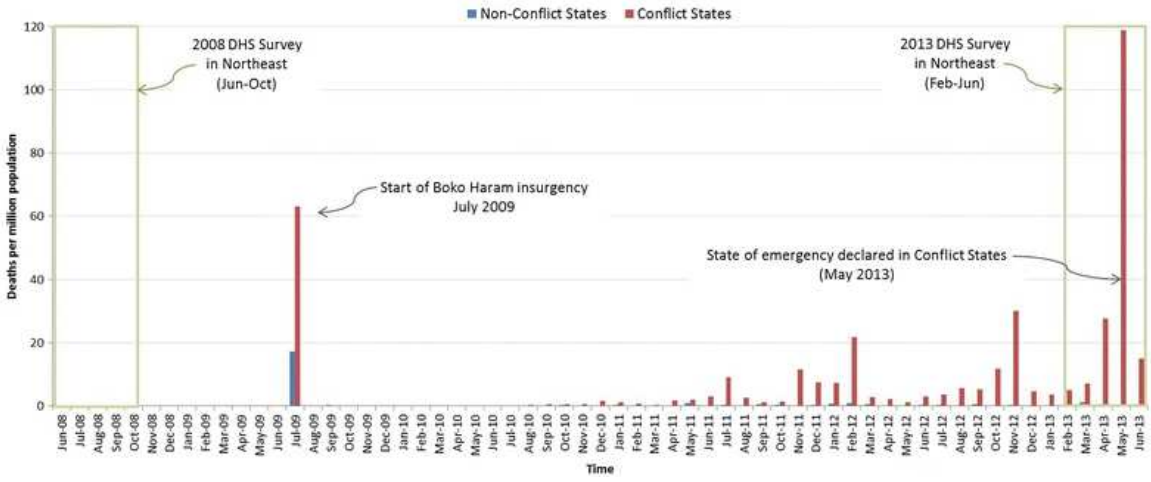
The emergence of Boko Haram can be traced back to 1995 when it started as a radical group under the leader of Abubakar Lawan (Amusan & Oyewole, 2014). The group initially was called *Jama'atuAhlisSunaLidda 'awatiWal Jihad,* which means, People Committed to the Prophet's Teachings and Jihad (Amusan & Ejoke, 2017). Boko Haram emerged as a political influence in Maiduguri, the northeastern part of Nigeria, and grew in popularity in 2002 under the leadership of Mohammed Yusuf (Amusan & Ejoke 2017). Under Yusuf's leadership, the group gained popularity and followership under the guise of helping the community. For example, Yusuf established a mosque and an Islamic school in a building he constructed for disadvantaged members of his community and enrolled children in the Islamic school (Amusan & Ejoke, 2017). The building complex was used by Yusuf as a recruiting ground to meet his ideals and goals of forming a jihad movement to topple the government of Nigeria (Farouk, 2012). His followership comprised of children and youth from ages 17 to 30 (Amusan & Ejoke, 2017). Yusuf was apprehended by the Nigerian military forces, and subsequently, he died in prison in 2009 (Amusan & Ejoke 2017; Farouk, 2012). The death of Yusuf resulted in the organization engaging in wide radicalization under the leadership of Abubakar Shekau (Adebayo, 2014). Abubakar Shekau restructured Boko Haram and amassed lethal weapons and military equipment, and the group also utilized fatal approaches to

accomplish the organization's goals (Sergie & Johnson, 2015). The organization has engaged in multiple terror activities and attacks since the current leader transformed the organization into a religious sect, killing mostly Christians in Nigeria (Akinola, 2015).

The Boko Haram insurgency (BHI) is believed to be the most destructive outbreak of violence in the country of Nigeria, since the country's civil war (Abdulmalik et al., 2019). The organization has engaged in mass murder, abductions, suicide bombings, and assassinations of significant citizens (De Montclos, 2014). The insurgency of Boko Haram has led to thousands of homicides, kidnappings, and imprisonment of victims (Mohammed, 2014). The consequent result of the organization's insurgency led to millions of families displaced from their homes, with some fleeing to neighboring countries such as Chad, Cameroon, and Niger (Brechenmacher, 2019; Osumah, 2013). In 2014, 276 Chibok school girls were abducted from their institution of learning. These abductions brought Boko Haram into international scrutiny. Figure 1 shows a timeline of Boko Haram's activities.

Figure 1

Timeline of Boko Haram's Involvement in Terror Between 2009 and 2013



Note. From "The Impact of the Boko Haram Insurgency in Northeast Nigeria on Childhood Wasting: A Double-Difference Study," by G. Dunn, 2018, *Conflict and Health*, *12*, p. x.

By 2012, the membership of Boko Haram had risen to between 15,000 and 50,000 followers (Onuoha & Oyewole, 2018). The organization has extended recruitment exercises to the countries that border with Nigeria, including Chad, Cameroon, Ghana, and Niger Republic (Brechenmacher, 2019). Between its inception and 2015, Boko Haram has caused more than 20,000 fatalities (Onuoha & Oyewole, 2018). With its use of terror, the group's actions have had direct and indirect effects on the Nigeria's politics and economy and on the welfare of the general population where the organization's presence was greatly felt (Olufunmilade, 2017). Figure 2 expresses the fatalities by Boko Haram.

Figure 2

Boko Haram Fatalities

	2009	2010	2011	2012	2013	2014	2015	2016	2017
Incident	20	37	123	379	272	415	456	320	423
Fatalities	817	75	594	1649	2974	7713	8852	2815	2679

Note. Onuoha and Oyewole (2018)

As indicated, the organization initially focused their objectives on the advocacy of Islam in the northern region of Nigeria and against bad governance (De Montclos, 2014). However, as time progressed, the organization extended their goal to fighting against western education (McDonnell, 2017). One of the driving forces of the organization was their rejection of the Western education, which they viewed as sinful (Ojo, 2017). For this reason, the organization promoted financial empowerment and Islamic education for girls (De Montclos, 2014). Consequently, the community saw the organization as an opportunity to secure their financial freedom (De Montclos, 2014). While women struggled with poverty, patriarchy, illiteracy, early marriage, and corruption, some found an opportunity for the organization to help them secure their freedom while reducing their financial hardships (De Montclos, 2014). Most followers of the organization valued the moral and religious anchor that Boko Haram provided. The initial interaction between

women and Boko Haram was mainly community-based. The communities in the state of Borno appreciated Boko Haram as a community-based organization. However, part of the society raised concerns about the indoctrination of terror activities and Jihadist acts by Boko Haram members. Yusuf's ideologies seemingly contained hate messages about Western ideologies (McDonnell, 2017).

While Boko Haram as an organization does not have a long history in Nigeria, the war and related insurgency have resulted in different trends. The northeastern region of Nigeria has experienced economic, political, social instability, and psychological distress as a result of the activities of the group (Adepelumi, 2018; Amusan & Ejoke, 2017; Terwase, et al., 2015). For example, Bourne (2018) postulated that the scale of hunger, illness, displacement, and death caused by the BHI in the northeastern region of Nigeria had reached an alarming rate. It is suggested that up to 2.8 million Nigerians from Borno, Yobe, and Adamawa States, the three most affected regions by Boko Haram, have been displaced, of which 80 percent are not placed in camps (2018). It is also estimated that more than 20,000 indigens have been killed by the group, while approximately 450,000 children suffered from severe acute malnutrition, and more than 4.4 million people face severe food scarcity and insecurity in the Lake Chad region (2018). It is also important to note that Boko Haram has extended its operations to certain cities in the States of Kogi, Kaduna, Kano, Gombe, and Abuja, the Federal Capital Territory (Osumah, 2013).

The internal displacement of the indigens by the operations of Boko Haram in northern Nigeria has driven both humanitarian and health crises in that region (Osumah, 2013). According to existing literature, internally displaced persons (IDPs) are at a higher

risk HIV infection, and illegal drug use and abuse are on the rise due to the IDPs' exposure to substances (2013). Osumah (2013) also asserted that the IDPs are more vulnerable to sex trafficking, sexual abuse, and violence as a result of living in temporary shelters, the loss of their sources of livelihood, and a lack of access to quality educational and recreational opportunities.

According to Langer, Godefroidt, & Meuleman (2017), the Boko Haram insurgency in the northern region of Nigeria and the abduction of the Chibok girls have caused direct and indirect trauma for directly affected individuals, their families, and close relatives. While death is the most significant loss attributed to the Boko Haram insurgency, social interruptions and psychological effects have left behind far more problems for the affected communities (Amusan & Ejoke, 2017; Bourne, 2016). Most impacted by these insurgencies are children; they become the most vulnerable group of people in the community and subject to terrorism-related violence. These insurgencies may cause children trauma and mental health-related issues (Vieselmeyer, Holguin, & Mezulis, 2017).

Psychological Implications of the Boko Haram Insurgency on Children Victims in Nigeria

Disasters such as terrorist acts yield a myriad of negative implications and outcomes, including death, post-traumatic disorder, and related psychopathology issues. Terrorist attacks cause destruction and disruption in communities, with children suffering far more consequences than others. Children face diverse uncertainties in the wake of terrorism. Often, they become victims of other forms of violence, including terrorism.

Children's exposure to terrorism may occur directly or indirectly. According to Pfefferbaum, Noffsinger, Wind, and Allen (2014), children's interpersonal exposure to violence such as terrorism occurs when children lose a family member in an attack, when they view violent acts through the media, or when they become witnesses to the terror. According to Gurung et al. (2017), terrorism creates an unsafe environment for children by denying them critical resources in their childhood including parental love and care, security, nutrition, and shelter, among others. This disruption results in trauma in children, which consequently leads to psychological instability in the aftermath of a terrorist attack (2017). Parental displacements, the death of their close family members, friends, and parents, and witnessing other horrific incidents from terrorism form an unwanted foundation for psychologically related issues among children. In the case of Nigeria, children were directly exposed to Boko Haram insurgency, as the terrorist attacks were carried out in the presence of the children (Amusan & Ejoke, 2017).

The rise of Boko Haram in Nigeria is linked with several effects on many sectors of the country, especially children and their families. Olufunmilade (2017) asserted that the Boko Haram organization is associated with the highest number of lives lost in the African continent. Children have been named as the most affected population by the operations of Boko Haram, not because they were recruited into the organization but because they suffer the most effect of the organization's presence in the northeastern region of Nigeria through the loss of their parents (2017). According to research conducted on the state of children in the country, it was found that, as of 2018, most of

the children from the affected regions suffered from vices such as displacement, poverty, death, kidnapping, and lack of access to quality education (Amusan & Ejoke, 2013).

The recruitment of children into the organization and abduction of women and schoolgirls by Boko Haram has caused some psychological impairments on minor victims. The abducted children were forced and trained to be involved in armed robberies and combats and become tribal spies and suicide bombers (Amusan & Ejoke, 2013). Human Rights Watch (HRW, 2014) reported in the study they conducted with 30 children that escaped from the captivity of Boko Haram that abducted women with Christian orientation were threatened to death if they refused to renounce their Christian faith and beliefs. The study also indicated that young girls were physically, sexually, and psychologically abused, were forced into marriages and military participation and activities, and were brain-washed to become suicide bombers (2014). These and other unreported acts of violence caused victims to experience symptoms of posttraumatic stress disorder, such as hypervigilance, hyperarousal, nightmares, sleeplessness, lack of focus, fidgety, irritability, and fear of re-abduction (2014). The traumas by these terrorist insurgencies can be life-threatening for the child victim.

Boko Haram insurgency has led to the separation of many children from their families and the displacement of the children in different parts of the country. These separations and displacements significantly affect the psychological welfare of the children, leading to increased rate of childhood depression and emotional imbalance (Wells, 2017). According to Adepelumi (2018), minor victims of Boko Haram insurgency suffer from acute stress disorder (ASD), with symptoms that resemble PTSD.

The distinction between ASD and PTSD is in the duration of the symptoms. ASD is a mental health condition which occurs when a child has emotional reactions to trauma and traumatic events that cause the child emotional discomforts, such as accidents, natural disasters, wars, and in this case, terrorist attacks (2018). Some of the symptoms that the minor victims of BHI suffered included anxiety when there is a resemblance to their lived experiences, lack of concentration, re-experiencing of the trauma, and moodiness (HRW, 2014).

Terwase, et al. (2015) in their article, *The Psychological Trauma on Boko Haram Victims in Nigeria: Conflict Resolution Perspective*, reported that both parents and children experienced psychological trauma resulting from the BHI. Incidences of kidnapping, bombing, living in unfavorable conditions in IDPs camps, and staying in refugee camps in neighboring countries have equally caused psychological trauma for both the parents and children (2015). The authors concluded in their studies that in the case of the Chibok schoolgirls abduction in 2014, some of the girls' parents have died as a result of the psychological trauma of the emotional pain inflicted on their daughters by Boko Haram (2015). The agony of children living alone without the care of their parents resulting from the BHI has also caused psychological trauma for the child victims (2015).

In comparing the degree of the impact of victimization on children and how the different genders experience and respond to trauma, Duarte, et al., (2011) postulated that female child victims endure more by internalizing mental challenges as compared to male victims. On the other hand, male children experience externalizing psychological challenges when they become terrorism victims (Lengua, Long, Smith, & Meltzoff,

2005). Boys that have experienced violence through terrorism would later engage in criminal activities, such as robbery, murder, substance abuse, and other societal ills (2015). Research studies have also expressed the vulnerability of girls in overcoming the mental abuse they experienced in terrorist acts as compared to boys (Hoven, Duarte, Lucas, et al., 2005; Felix et al., 2010). Female victims take longer periods of time to overcome their trauma as compared to their male counterparts (2010). However, both boys and girls can recover from the psychological effects of trauma when they engage in treatment. Sharma et al. (2017), asserted that children are dynamic in coping with the environment they live in, even when they are adversely affected by traumatic events such as terrorism, violence, and related vices. Consequently, early intervention measures for child victims of BHI may enable them to have positive and healthy lives. These treatments do not have to be clinical in nature where there are no clinically trained professionals to work with the victims. The interventions can be psychoeducational and psychosocial in nature. This recognizes the need for timely caregiving intervention in averting the mental problems that are related to exposures to terrorism.

Psychological Implications and Consequences of Trauma on Care providers

While the threat of Boko Haram to the security and stability of Nigeria has received a wide audience both nationally and globally, there is a paucity in the research on those providing care to the child victims of the Boko Haram insurgency. Little is known about their psychological wellbeing and their affect resulting from working with minor victims of the BHI. But it may be deduced that the care providers to the victims might be potentially exposed to the ills and insurgencies of BH. Additionally, it is not

known if care providers were directly or indirectly affected by the BHI, which would cause the care providers complex trauma. Often, care providers are relegated to the background and their work with trauma patients is not recognized as contributing positively to social change. According to Adams, Boscarino, and Figley (2006), psychological consequences of providing care and social support to trauma patients have been long documented, but few studies have centered on formal care providers. Formal care providers can be classified as therapists, counselors, social workers, nurses, and para-clinicians (Potter, Deshields, Divanbeigi, Berger, et al, 2010).

The caregiving profession is regarded as essential assets and resources in the health care system. Their roles may be diverse in nature, but ultimately, they share the common goal of providing quality care to the families or clients they work with. Studies have demonstrated that providing quality care can be both rewarding and stressful (Adams, Boscarino, & Figley, 2006; Razali, Ahmad, Rahman, et al., 2010). Razali, et al., (2010) labeled the stress from caregiving as the "burden of care." Hypothetically, workers in the caregiving profession may want to alter the behaviors of their clients through emotional support, and in the quest to provide the best care, they become emotionally and physically exhausted. Consequently, the resultant consequence of working with trauma clients is that they suffer from physical exhaustion, social alienation, and psychological distress (Adepelumi, 2018; Figley, 1995). According to Gurung et al. (2017), the initial reaction to traumatic events entails confusion, sadness, anxiety, agitation, dissociation, and exhaustion, among other vices. Caregiving can result in stress, and trauma can compound the stress levels of the care providers, which

subsequently hampers the care providers' ability to deliver quality services to their clients (2017). Stress compromises the care providers' ability to be an effective source of hope for their clients.

McCann and Pearlman (1990) coined the phrase vicarious traumatization (VT) to describe the collective, destructive, and pervasive effects on mental healthcare providers from their exposure to recurring traumatic materials resulting from their work with their patients (Michalopoulos & Aparicio, 2012). According to the literature, care providers to trauma victims experience the same effects psychologically because trauma is non-discriminate (2012). Vicarious trauma impacts therapists and care providers negatively, including their sense of self-worth (2012). The impact of trauma on care providers' self-worth may lead to on-going symptoms of posttraumatic stress disorder (PTSD), such as feelings of rage, anger, grief, and trepidation (Adepelumi, 2018).

Cohen & Collens (2013), in their study, explored the effect of trauma work on psychotherapists providing direct services to traumatized clients and survivors. The writers postulated that not only do therapists experience vicarious traumatization, but they also experience vicarious posttraumatic growth (VPTG). According to Cohen and Collens (2013), the existing literature provided by therapists on their experience of exposure to graphic events and human cruelty indicate that care providers may alter their self-perception, their work, and their worldview. The research also indicated that direct care providers in some cases may experience disturbing and obtrusive symptoms similar to the traumatic stress symptoms exhibited by trauma survivors or victims (2013). Additionally, Kadambi & Ennis (2004) investigated the concept of vicarious

traumatization as it relates to therapists' negative experiences in providing direct therapeutic services to survivors of trauma. They opined that not all therapists who are exposed to trauma materials from their work with trauma survivors experience the same level of trauma. However, they concluded that therapists working with patients who have experienced or undergone psychological trauma are at an increased risk of being negatively impacted by their work (2008).

Burnout is closely associated with the trauma that comes as a result of providing care to trauma patients (Cieslak, Shoji, Douglas, Melville, & Luszczynska, 2014). Leiter and Maslach (2015) defined burnout as a phenomenon that relates to the psychological distress a care provider experiences as a consequent result of his or her daily work activities. McCann and Pearlman (1990) described the high rates of burnout among providers of care to trauma and disaster victims. They equated working with victims as working with seriously ill patients, victims of poverty, or patients with severe mental or social issues (1990). The term burnout refers to the mental and emotional "strain of working with a difficult population" (p. 133). Some of the burnout symptoms that care providers and providers experience as a result of providing direct care to trauma victims include loss of compassion or empathy, depression, and melancholy (Adams, Boscarino, & Figley, 2006; Jordan, 2010;). It is therefore important to understand the coping mechanisms that care providers of Boko Haram victims have, given that providers suffer psychological symptoms similar to the victims' (Adepelumi (2018).

In describing the challenges that care providers encounter when working with trauma individuals, it is important to elaborate on the significance of compassion fatigue

(Day & Anderson, 2011; Cocker & Joss, 2016; Figley, 1995). Compassion fatigue as defined by Figley (2013) is the diminished ability or interest in showing empathy to clients, or the concept may be described as carrying the pains of other people. This is the consequent result of the care providers' behaviors and feelings toward their exposure to others' traumatic events. Day and Anderson (2011) maintained that care providers, in providing psychological and social services to traumatized individuals, experience compassion fatigue. Various authors describe this condition as secondary traumatic stress (STS, Day & Anderson, 2011; Cocker & Joss, 2016). Compassion fatigue has a similar manifestation to post-traumatic stress disorder, and its symptoms may include difficulty in sleeping, fear, recurring pictures of traumatic events, and behavioral and cognitive reminders of the trauma events (Cocker & Joss, 2016). The level of confidence in providing quality services makes care providers develop secondary traumatic stress because they immerse themselves in their clients' experiences.

The health of care providers is equally important in care delivery and affecting social change. Consequently, it is imperative that care providers incorporate safe and consistent self-care practices in their profession. Stress is a major health hazard. Therefore, to prevent care providers from experiencing negative effects from their interactions with their trauma clients, McFadden, Campbell, and Taylor (2014) advocated for institutions or agencies to provide resources to care providers to manage their stressors and minimize the chances of experiencing vicarious trauma. Institutional resources may include favorable working conditions, policies, and administrative support

(Sansbury, Graves & Scott, 2015). These protective measures equip care providers to handle traumatic events effectively with care, consequently, avoid vicarious trauma.

Barriers to Mental Health in Nigeria for Care providers

Mental health and self-care practices are relevant in managing victims of terrorism. Experiencing traumatic events such as violence can cause mental disorders to victims. These medical challenges include personality changes, PTSD, depression (Scheiderer, Wood, & Trull, 2015). Therefore, it is essential to provide prompt treatment to a pathological stress response. If left untreated, these disorders may lead to chronic health conditions. Researchers (Ehring, Welboren, Morina, Wicherts, Freitag, & Emmelkamp, 2014; Jacques-Tiura, Tkatch, Abbey, & Wegner, 2010), have extensively affirmed how various evidence-based practices are effective for treating trauma. Besides, mental health is highly essential for survivors of trauma. However, only a small section of trauma victims suffering from mental diseases benefit from professional treatment (McChesney, Adamson, & Shevlin, 2015). Besides, they do not easily consider psychotherapy or mental health processes as a method of treatment (2015).

While encouraging victims of trauma to undergo adequate therapy is significant, studies have expressed concerns that victims may face an array of barriers to mental health services (Bryant et al., 2011). Bryant, et al. (2011) offered a definition of mental health services as professional facilities where medical specialists such as psychologists, psychotherapists, and psychiatrists apply evidence-based techniques to treat mental disorders and facilitate psychological wellness. In underscoring the importance of mental health services, Cage, et al., (2018) separated the barriers to mental health into two

categories: internal and external obstacles. The external obstacles include having no or adequate mental health facilities, while the internal barriers include stigmatization (2018). Assessing these types of obstacles is essential in enhancing the survivors' use of mental health services.

In the case of Nigeria, the accessibility to health care services is the primary barrier to mental health. According to Anyebe et al. (2021), Nigeria has less than ten psychiatric hospitals that serve over 150 million people. Moreover, there are only eight schools of psychiatric nursing and an estimated 12 medical schools in Nigeria, and most of these facilities are concentrated in cities, with only a few of them in rural areas. On the other hand, the ratio of qualified mental healthcare practitioners (a ratio of 4:100,000) to the population has been an obstacle to care providers' effectiveness in delivering timely and quality mental health services (Carbonell et al., 2020). Additionally, limited training resources and uneven distribution of resources have disrupted the effective recognition of mental health as an essential medical issue in the Nigerian community, thereby further reducing the number of qualified mental health care providers.

Secondly, Nigeria has experienced high stigmatization of mental illnesses amongst the populace. According to Olagundoye, Akhuemokhan, & Alugo (2017), mental health has been rooted in supernatural belief that it is untreatable, and consequently, it is regarded as a curse (2017). This superstitious belief about and the society's approach to mental health has extensively hindered the effectiveness of mental healthcare workers in Nigeria.

Thirdly, in addition to the stigma and discrimination of people with a mental health condition, there follows a heightened feeling of shame associated with mental illness. According to Carbonell et al. (2020), care providers, families, and individuals with mental health conditions have viewed the feeling of guilt as a significant barrier to health care accessibility. The psychiatric hospitals and related sections within the healthcare system have been viewed as places for mad, lunatics, and crazy people; therefore, it is an abomination for one to be seen in those facilities (2020).

Lastly, there is the economic barrier associated with delivering mental health care to patients in Nigeria. Travel distance, cost of transportation, loss of productive income, and the high cost of services have impeded the efficiency and delivery of mental health care services by providers (Jack-Ide & Uys, 2013). Due to the lack of evenly distributed mental health care services and facilities in Nigeria, clients and/or care providers are subjected to traveling long distances to access healthcare services in certain parts of Nigeria (2013). These long trips to access mental health services were deemed costly and cumbersome (2013).

The availability of mental health services in a country's healthcare system defines the ability of professional mental health care providers to deliver quality and timely services effectively. However, in the case of Nigeria, the diverse barriers to mental health care for care providers can be summarized as the absence of mental health initiative from the country's healthcare plan, lack of sufficient facilities and funding, reduced or lack of effective integration with primary care, and inadequate facilities and human resources to

effectively deliver the services. These barriers can be summarized as a combination of political, physical, and social obstacles.

Gaps in Literature

Previous studies about the phenomenon of Boko Haram insurgency and caregiving to minor victims have limitations in their research approaches. For example, the existing literature on this phenomenon has been based on the justification of the organization's acts, the impact of the group's insurgency on the nation's economy, and politics, healthcare system, and national security (Amusan & Ejoke, 2017). They express important concepts and elements of trauma and the socio-political instability in Nigeria (Amusan & Ejoke, 2017; Amusan & Oyewole, 2015; Terwase, et al., 2015). However, these studies failed to consider how terrorism intensifies or adds to pre-existing trauma on children. Additionally, the studies fail to provide details on the various aspects of understanding the wellbeing of the care provider and the victims. From the analysis, the major areas that have inadequate information and gaps included the psychological consequences of terrorism among the minor victims, the psychological implications of vicarious trauma on care providers to the victims of Boko Haram insurgency, and the barriers that impede mental health deliveries in Nigeria.

Diverse gaps exist in the literature review concerning the experience of providing care to minor victims of Boko Haram insurgency in Nigeria and the subsequent experiences of care providers in attending to this population. We drew from comprehensive research studies which have been conducted on the psychological implications of trauma on children and the child victims of Boko Haram insurgency in

Nigeria. More so, with Nigeria posing unique political, religious, and cultural aspects, less research has been conducted concerning the care providers' lived experiences in addressing the psychological wellbeing of Boko Haram victims in Nigeria. While care providers' experiences with Boko Haram child victims can result in inconsistency, the study on Nigeria's case would present new and deepened knowledge regarding the experience.

Descriptive results can be drawn from past research linking poor children's health outcomes in the terrorism-affected regions of Nigeria, which it is ascertained, has resulted to the children's social disruptions and displacements (Amusan & Ejoke, 2017; Sessions et al., 2017). While other factors may contribute to the conflict, the children's psychological well-being can be directly influenced by the magnitude of the Boko Haram activities. However, the findings emphasize the role of care providers and appropriate programs and policies to support the children in the terrorist marred regions. With minimal recognition of mental health services, the care providers' work has been compounded by minimal resources, traditions, and stigmas, linking mental health issues with cultural beliefs (Jack-Ide & Uys, 2013; Olagundoye et al. (2017). Lack of sufficient human resources has made caregiving a stressful experience to take on. In summary, there exists no review of terrorism in Nigeria and the fate of the children affected from the care providers' perspective.

On the other hand, many psychological symptoms among the population affected by terrorism are widely documented from the reviewed articles. The research also provides evidence that a portion of the affected populace is resilient in the wake of

trauma from war situations. Nevertheless, it is indispensable that children and other terror victims receive mental health care services as part of their reform, reconstruction, and rehabilitation process. The study of the psychological implications and consequences of war has given a solid push to develop a caregiving model for mental health care services. The study on care providers' experiences when providing care to children affected by Boko Haram insurgency could subsequently add new understanding and knowledge in bridging the gap between childhood experiences and their mental health well-being while focusing on care provider's psychological well-being.

Summary and Conclusions

Terrorism, conflict, and related vices have been characterized as the source of suffering and are significant determinants of children's development, their mental health, and psychological well-being. The insurgence of the Boko Haram group has left the affected region of Nigeria with devastating effects, such as the abduction of children, deaths, destruction of properties, displacements, and many other related problems. The impact and consequences of these terrorist attacks in Nigeria have also led to increased demand for mental health services, hence the inception and adoption of the mental health act in the country. The literature review has utilized various scholarly and peer-reviewed articles, among other credible sources, in exploring the phenomenon of Boko Haram insurgency in Nigeria. The chapter has provided a deep insight into the psychological implications and consequences of Boko Haram insurgency in Nigeria. While the history of terrorism in Nigeria is not as old as the country, the Boko Haram insurgency has increased demand for mental health services due to trauma resulting from the constant

war, terror, and conflict in the affected regions. Through the diverse and multiple sources utilized in this literature review chapter, it can be deduced that terrorism has long-term effects on children's psychological well-being, which is witnessed through the children's weak academic performance, problems in coping with life demands, and increased cases of PTSD (Adepelumi, 2018; Amusan & Ejoke, 2017).

The increased recognition for the role of care providers in improving life quality by way of addressing mental health related issues and effective work-life balance are recognized as a significant facet to ensure second-hand trauma is minimized. Working with patients who are experiencing pain, trauma, and suffering can negatively influence the care providers' psychological well-being. Drawing from the literature review, compassionate fatigue has received considerable focus. Workplace-related stress resulting from burnout has resulted in the ineffectiveness of care providers regarding their work in addressing medically related health concerns. At the same time, diverse barriers to care provider services impede their efforts to care for children suffering from psychological issues amplified by terrorism. Nigeria's economic instability and development milestones have compounded mental health providers' work and effectiveness equally. While it has been identified that terrorism negatively impacts children and other victims' psychological well-being, there is a need to develop effective measures within the country's healthcare system to improve the care providers' impact on their work.

Despite diverse barriers facing the caregiving work in addressing mental health-related issues, different misconceptions can be linked to the slow development of this

industry in Nigeria. As a result, the misconceptions complicate the care providers' tasks. These included financial constraints, inadequate medical facilities, human resources, and the uneven distribution of the mental health care unit, making the experience a daunting job, when working with victims of Boko Haram. In addition to formulating effective measures to increase efficiency in mental health care service delivery, increased awareness and the care providers' emotional stability are vital in helping Boko Haram terrorist victims. Care providers' welfare is equally important in addressing the vicarious trauma they experience from working with trauma victims.

Chapter 3: Research Method

The qualitative study was conducted to understand the lived experiences of care providers to minor victims of Boko Haram insurgencies (BHI) and the effect of their experiences as care providers. The study also aimed to explore availabilities of resources for the minor victims in Nigeria as experienced by care providers and how care providers implement or practice self-care for sustained mental healthcare. In exploring the lived experiences of care providers to the BHI minor victims, the study sought to bridge the gap in professional literature about the phenomenon of the BHI in Nigeria and experiences of providers of care to the minor victims.

Chapter 3 will discuss the research design rationale and methodology used in this study. Additionally, this chapter will describe the research question, the role of the researcher, the sample size, sampling approach, instrumentation, data collection process, data analysis, and lastly, the ethical procedures and consideration that guided the recruitment of research participants. The study will also discuss the validity and trustworthiness of the study in this chapter.

Research Design and Rationale

This qualitative research study was conducted using the phenomenological research design, which is used to examine the lived experiences of research participants who have first-hand experience or lived through a phenomenon (Moustakas, 1994). Qualitative research design helps the researcher examine or study ways in which research participants understand a phenomenon and how they generate or make meanings from the phenomenon that is under investigation in their natural setting (Patton, 2015). This

approach is used when the phenomenon that is been studied can only be depicted and explained through the participants' description (Giorgi, 2012). Because of the lack of literature about the effects of providing care to minor victims of BO in Nigeria, it is important to obtain information from the care providers who provide care or work directly with the population. As such, phenomenology was the most appropriate qualitative tool to utilize in capturing these experiences (Creswell & Poth, 2018). The qualitative design allowed me to use participants who have first-hand experience of the phenomenon that is been examined in their natural setting (Burkholder et al., 2016; Leedy & Ormrod, 2010). It gives room for individuals to make meaning of their experiences (Ospina, 2004; Ravitch & Carl, 2016). This helped answer the research question: What is the lived experience of care providers who provide direct care to child victims of Boko Haram terrorist attacks in Nigeria?

There are several philosophical assumptions of qualitative research. The philosophical assumptions indicate the stance that a researcher would take (Creswell & Poth, 2018). These assumptions determine the type of qualitative inquiry a researcher will engage in or carry out. One of the philosophical assumptions of the qualitative design approach is ontology. The ontology assumption investigates the nature of reality. Some researchers who lean toward the ontological philosophical approach use quotes and themes to relay the words of the participants in a study. Researchers with ontological assumption describe the experiences of research participants. A typical example of an ontology assumption is phenomenology qualitative research design. Other examples of qualitative philosophical assumptions include epistemology (where the researcher

conducts a qualitative study in the natural domain of the participants), axiology (where the researcher addresses the beliefs and ideals that shape the narrative candidly), rhetorical (where the language of the researcher is intentional and uses the qualitative design language, such as credibility, transferability, and dependability), and methodology (where the procedure of the qualitative research is defined). Therefore, qualitative research design uses a systematic approach in conducting a research study.

Reaching data saturation is an important aspect of qualitative research, even though there is no agreed or validity means of establishing saturation objectively (Francis et al., 2010; Lowe et al., 2010). This simply means reaching a point in data collection where information or collected data no longer leads to novel information or discovery of new themes to answer the research question (Ravitch & Carl, 2016). However, the guide to determine data saturation is to establish a minimum sample size for initial analysis and determine from there how many more interviews will be conducted based on already collected data without new ideas or information emerging from the interviews (Francis et al., 2010).

Role of the Researcher

Qualitative research as a research approach is not only interpretative in nature but also narrative (Merriam & Tisdell, 2018; Ravitch & Carl, 2016). The data collected are the views of the research participants regarding their lived experiences. These narratives of the research participants are subsequently interpreted, and the general themes are synthesized to derive meaning from the same (Merriam & Tisdell, 2018). This is the reason why the role of the researcher in qualitative research is significant.

The role of the researcher in a phenomenological inquiry is distinct. As a researcher, I must have the ability to bracket my prejudices, judgments, biases, preconceived notions, or prior knowledge about Boko Haram to enable me to conduct the study accurately and objectively (Moustakas, 1994; Percy et al., 2015). According to Moustakas (1994), epoché is having the ability to desist or abstain from judgments. With the use of epoché, bracketing, self-reflection, journaling, memo-writing, and clinical supervision, I managed my biases about the organization and its operations in Nigeria. This process allowed me as a researcher to be open and be fully present to the lived experiences of my research participants (Mihalache, 2019; Moustakas, 1994). Additionally, my clinical supervisor challenged my biases as they emerge in my writing (Ravitch & Carl, 2016).

Further, I ensured that subjects in this research study were given informed consent and granted autonomy. I also made sure they were not harmed in any way by the conduct of the research and were treated justly and in a non-discriminatory manner. These aspirations are in line with the Belmont Report (OHRP, 2018) and the four bioethical principles of autonomy, beneficence, nonmaleficence, and justice (Haswell, 2019).

Methodology

The research participants that were used in this study were both professional and non-professional mental health care providers who work directly with minor victims of Boko Haram in Nigeria. I worked with a nonprofit organization to identify research participants. A nongovernmental organization is already identified in the Federal Capital Territory of Nigeria, Abuja. Because I reside in the United States, I travelled to Abuja,

Nigeria to interview the participants in their natural setting (see Ravitch & Carl, 2016). The criterion for participant selection was participants who provided direct care to minor victims of Boko Haram, both in clinical and non-clinical setting in Nigeria. No participant was excluded from the research who met the identified inclusion criterion during the selection process based on their religion, gender, or socioeconomic status. However, the study excluded individuals with no prior history or experience of working with children who are victims of Boko Haram. Data analysis involved generation of themes and ranking the themes in order of importance.

Participant Selection Logic

Any research effort regardless of whether it is qualitative or quantitative will require having a representative sample. This is because it is not feasible to interview all the members of the population that are of interest to the research. For this reason, the parameters for selecting the participants must be clearly defined. These parameters include the sampling technique to be used as well as the instrumentation and data collection. The population of interest for this research study was care providers in Nigeria who provide services to Boko Haram minor victims.

Sampling and Sampling Procedures

Sampling for any research effort helps in determining the kind of human subjects that will be selected from the target population (Creswell & Poth, 2018). There are several types of sampling that include convenience sampling, quota sampling, and purposive sampling amongst others (Patton, 2015). The type of sampling used depends on the research design used. For this phenomenological qualitative study, the sampling

chosen is criterion sampling or purposive. This is the type of sampling in which the prospective participants must meet some predetermined inclusion criteria. The overriding criterion that every participant met is the participant's experience with the events or phenomenon under study. As a rule, the prospective participants must have in common the shared experience, but the experience may vary in their individual characteristics such as gender, age, and socioeconomic status amongst others (Moser & Korstjens, 2017). Purposeful sampling is recommended in qualitative study to ensure that the participants in the study could respond to the interview questions (Ravitch & Carl, 2016). Additionally, the sampling gives the ability to select participants who have a better awareness and understanding of the phenomenon that is been studied, and it will better educate the researcher about the phenomenon of Boko Haram (Patton, 2015).

Instrumentation

The research instrument used for this phenomenological study was face-to-face interviews (Moser & Korstjens, 2017). The interviews were conducted with participants who met the inclusion criteria. The participants narrated their experiences regarding the phenomenon of the Boko Haram in English. The questions were broad enough to give the participants greater flexibility and freedom to answer them as completely as they could. However, I used both guided questions and semistructured interview guidelines to obtain rich and detailed information from the participants (Patton, 2015). This allowed the participants to narrate their experiences from their own perspective and without restrictions (Moser & Korstjens, 2017).

I also used a demographic form to collect the research participants' demographic information (see Appendix B). The form consisted of participants' first names, gender, age, religion, education, and how many years they have provided care to the minor victims. Though participants' first names were obtained, I used pseudonyms during data analysis process to maintain confidentiality of the clients.

Procedure for Recruitment, Participation, and Data Collection

The selection of participants in a study has a significant impact on the quality of information attained (Hancock & Algozzine, 2016). The most significant part of data collection is to identify research subjects who have the best information that will address the study's research question (Hancock & Algozzine, 2016). Thus, I recruited participants for the study from Nigeria who have direct contact with minor victims of Boko Haram. I identified a nonprofit, nongovernmental agency in Abuja that works with the population. A formal conversation was initiated with the organization, and the organization assigned a master level psychologist to support me in identifying possible participants candidates who provide care to the minor victims of Boko Haram after Walden University's IRB approved the study (IRB approval no. 04-12-23-0744898).

Participation in the study was based on the satisfaction of the inclusion criteria. As part of the recruitment process, flyers were distributed to the employees of the nonprofit organization in Abuja, Nigeria. The recruitment was coordinated with the assistance of the appointed staff member from the nonprofit organization. The research participants were screened during a pre-interview telephone call to ensure they meet the inclusion criteria. Participants were informed that their participation in the study was

voluntary, and they were required to sign a consent form. The informed consent was read and explained to the respondents who met the inclusion criteria. The informed consent form reemphasized that participation in the study is voluntary, and there was no obligation for anyone to participate in the study, and it could revoke any time if any feels uncomfortable. The informed consent also outlined the purpose of the study, significance, procedures, and the process of storing collected data

I then scheduled a one-on-one interview at a time that was convenient for the participants. It was necessary to use semistructured interview questions to allow the participants to have the liberty to express and share their experiences in working with minor victims in the wake of BO activities in Nigeria. This method of data collection allowed participants to properly articulate in their words the intensity of their lived experiences (Hancock & Algozzine, 2016). This helped obtain thick and rich information about participants' experiences in relation to providing care to victimized children from the activities of Boko Haram. The location of the interview was in the participants' office at the agency in Abuja, Nigeria. Interviews lasted between 45–60 minutes and were recorded.

I compensated the participants for their transportation to and from the interview location. The equivalent of $20 was given to each participant to cover the participants' transportation costs. This amount is an equivalent of N11,400 in the local currency, Naira, based on the current exchange rate.

There are different perspectives about the number of sample size in qualitative research. There is no specific definitive sample size in qualitative inquiry (Creswell &

Poth, 2018; Patton, 2015; Ravitch & Carl, 2016). However, Patton (2015) posited that the size of the population is not a criterion to determine an appropriate size for a qualitative study, but it should instead answer the research question adequately. Though Creswell and Poth (2018) postulated that data may be collected until new and current themes are saturated, Patton (2015) would recommend a minimum sample of participants can be used depending on the objective of the phenomenon that is been studied. In accordance with sample size in qualitative research, saturation is obtained when there no new information is shared by research participants or when the researcher sees repeated or similar responses over and over (Ravitch & Carl, 2016). Therefore, the tentative sample size consisted of a minimum of seven and a maximum of 12 participants.

Data Analysis Plan

The analysis of the collected data is an integral part in qualitative study, and different authors have proposed different procedures to analyze data (Moustakas, 1994; van Manen, 2016; Yin, 2017). For instance, Merriam and Tisdell (2015) posited that data should be analyzed at the same time as data are collected. Such an endeavor gives the researcher the opportunity to make necessary amendments along the way and to test the emerging themes, concepts, and hypotheses (Ravitch & Carl, 2016).

The major data sources in this study consisted of the transcripts of the audiotaped interviews with the participants as well as my field notes. I analyzed the data by reviewing the recorded audio several times and transcribing verbatim the data into a Word document to capture the essences and meanings of the phenomenon as narrated by

the participants (see Creswell & Poth, 2018). Direct quotations of the participants interview were used in the analysis of the data.

Multiple digital voice recording devices, including my smart phone, were used to capture the participants' responses to the interview questions. To maintain the participants' anonymity and confidentiality, I assigned study pseudonyms to all data documents. I also encrypted identifiable data and securely stored all data documents. I listened to the audio recordings multiple times, reviewed, and transcribed the data into a Word document. After the transcription of the data, I reviewed the transcripts to identify themes that were coded (Ravitch & Carl, 2016) while keeping in mind epoché (Moustakas, 1994).

I followed the phenomenological process to analyze data. The first step in data analysis in phenomenological research is called horizonalization (Moustakas, 1994). Horizonalizational allows the researcher to discover specific statements in the transcripts that identify any information about the phenomenon of the participants (Moerer-Urdahl & Creswell, 2004), treating each statement of the research participants with equal value (Moustakas, 1994). Following horizonalization, I deleted statements that are repetitive and/or overlapping (Moerer-Urdahl& Creswell, 2004), leaving only the horizons or the textural meanings of the phenomenon (Moustakas, 1994). I analyzed the identified statements and clustered them into themes or meaningful units (Moustakas, 1994).

Following the horizonalization process, thematic analysis was used to develop the textural and structural descriptions of the phenomenon of the Boko Haram insurgencies. In thematic analysis, the researcher identifies themes as information emerges that will be

examined considering the research question of the study (Hancock & Algozzine, 2016). The process of developing both the textural and structural descriptions of the phenomenon requires the researcher to highlight the "what" of the experiences in textural descriptions and the "how" the phenomenon was experienced in structural descriptions (Moerer-Urdalh & Creswell, 2004).

The next step in data analysis in a phenomenological study is imaginative variation (Moustakas, 1994). The imaginative process allows the researcher to look for potential of feasible meanings using imagination (1994). Imaginative variation depends on intuition as a means to incorporate structures into meanings, and subsequently, develop into structural themes (1994).

The last process of data analysis is the process of intuitive integration (Moustakas, 1994). Intuitive integration is the process of synthesizing the textural and structural descriptions of the phenomena into a unified statement of the essences or meanings of the experience of the phenomenon as a whole" (1994, p.100). The description of the lived experiences of the care providers to the minor victims of Boko Haram insurgencies will be synthesized or developed into essences or meanings. According to Moerer-Urdahl and Creswell (2004), the description of the essence ultimately captures the meaning ascribed to the lived experiences of the study participants.

The researcher will use the NVivo qualitative software to analyze and categorize or cluster the data into themes. Themes that answer the research question about the lived experiences of providing care to children who have experienced trauma from the insurgencies of Boko Haram will be identified using a coding method. Thematic analysis

would include similarities and differences found in the data (Ravitch & Carl, 2016). These will explain the phenomenon under investigation, and at the same time, answer the research question. Lastly, for record keeping and securing of all research materials and data, I printed the generated results and stored them in a password-secured safe. For additional security, the research results were saved in a memory card and secured in a safe.

Discrepant Data

Discrepant data is data that do not conform to or align with the general direction of the themes generated or identified after coding (Ravitch & Carl, 2016). According to Creswell and Creswell (2018), data that contradicts the themes is referred to as discrepant information. The primary objective of the study is to understand the lived experiences of care providers in relation to their emotionality and self-care practices as they work with children victim of Boko Haram. It is therefore imperative to recognize the uniqueness of each participant's experience, varying, and disharmonious information shared by each participant. Consequently, all data will be given equal weight during the analysis process without interpreting or placing more value on one participant's experience than others. In employing Moustakas' (1994) modification of van Kaam's data analysis modification process, I carefully identified data that do not fit into the common themes during the data analysis process.

Issues of Trustworthiness

Trustworthiness in qualitative research refers to issues of validity (Ravitch & Carl, 2016). Trustworthiness attempts to answer the question: can the results of the

research study be trusted to be a true representative of the experiences of the participants in a qualitative research study? Validity in qualitative research does not carry the same connotation as it does in quantitative research (Denzin & Lincoln, 2017). Qualitative validity refers to the researcher's use of processes to ensure the accuracy of the findings and the researcher's ability to convey or depict the research participants' experiences accurately (Burkholder, et al., 2016). Validity in qualitative research involves the ability of a researcher to establish whether his or her findings are accurate from the perspective of the researcher, the participant, or readers (Creswell and Creswell, 2018). Therefore, trustworthiness in qualitative research should indicate the dependability, reliability, credibility, and conformability of the study (Burkholder, et al., 2016)

Denzin and Lincoln (2017) proposed four criteria to be used in pursuit of trustworthiness in qualitative research. These include credibility, transferability, dependability, and confirmability (2017). These criteria improve the researcher's capacity to analyze the correctness and integrity of the research findings as well as persuade readers of that accuracy.

Credibility

Credibility in qualitative research replaces the concept of internal validity in quantitative research. While internal validity seeks to ensure that the test measures what it claims to measure (Creswell & Poth, 2018), credibility attempts to answer the question about the congruency or trustworthiness of a qualitative finding (Denzin & Lincoln, 2017; Morse, 2015). Denzin & Lincoln (2017) also asserted that credibility evaluates whether the study results represent the interpretation or understanding of the original data

drawn from the research participants. Attaining credibility in qualitative study can be done through observations, engagement, peer debriefing, member checking, and triangulation (Creswell & Poth, 2018).

The findings of the study may be conveyed using a detailed or 'thick' description of the research participants' narration. This description may transport readers to the scene and add a sense of shared experience to the discussion. The results become more realistic and deeper when qualitative researchers provide extensive descriptions of the surroundings or offer multiple perspectives on an issue. This approach can improve the reliability of the results. Clarification of the researcher's bias should also be provided, as this improves the study's credibility (Creswell and Creswell, 2018).

Member Checking

Member checking is the process of assessing the accuracy of the qualitative research findings by returning the final report or specific descriptions or themes to participants and asking if their experiences or textural or structural narratives were captured (Creswell & Creswell, 2018; Ravitch & Carl, 2016). This approach may entail conducting a follow-up telephone call with study participants and giving them the opportunity to remark on the findings (2018).

The reliability of outcomes is a cornerstone of high-quality qualitative research. Member checking, also known as participant validation (Ravitch & Carl, 2016), is a technique for determining whether or not results are credible. Participants are given data or outcomes to check for accuracy and resemblance to their own experiences. In a list of validation approaches, member checking is frequently discussed. The benefit of adopting

the approach, as well as its contrast with the interpretative perspective of qualitative research, may be overlooked in this simplified reporting (Birt et al., 2016).

To determine whether a method is compatible with a study's theoretical position, it is crucial to investigate how and why member checking was performed. Researchers must be open about what they seek to accomplish with the approach and how their assertions about credibility and validity align with their epistemological position (Creswell & Poth, 2018). The researcher will achieve member checking process by returning the individual interview transcript to participants. This will give the participants the opportunity to review the transcribed data and provide their feedback on the validity of their captured experiences by the researcher.

Triangulation

Triangulation is the process of evaluating evidence from different data sources by a researcher to develop a cohesive argument for themes (Morse, 2015). Triangulation is claimed to add validity to a study if themes are created based on the convergence of data from different sources of data or opinions (Creswell and Creswell, 2018). According to Morse (2015), triangulation minimizes the risk of systematic biases and chance associations. Patton (2015) advocated for the use of triangulation to ensure the trustworthiness and dependability of a research study. To achieve this process, my Dissertation Chair and a Committee Member reviewed the study as progress was made with the research writing and the finished findings of the study.

Peer Debriefing

Another strategy to improve the study's accuracy is to employ peer debriefing. This is the process of using an unbiased and independent individual (a peer debriefer) to evaluate the researcher's transcripts, methodology, and final report to ensure that it can be understood by the public other than the researcher (Ravitch & Carl, 2016). It improves the validity of the research by working with one or more peers with no personal interest in the topic. This method adds validity and reliability to a study by involving an interpretation by someone other than the researcher (Creswell and Creswell, 2018). I achieved this process by having a qualified and unbiased colleague analyze and critique my research process, including the transcripts, methods, and conclusions of the study, including my dissertation committee.

Transferability

Transferability refers to the degree to which research study outcomes can be transferred or generalized to different of other studies or settings (Burkholder, et al., 2016). The qualitative researcher can improve transferability by thoroughly articulating the research context and the key assumptions that guided the study (Creswell & Creswell, 2018). According to Moustakas (1994), the significance of translating research participants' lived experiences into rich, thick, and textured description is a key component to ensure transferability. Through purposeful sampling, I achieved transferability by utilizing variation in participant selection based on their work experience, diversity, and nature or type of work each participant provides to the minor victims of Boko Haram insurgencies. The selection process increased the probability of

obtaining data represents a broader trajectory of experiences of the phenomenon under investigation (Ravitch & Carl, 2016).

Dependability

Dependability in qualitative research study denotes the consistency in obtaining and analyzing data and reporting the results of the study (Burkholder, et al., 2016). The concept of dependability highlights the need for the researcher to account for the evolving context in which the research takes place. It allows for an audit trail of how data was collected and of categories generated through field notes, memos, and journals (2016). To achieve dependability, I kept a trail of the changes that occurred in the process and documented how these changes influenced the way the study was conducted (Creswell and Creswell, 2018). Therefore, the inclusion of the research design and methodology used in data collection and analysis will help to establish dependability (Shenton, 2004). Additionally, to enhance dependability, I maintained detailed journal and memo entries of the evolving nature of the study's different phases (Morrow, 2005).

Confirmability

In qualitative research, the researcher is assumed to provide a different point of view to the topic. Creswell and Creswell (2016) defined confirmability as the extent to which test results may be substantiated by other individuals. Burkholder, et al. (2016) posited that to achieve confirmability in qualitative research, researchers will arrive at the conclusions when the same data is analyzed. Patton (2015) asserts that confirmability should ensure that findings from the research should portray the results and ideas of the participants rather than the researcher's inclinations or attributes. Enhancing

confirmability can be done in a variety of ways. Throughout the investigation, I documented the techniques used for collecting data and analysis techniques (Creswell and Creswell, 2018). Secondly, having the Walden University dissertation committee review and critique the study added confirmability to the research study.

Ethical Procedures

There are no research studies that are void of ethical issues. However, researchers can take some practical steps to minimize harm to human participants in the study. Consequently, in conducting this study, some ethical procedures during qualitative research were followed to protect participants who were recruited for this study (Ross, Iguchi, & Panicker, 2018). Follow the guidelines the American Psychological Association Ethics Code of do no harm and respecting the autonomy of research subjects remained at the forefront of my research (APA, 2017).

The first step to consider in this process is to apply and obtain approval to conduct the field study from the Walden University's Institution Review Board (IRB). As part of the IRB application process, information about the non-profit organization and permission obtained from the organization to conduct the study with their employees was included in the application. I provided the IRB committee with a copy of the informed consent form designed to be given to human subjects before their agreement to participate in the study. As part of the preservation of the bioethical principle of autonomy (Haswell, 2019), and the recommendations of the Belmont Report (OHRP, 2018), I endeavored to be transparent. Consequently, the informed consent form indicated the voluntary nature of the study by highlighting that the subjects' participation

was voluntary. Additionally, I outlined the purpose and benefits of the study and my strategy to distribute and inform the public about the outcomes of the study on the consent form. I captured the process of maintaining anonymity of the participants on the consent form to preserve their privacy and confidentiality. Time allotted for the interview was also communicated to the participants verbally and on the consent form. The participants were encouraged to ask me questions and withdraw from the study if they felt uncomfortable with the study. I did not offer renumeration to the study participants. Therefore, the subject of renumeration was disclosed in the consent form and also explained to the participants that they would not be renumerated. I identified some professionals who could provide psychoeducation about trauma to participants as a safeguard in the event the research becomes a trigger for them. The list of agencies and professionals was included in the IRB application form.

Another step to consider in this process is the treatment and storage of collected data. In line with the ethical consideration of human subjects, I stored all information used in the study in a digitally locked safe in a closet where no one has access to it. The protected information included transcripts, recordings, raw data, and my memos and journals. I used a Microsoft Surface Pro to compose my dissertation. The Surface Pro is concise, passworded, and safe for storing information obtained from the participants. Due to its size, I stored the Surface Pro in the safe. All raw data obtained from the study participants will be stored in the safe for a period of five years from 2022 and will be disposed of safely thereafter.

Summary

The study utilized a qualitative inquiry to document an understanding of the lived experiences of care providers to a specific population in the wake of Boko Haram uprising in Nigeria. Qualitative research aimed to obtain insight and understanding into how a particular group of people perceive events and circumstances surrounding an issue. The object of this study was to understand the lived experiences of individuals who care for minor victims of the insurgency of Boko Haram. The research design was a phenomenological inquiry that sought to describe the lived experiences of the child survivors of Boko Haram activities through the eyes of their carers. Criterion purposive sampling was used to recruit human subjects for the study, and structured and semi-structured face-to-face interview questions (instrumentation) were employed during the data collection. This was the preferred mode of interview because it provided the structure and setting for a holistic approach to securing information for the study.

In this Chapter, I also discussed data analysis and the subject of trustworthiness. In exploring the lived experiences of care providers to minor victims of Boko Haram in Nigeria, I hoped to contribute to the body of literature in this field and subject matter and possibly contribute to the positive change in the health care industry in Nigeria. Making public the experiences of individuals that work in the frontline who provide services to minor victims may raise awareness of mental health issues that are unaddressed in the country.

In conclusion, Chapter 3 provided an overview of the qualitative processes needed to conduct the study by examining the role of the researcher, the methodology used, and

selection of participants for the study. Data collection and analysis, sampling strategy, and ethical procedures were equally evaluated in this chapter. In Chapter 4, I will present the findings and results from the data analysis.

Chapter 4: Results

The aim of this qualitative phenomenological study was to understand the lived experiences of the service providers to minor victims of Boko Haram in Nigeria and the effects their work may have on them as caregivers. I used semistructured interviews to obtain nine service providers' experiences, stories, and narratives about their work with minor victims of Boko Haram. The interviews were conducted individually using open-ended questions to obtain in-depth data about their individual experiences. Each interview was hand-typed and reviewed with the participants to ensure that responses were properly captured. Five themes emerged, and these themes were supported by subthemes that described the participants' experiences in working with minor victims of Boko Haram insurgencies. In this chapter, I will include a review of the emerged themes from the analysis of the data collection from the interviews, and the demographics of the participants. Additionally, I will provide a description of the process by which were data collected and analyzed. I will also attempt to describe the evidence of trustworthiness to confirm the credibility, transferability, dependability, and confirmability of the study. Lastly, the chapter will present the summaries of the research findings and attempt to answer the research question.

Setting

I conducted the interviews by telephone within 1 week of my arrival in Nigeria. Due to the distance between the participants and my residence, and for safety reasons, it was important to conduct the interview by telephone. Several unsuccessful attempts were made to use the Zoom to conduct the interviews on the first few days. Due to the poor

internet connectivity in the country, it was best to use either WhatsApp or local telephone lines to conduct the interviews. All nine study participants agreed to be interviewed by phone. Informed consent was sent to all participants via email, and each, after reviewing the consent, returned to the email with "I consent" to participate in the study. I called each participant to schedule their appointments for the interviews. At the scheduled interview time, I called each participant. I thanked the participants for choosing to be part of the study and gave them the opportunity to ask any questions pertaining to the study, the researcher, and the university. I reminded the participants that they could stop the interview at any given time if they felt uncomfortable with the interview with no consequences on them. All interviews were conducted with each participant uninterrupted from the comfort and privacy of their rooms.

Demographics

Participation in the study was targeted at service providers who work with minor victims of Boko Haram insurgencies in Nigeria. Participant inclusion primarily focused on 18 years or older services providers living in Nigeria, regardless of their cultural or religious backgrounds. The nine participants were recruited through purposeful sampling to make certain the study participants met all the inclusion criteria for the study as indicated in the demographic survey and flyer that were emailed to the participants before the interview was conducted. Vulnerable populations were excluded from the study.

To ensure that the privacy of all participants was maintained, I designated an alphabet and a number to each participant to safeguard and protect their identities. All identifying information was removed from all transcripts to add additional protective

factors. The study participants included three males and five females. Three participants identified themselves as Muslims, while six said they were Christians, and all were above 18 years old (see Table 1).

Table 1

Demographic Information

Participant	Sex	Age range	Years as a provider	College degree	Religion
P1	Female	20–30	3	Yes	Christian
P2	Female	20–30	5	Yes	Christian
P3	Female	20–30	5+	Yes	Christian
P4	Female	31–40	4	Yes	Christian
P5	Female	31–40	5-6	Yes	Islam
P6	Male	31-40	7	Yes	Christian
P7	Male	31-40	5	Yes	Christian
P8	Male	31-40	4+	Yes	Islam
P9	Male	31-40	3	Yes	Christian

Data Collection

Data were collected from nine study participants through semistructured interviews. Each interview lasted approximately 60 minutes, at various times and dates, based on study participants' schedule and availability. Interview questions were used to direct the telephone interview. All responses were hand-typed by me and reviewed by the participants to ensure that their responses were captured verbatim. I used follow-up questions to explore more about the participants' experiences and responses for clarification of their responses and understanding. Where interview questions were unclear to the participants, I would rephrase the question for clarity.

I was unable to use the NVivo software to code the themes, so I hand-coded them. At the end of each interview and review by the participants, I thoroughly reviewed the

responses to the interview questions to identify the emerging themes and marked them in red ink. I also linked the themes with the participants' responses and tabulated the themes and responses accordingly for ease of access. To protect the anonymity and confidentiality of participants, numbers were assigned to each participant, P1 through P8. No identifying information was used to avoid possible disclosure of participants.

Data Analysis

To analyze the collected data, I used Moustakas' (1994) modification of Van Kaam's process of analyzing phenomenological data. I hand-typed the data and reviewed the data several times. I marked emerging themes in red ink on the interview question document of each participant. Additionally, I printed the responses of the study participants to re-read, and subsequently, I identified the subthemes that emerged from re-reading the printed responses. In using epoché, I bracketed my biases, subjectivity, prejudgments, and preconceptions I had about Boko Haram and the organization's activities in Nigeria (see Moustakas, 1994). I set aside any knowledge I had about the insurgencies of Boko Haram to ensure that I viewed the phenomenon from a fresh perspective.

Coding Procedure

The research question for this study invited participants to describe their experiences in providing care to minor victims of Boko Haram activities in Nigeria. After reviewing the transcripts numerous times, I used Moustakas' (1994) modification of van Kaam's phenomenological data analysis method, horizonalized the data, and matched the essence of each data collected with the goal of categorizing the themes and their

meanings through coding. The data were reviewed a few more times after printing them to ensure that the essences or meanings of the experience of the care providers were captured (Saldaña, 2016). I wrote the codes by the margin of the printed transcripts. Each code that met the inclusion was clustered into themes and subthemes and compared to the rest of the data. Subsequently, I generated a textural description for each study participant, and emerging themes and subthemes were identified in each individual structural description (Moustakas, 1994).

Themes

Three overlapping themes and seven subthemes emerged from reviewing the transcripts. These themes and subthemes are listed in Table 2.

Table 2

Themes and Subthemes from Data Analysis

Themes	Subthemes
Theme 1: Trauma Exposure	Subtheme 1: Vicarious Trauma
	Subtheme 2: Compassion Fatigue
	Subtheme 3: Burnout
Theme 2: Support	Subtheme 1: Helplessness
	Subtheme 2: Training/Resources
Theme 3: Professional Care	Subtheme 1: Self-Care
	Subtheme 2: Compassion Satisfaction

Theme 1: Trauma Exposure

All the nine study participants collectively expressed that there is a level of exposure to trauma as a result of their work with minor victims of Boko Haram insurgencies. Each participant expressed having developed some symptoms of posttraumatic syndrome disorder, including anxiety, flashbacks, and sleep issues.

Additionally, most expressed that they experienced vicarious trauma, compassion fatigue, and burnout resulting from their work.

Subtheme 1: Vicarious Trauma

The acknowledgement of experiencing some symptoms of trauma by the participants was in direct response to their expression of how their work with the population has impacted their overall life. Two participants expressed that their work with the minors reminded them of their own past "traumatic experiences" and "some of my childhood experiences." Participant 4 stated, "Psychologically, it just reminded me of some of my childhood experiences and how vulnerable children are and the long-time effect it could have on an individual if psychological intervention is not accessed early enough." Participant 6 narrated how listening to the stories of minor victims of the insurgencies "repeatedly was exposing me to vicarious trauma because some of stories they told was a trigger to my personal experience." Participant 6 also added, "I have overcome traumas myself."

In response to avoidance of thoughts, places and things that may remind the participants of stories from their clients and repeated exposure to their clients' experiences, Participant 1 stated that, "I do force myself to avoid certain thoughts, feeling, places, and activities …, because when that occurs, it is a flashback for me." Participant 1 also acknowledged that, "I have difficulties falling and staying asleep based on the past event that the children might have told me. I could just have a flashback on it, and it would disorganize my sleep and mood." Participant 4 recalled experiencing "vicarious trauma such as having flashbacks from listening to their stories," referring to

the minor victims' stories of how their parents and/or siblings were killed or raped in their presence.

Psychological impact resulting from exposure to repeated stories from the field was significant in some participants' narration. Participants 5, 6, 7, and 8 noted a substantial impact of their exposure to the victims. Participant 5 stated,

> I felt sick, having physical pains, psychotraumatic pains, vicarious trauma, and sometimes, I kept on having reoccurrence thoughts of the experience shared by my client. I had constant feelings of sadness, worried, fear, and strong concern, physically tired, exhausted, trouble sleeping, irritability, my level of anxiety increases and satisfaction of life decreases.

Additionally, Participant 6 described the experience of the exposure to the minor victims' stories by indicating that "I became more emotional after hearing a lot of stories." Participants 8 expressed,

> Psychologically, being exposed to various narration from the children and even witnessing some, I am both cognitive distortion and vicarious trauma bound. When counseling new profiles of children who share their experiences, I am vulnerable to vicarious trauma and I lose sleep—anxiety, fear. Knowing that such things can happen again, and that makes me lose sleep. I almost have insomnia at a minimum level as a result. The narratives of the children play in my head.

Subtheme 2: Compassion Fatigue

In addition to experiencing vicarious trauma, five out of the nine participants indicated that they experienced compassion fatigue resulting from their work with the

minor victims of Boko Haram insurgences. Participant 2 explained that "Sometimes, I feel trapped. I feel like I haven't done enough mostly, especially when a child …. says he/she hasn't eaten or doesn't have what to eat." Participant 4 shared how the limitation of resources she needs to work with, support, and assist the minor victims "affects me" and causes "me to lose sleep over some traumatic experiences of my client." Participant 8 explained,

> When compassion fatigue sets in, like, a lot of time, you realize I get trapped in my MHPSS [mental health and psychosocial support] scope. I feel like it is a livelihood rather than support for the children. I am limited in my ability to support the children due to funding my organization is provided. Care for the children is wholistic, but I am limited to provide only support. I do the same for these children, especially when I don't get the funding to provide the right treatment as a psychologist, to gain emotional release, etc. It is frustrating if your intervention does not readily cover those areas. There are times when events overwhelm your interventions – more issues come up as you begin to profile the children you are working with, the reality of those that need help (30–300 children displaced) overwhelm interventions, and it leaves you with a feeling that you are doing little or nothing, leaving you emotionally drained. Periods where you explore all referral pathways and your clients (children) are not accommodated, leaves you utterly unnerved and demoralized.

Subtheme 3: Burnout

Another consequence of working with minor victims of Boko Haram insurgencies as experienced and expressed by the study participants was burnout. Some participants explained how the stories from their clients are expressed physically and emotionally. Participant 2 noted, "I am stressed and tired, my body gives me signals, so I get irritated." Participant 3 explained that "A lot of time, … physical tiredness is always there because of the time I spend with the children. Emotionally, I feel tired. I don't know how to explain that, but it is related to the job." Participant 3 further added, "Physically, it tells on my health because of the demanding nature of the work." In narrating the experience, Participant 5 expressed that "Sometimes, I experience fatigue, burnout, especially during March, April, and May (peak periods, outbreaks of cholera, malaria, fevers, and typhoid) because there is no water." Participant 6 noted that "Physically, I experienced issues like fatigue—the workload is one of the issues—8 pm to 4 pm, struggling with breaks, writing reports…, you feel weak. Work with children is engaging and challenging, I experienced exhaustion as a result."

Theme 2: Support

Support was another theme that echoed in the participants' interview. Some participants felt that their interventions and/or level of care they provide their clients are insufficient, primarily due to insufficient funds and financial support from their donors. Some participants felt that if adequate funds were available, they would provide substantial care and/or intervention to the children, more than they are currently doing.

Subtheme 1: Helplessness

The study participants noted that not having sufficient financial support to provide care to the minor victims of Boko Haram insurgencies was a handicap to the quality of care they provide. There was a sense of helplessness from the participants' narrations. Participant 1 said, "Sometimes, I feel trapped as a caregiver having this feeling that am not doing much," while Participant 3 noted, "I feel trapped sometimes, not doing enough due to the funding from our donors, …, but there is nothing I can do about it."

In referring to the limited financial support the participants have to provide care to the minor victims, Participant 5 stated:

> With all the challenges of the clients, for example, medical issues, this is where money comes into place, and where there is no money, some husbands in the IDP (internally displaced persons) camps, for example, don't give their pregnant wives permission or allow them to go for antenatal care. Sometimes, I use my own money to care for them, and I too don't have much. So, in such situations, it is a really big challenge for us.

Participant 8 expressed a sense of helplessness in his inability to provide clinical interventions because of insufficient financial support:

> It is frustrating if your intervention does not readily cover those areas, but we make referrals to other organizations, such as for physical ailments. But these organizations also have their clients, which they might not readily be available to accommodate other children because they may have met their budget with their own clients.

Participant 4 explained the impact of lack of financial support on the children:

> Some children may need food to eat or an opportunity to go back to school, but my services are only to support them with psychological services, and this could limit the support some children may require as part of their coping skills.

Subtheme 2: Training/Resources

Some participants emphasized the importance of having unconditional support and sufficient training, supported by their individual organizations in their work with the minor victims of Boko Haram insurgencies. While some participants indicated that they have the support of their organization, some advocated for more. The support ranges from having additional training, pay increase, to having a better social network and corporate recognition. Participant 1 explained:

> I don't always get the support I need most times. The working resources are limited, support is not always 100%, and that could affect my work in a negative way. Lack of support, lack of having sufficient workspace/environment means therapeutically my work is restricted; I have limitations of what I can do. But, with support from organizations, it will make my work easier. I don't have the capacity to do what I should be doing for the children in terms of child-friendly space.

Participant 2 noted that it is insufficient to have internal trainings or trainings within their organization, but "a joint training with other organizations" and providing "feedback in real time" will be more advantageous. While Participants 3 and 5 expressed

that their organizations provide their workers with trainings and resources, they advocated for more trainings and financial renumeration as an incentive.

Participant 3 stated, “My company can do more, by providing monthly allowances besides the salary. It will go a long way, especially with the inflation.” Participant 5 noted that, “.... there is always room for more trainings. New things are coming up all the time – more trainings on psychological tools to diagnose clients for good outcome results, more advanced therapies, such as CBT, to work with the clients.” Participant 6 re-echoed the need for advance training and resources:

> My organization can support me by sending me to a more advance training. I only have basic skills; I can be sent to formal training institute for more advanced skills. I want to have a course in psychology and trauma so I can do better than I am doing now. My work is valued by my organization, but more still needs to be done in terms of staff welfare and response to urgent needs that requires immediate response.

Participant 8 additionally advocated for a reward system by the organization:

> Reward system adds value to the company, apart from the salary structure, to motivate staff. It doesn’t have to be monetary, a form of recognition like a promotion, etc., social support systems like funded breaks and trainings/workshops.

Theme 3: Professional Care

All participants agreed that the importance of self-care as care providers cannot be over-emphasized. While some felt they make it a point of duty to internally take time off

as a good self-care practice, some participants stated that it would be worthwhile if their organizations incorporated self-care into their policy.

Subtheme 1: Self-Care

As part of professional care, Participant 2 stated, "I take time to rest to avoid burnout. I talk to my colleagues, …. listen to music. Draw, write, and go to the gym." Participant 4 noted,

I find time to go on leave (vacation) to refresh or talk to my therapist. I engage mostly in relaxation activities such as deep muscle relaxation to help me cope." Participant 6 also noted:

> When exhausted I seek for a leave, and we are at liberty to go on leave to unwind at any point in time. I usually play outdoor games and listen to music to relax. We have indoor sports within the organization, and we organize self-care training sessions for the staff on Thursdays and Fridays every week."

Participant 8 advocated for organizational incentives in support of professional care:

> Institutionalizing care and support model – in the sense that maybe an organization puts up a standard system for the caregivers – mandatory to take off time (3 times) in 3 months, good for mental health, health insurance – the company supports you significantly with 80%, it gives you a sense of belonging and justifies your commitment to the work, make it compulsory. We don't get ample time to work on relaxation.

Some participants expressed that they lean on their spirituality or faith for self-care in addition to their common practices. Participant 3 noted that, “Most of the time, I result to faith-based practices and self-care.”

Subtheme 2: Compassion Satisfaction

The participants expressed a sense of satisfaction in their work with minor victims of Boko Haram insurgencies. They agreed that though their repeated exposure to their clients’ traumatic stories cause them distress, their role as a service provider leaves them with great fulfilment. Participant 1 stated, “I can never sometimes have a sense of worthlessness, discouragement or resentment associated with my work” Participant 5 acknowledged that working with the population has enable “me to understand people more, build empathy, hope, accept reality, build resilience, have high sense of peace. It was wonderful.”

Participant 4 stated:

> I actually feel way more fulfilled working with children especially when I could see smiles on their faces after undergoing some psychological intervention and they begin to bounce back to their lives. I do have a sense of fulfilment especially when I see that the children are doing way better than the first time, I saw them and that they have overtime-built resilience to help them cope with their past experiences.

Participant 6 re-echoed the sense of satisfaction, “I have fulfilment and I am happy doing my job. Fulfilling because of the kind of people I am helping, making a lot of impact, affecting their lives, my culture, and language helps a lot to direct the children and

psychologists, giving back, satisfaction, there is joy in it and fulfilment." Participant 7 also noted, "I feel fulfilled because I have worked with over 30,000 children and a lot of them benefited from the activities I created and some of the adolescent children are facilitators today."

Evidence of Trustworthiness

Credibility

Credibility was established by confirming that the phenomenon under study was accurately documented (Shenton, 2004). Credibility was accomplished by adopting and implementing validated research questions. Additionally, I used peer debriefing and member checking in an attempt to achieve and maintain the credibility of the data collected. I read the hand-typed responses of the interview back to the participants to ensure that I captured their responses and essences of their experiences (Ravitch & Carl, 2016). The participants confirmed affirmatively that their responses were captured, and the phenomenon understood.

In peer review, I contacted a colleague who has done some clinical work with trauma patients and adoption families to confirm some themes that emerged from the transcripts. Because no identifiers were used in the data analysis, the confidentiality of the participants were maintained as feedback was provided by my colleague.

Transferability

Transferability in qualitative research is defined as the ability to apply a study's outcomes to different times and places (Burkholder, et al., 2016). In order to achieve transferability, I employed the participant variation in the selection of study sample. I

selected participants that work for different organizations with varied lengths of service in the field and had previously or currently work with minor victims of Boko Haram insurgencies, to interview. The selection method yielded a varying number of participants with distinct experiences.

Dependability

To address and maintain dependability, an audit trail of the documentation of each part of the study procedure was well kept for safe-guarding or keeping of the obtained documents. I recorded in detail the process of information gathering to allow future studies to repeat or replicate the work (Ravitch & Carl, 2016). Additionally, by recruiting study participants from different organizations to obtain varying perspectives, perspectival triangulation was achieved (2016). Participant pool consisted of service providers from different parts of Nigeria that are affected by Boko Haram, length of years and experience in the field, and clinical and non-clinical workers.

Conformability

According to Shenton (2004), conformability in qualitative research ensures that the research findings reflect both the experiences and ideas of the study participants, and not the researcher's ideas or biases. To achieve conformability, I used epoché (Moustakas, 1994) to mitigate any biases I may have had about Boko Haram and the organization's activities in Nigeria. Any pre-conceptions or judgments about the organization were noted. I journaled the emotions that came up for me when the subject of Boko Haram was mentioned. I also expunged any prior knowledge I might have held about the organization and approached the phenomenon from a novel perspective (1994).

Results

The research question for this study investigated the lived experiences of providing care to minor victims of Boko Haram insurgencies in the northern part of Nigeria. There were three themes identified in this study: (a) trauma exposure, (b) support, and (c) professional care. There were seven subthemes identified: (a) vicarious trauma, (b) compassion fatigue, (c) burnout, (d) helplessness, (e) Training and resources, (f) self-care and (g) compassion satisfaction. The theoretical foundation for this study was compassion fatigue (CF, Figley, 1995), burnout, and vicarious trauma models (McCann & Pearlman, 1990). Researchers have focused attention on the psychological and physical exhaustion resulting from working with trauma patients by service providers. It was appropriate to use the theoretical model to understand the lived experiences of care providers to minor victims of Boko Haram insurgencies in Nigeria.

The participants in this study identified the psychological impact of providing care and support to minor victims traumatized from the violence and terroristic attacks by Boko Haram organization. The participants identified mental health as a major concern in the field. All participants indicated that they had suffered psychological distresses and compassion fatigue in one form or the other, resulting from their work and exposure to trauma work. Some of the symptoms listed included depression, anxiety, posttraumatic disorder, secondary trauma, isolation, and others. Consequently, the interpersonal relationship is hampered. The findings are supported by available data on vicarious trauma (Adepelumi, 2018; Terwase, et al., 2015). Participant 9 described their experience:

> It has affected me in a way that I sometimes go home with some thoughts in my head (reflection). Sometimes I dream of the experience shared, their vulnerability has made me have a different view about life and find it hard to socialize so I isolate myself from other activities in order to collect myself together, because I sometimes find no joy of doing some personal activities.

Some participants also reported that their work with the minor victims have impacted their social and interpersonal lives. While some of the impact may be positive, some participants expressed that they have lost almost all their network of friends. For example, participant 8 reported,

> Socially, it has dampened my social network and inter-personal tendencies, considering the context of the volatile environment. The social environment is not aiding an improved social life for me.

Participant 2 noted that her work with her clients has, reflectively, challenged them to be more gregarious. This is viewed as a positive instead of a negative effect. Participant 2 stated:

> Dealing with victims affected my life socially in the sense that I was actually an introvert (before working with the children) and working with children has made me a different person, because I have to be friendly, accommodating, patient with them. But has brought a different personality out of you.

Additionally, some participants described their work with the minor victims as positive, even though it was challenging. Participant 5 for example noted:

> At first, it was kind of difficult, when I put myself in my clients' shoes I became a stronger person, ready to adopt to any situation I found myself. I have the ability to understand people more, build empathy, give hope, accept reality, build resilience, high sense of peace and so, on. It was wonderful.

Summary

The aim of this research was to gain more insight on how service providers to minor victims of Boko Haram insurgencies viewed their lived experiences as they work with their clients. I recruited nine participants for the study and the semi-structured interview questions generated rich data that described the lived experiences of the study participants. I interpreted the data using open coding analysis, which yielded three themes and seven subthemes. In Chapter 4, I have provided the details of how the study was conducted, beginning with the setting, demographics, data collection, data analysis, themes and subthemes, and evidence of trustworthiness, which included credibility, transferability, dependability, and conformability. In Chapter 5, I will discuss the interpretation of the findings, limitations of the study, recommendations for further research, the implications, and conclusion.

Chapter 5: Discussion, Conclusions, and Recommendations

The Boko Haram insurgency in Nigeria has had significant psychological and emotional impact on its victims and the caregivers who provide rehabilitation services to survivors. Earlier commentaries on Boko Haram insurgency have focused on its impact on business and economy in Nigeria particularly in North-Eastern Nigeria (Othman et al., 2015), cost in human resources and infrastructure (Dunn, 2015; Ikpe, 2017), and security (Amalu, 2016). However, no previous study on Boko Haram insurgency in Nigeria has concentrated on the psychological and emotional impact of the insurgency on the lived experiences of the service providers to minor victims of Boko Haram in Nigeria. The purpose of this study was to capture the lived experiences of those that provide services to the minor victims of Boko Haram insurgencies in northeastern Nigeria. Nine field workers from the northern part of Nigeria participated in semistructured interviews. Three overarching themes emerged from the data: (a) trauma exposure, (b) support, and (c) professional care. Correspondingly, seven subthemes were identified: (a) vicarious trauma, (b) compassion fatigue, (c) burnout, (d) helplessness, (e) training/resources, (f) selfcare, and (g) compassion satisfaction.

This final chapter summarizes this study on the lived experiences of service providers to minor victims of Boko Haram in Nigeria and the impact their work may have on them as caregivers. In Chapter 5, I will interpret the findings of this study. I will also discuss the limitations, make recommendations for future research, and provide the implications. Finally, I will provide a conclusion to this research.

Interpretation of the Findings

Data gathered from this study about the lived experiences of caregivers who provide direct care to child victims of Boko Haram terrorist attacks in Nigeria indicates the psychological, emotional, and social impact on these caregivers and by extension to families, relatives, and friends of all the victims of the atrocities unleashed by Boko Haram. Answering the research question from the data collected in this study, all the participants spoke about the pains they experienced providing care to the child victims in their care. However, the three overarching themes that resonated with the participants are trauma exposure as a consequence of providing direct care to child victims of Boko Haram insurgency. Second, inadequate support limits the capacity to provide satisfactory care to the child victims of the insurgency. Finally, lack of professional care decreases the quality and effectiveness of service delivery to child victims of Boko Haram insurgency.

Trauma Exposure as a Consequence of Providing Direct Care to Child Victims of Boko Haram Insurgency

The study's conclusion that trauma exposure is a consequence of providing direct care to child victims of Boko Haram insurgency in Nigeria is consistent with existing literature that indicates that people who provide services to disaster victims can be retraumatized by the experience of the people they look (Guzman et al., 2020), and caregiver impairment is common for trauma exposed populations in substance misuse (Vivrette et al., 2016). A recent study that involved nurses as frontline care providers in refugee camps in Jordan revealed possible inherent trauma, which they overcame by employing "several strategies …to distance themselves from refugees' psychological

condition by attempting not to engage personally." (Backlund, & Olausson, 2021, p. 8). However, the experiences described by these nurses are like those suffered by the participants described in this study. Another recent study on Rohinya refugees illustrated the gender-based violence against women by the Myanmar security forces and its impact on health workers and called for urgent interventions to address "potential vicarious trauma affecting health workers" (Green et al, 2022, p. 12).

Based on these experiences, the following definition for trauma exposure is presented, as the transformations that occur in an individual following their subjection to regular care of another, or a victim put at risk or traumatized by negative experiences, which may reduce the care provider's ability to function cognitively, emotionally, and physically. This definition is consistent with the trauma exposure experienced by the participants in this study. One of the participants stated,

> I do force myself to avoid certain thoughts, feeling, places or activities that remind me of a frightening personal experience because when that occur is a flashback on me and I will not really give my best in the course of counselling session. Sometimes I have difficulties falling and staying asleep based on the past event that the children might have told me, I could just have a flashback on it, and it would disorganize my sleep and mood.

The above experience by this participant echoes the pre-emptive inherent trauma exposure experienced by the nurses in Backlund and Olausson's study (2021), but deliberately repressed.

Another participant stated,

> At first yes, I felt sick, having physical pains, psychotraumatic pains, vicarious trauma…sometimes I kept on having reoccurrence thoughts of the experience shared by my clients. I had constant feelings of sadness…worried…fear and strong concern…physically tired, exhausted, trouble sleeping, irritability. My level of anxiety increases and satisfaction of life decreases.

These experiences are universal as indicted by Green et al (2022), where some participants are affected by the narratives of the people in their care. Another participant indicated that:

> Psychologically, the experience with the victims in the field was affecting me through nightmares and dreams about the victim's stories and experiences. I always visiting staff counsellor for sessions because it was seriously affecting my functioning.

The current study expands on previous studies about the impact of trauma exposure on care providers to victims of disasters, violence, and terrorism. The study points to a central conclusion that these care providers develop a range of health problems including PTSD (Henning & Brand, 2019, Sowder et al., 2018). The commonality of these findings and their widespread impact call for a globally systemic approach to address its reoccurrence.

Inadequate Support Limits the Capacity to Provide Satisfactory Care to the Child Victims of the Insurgency

This study's conclusion that inadequate support limits the capacity to provide satisfactory care to the child victims of the Boko Haram insurgency in Nigeria is

consistent with current literature that psychological, material, and training support can increase productivity and quality service delivery. Previous research suggests that intervention for trauma is constantly evolving and systematically undergoing reviews (Cook, Newman, & Simiola, 2019). Trauma is widely recognized as a health concern that requires specialized training for mental health professionals who are at the forefront for providing care and support to trauma victims (2019). Such training includes competencies in treatment modalities, knowledge, and skills acquisition in specific trauma domains, such as trauma-informed interventions. Training in these domains will equip the service providers to execute their task competently without feeling unsupported (2019). Some participants in the study were overwhelmed and complained of compassion fatigue and burnout. They expressed that they could have been more supported to provide satisfactory assistance to the child victims in their care. With regards to education and training support, one participant stated:

> There is always room for more trainings. New things are coming up all the time. More trainings on psychological tools to diagnose clients for good outcome results, more advanced therapies such as CBT to work with the clients. Now, we have three psychologists, we don't have enough (staff). Some of us are left in the organization, and I am not happy about it. We have a lot of clients but a few staff to help.

Cook, Newman, and Simiola (2019) highlighted trauma training issues for intervention and support for care providers who work with trauma victims. The authors found that though major improvement has been recorded in the provision of mental

health support, the need for basic training in trauma psychology is still required (2019). The authors reported the effectiveness of a trauma-related training program for mental health workers to improve professionals' knowledge, skills, attitudes, and confidence. These trainings are useful and adds value to the service providers' work with victims.

Lack of Professional Care Decreases the Quality and Effectiveness of Service Delivery to Child Victims of Boko Haram Insurgency

This study's assumption that lack of professional care decreases the quality and effectiveness of service delivery to child victims of Boko Haram insurgency in Nigeria is consistent with previous literature that frontline health workers and care providers experience burnout severity and poor quality of life tend to ignore their own self-care whilst caring for their clients' wellbeing. Research shows a prevalence of high burnout rate among care providers, they often neglect their self-care and put their health at risk for others (Naz, Hashmi, & Asif, 2016; Odachi et al, 2017). Much of the literature on professional care has focused more on patients' and clients' care with little or no attention given to the wellbeing of care providers (Aytekin, Yilma, & Kuguoglu, 2013; Odachi et al, 2017).

The World Health Organization (W.H.O., 1998) defines quality of life (QOL) as individuals' opinions of their situation in life within the matrix of their cultural values relative to their beliefs, aspirations, and interests. It also defines selfcare as a person's ability to nurture, sustain their welfare, avert illness, and manage illness either on their own or through the assistance of an expert (W.H.O., 2014). From these definitions, it is obvious that selfcare bring about professional QOL.

The theme of selfcare resounded well with all the participants in the current study and expressed compassion satisfaction despite experiencing high burnout from their demanding and risky jobs. Five participants expressed that they could take time off to nurture themselves if the need arose. The participants seemed to have a good understanding of selfcare and perhaps doing the right thing for themselves. However, it is not clear whether the quality of selfcare they described meets the World Health Organization standards in terms of their emotional, mental, physical, social, and spiritual wellbeing. Irrespective of the spectrum of selfcare practices that the participants engage in, it is imperative that service providers find time for self-nurture. While some practices may include seeking therapeutic services, others may include using recreational activities to nurture self. As part of self-care, spending quality time with families and friends can aid burnout, more so, when unwaveringly supported by their various organizations (Xu et al., 2019).

Limitations of Study

One notable limitation of this study is the size of the participants. The sample size of 9 participants was smaller than projected. It was impossible to generalize the findings of the study to all service providers who either currently work or had worked with the minor victims of Boko Haram insurgencies since the inception of the terrorist organization in Nigeria. The researcher did not take into consideration providers living in other parts of Nigeria other than the northeast.

Another limitation of the study is that of the participants' external circumstances that were beyond their control. During the interview, some participants had some

distractions they could not control such as noise at the background that might have led to participants filtering their responses to the questions. For example, one participant was in public transportation, and another was in a noisy environment while responding to the research questions. These external interruptions and intrusions could have contributed or limited the participants' ability to articulate their perceptions adequately (Ravitch & Carl, 2012).

Lastly, another limitation is possible subtle researcher's biases of Boko Haram's activities in Nigeria. As a citizen, the researcher is empathetic towards the victims of the organization's inconsiderate attacks. Noting these biases during the interview, the researcher made efforts to keep aside the judgments about and perceptions of the terrorist group and played the role of a researcher instead (Moustakas, 1994).

Recommendations

The findings of this study require further research to be conducted to include or extend future research to providers of minor victims of Boko Haram (BK) insurgencies residing in other parts of Nigeria. The participants in this study indicated that their clients resided in the northern parts of Nigeria, and services provided were limited to the victims residing in those areas. Boko Haram is a well-organized terrorist organization, known to carry out their indiscriminate attacks in neighboring countries to Nigeria, such as Benin Republic, Cameroon, Chad, and Niger, in addition to Nigeria (Center for Preventive Action, 2022). Consequently, future research should include providers or workers in the neighboring countries because the findings from this research cannot be generalized to those countries.

The present qualitative research explored the lived experiences of care providers to minor victims of BK insurgencies and the impact of their work on them. All participants found their work in the field traumatizing, and many acknowledged that their organizations have treatment protocols in place for them. However, this study did not delve into the treatment models or protocols the participants found effective for them. It is therefore, recommended that future studies could investigate the effectiveness of the treatment protocols specific to service providers in Nigeria, using a quantitative research method.

Implications

Within the first half of 2014 Boko Haram (BH) organization abducted nearly 300 young schoolgirls and killed 2,924 people including foreign nationals (Mantzikos, 2014). The total number of killings by BH in 2014 more than doubled the Islamic State killings at 1,459 and nearly six times that of al-Qaeda in the same period (2014). The number of internally displaced persons (IDPs) in North-eastern Nigeria in 2018 was two and a half million, which made Nigeria a country with the highest IDPs in Sub-Saharan Africa, 79% of whom comprised women and children (Salleh, Ahmad, & Jamil, 2018). Besides, illiteracy and unemployment rates at 85% and 60% respectively meant that North-eastern Nigeria became a vulnerable hub for recruitment into infamous Boko Haram sect. Nationally, 64 million Nigerian youth were reported to be unemployed as of 2020 out of a projected population of over 200 million (Ayoade, Odetunde, & Falodun, 2020). Understanding the socio-economic background of North-eastern Nigeria was necessary to comprehend the implications of the study. Of course, insurgencies are never anyone's

prescription. Rather, a de-escalation of its occurrence should be the pursuit and goal of government and international community. Therefore, implications, firstly at a microlevel for care providers who are at the frontlines giving support to victims of Boko Haram must be considered. A second implication at a macrolevel involves what must be done to curb the surge of insurgencies in Nigeria.

At a microlevel, to achieve productivity, service efficiency, and effectiveness from care providers of child victims of Boko Haram, and indeed any disasters – either natural or caused by human factors, the lived experiences of care providers must be investigated to have a greater understanding of the impact of the services they provide on their psychological and emotional wellbeing. This should involve providing adequate support for care providers in all areas of need to enable them to engage with their clients and to cushion the negative impact of vicarious trauma and excessive burnout.

The results from the current study contributed to filling the existing gap in both scientific and professional literature on the topic of understanding the lived experiences of service providers to the minor victims of Boko Haram insurgencies (BHI) in the northern region of Nigeria. The results obtained from the study may be used to understand the struggles service providers in Nigeria, go through in an effort to provide quality care to their clients. This understanding may ultimately increase the cultural sensitivity to trauma-informed work and mental health awareness in the society. Bringing the struggles of service providers to the global public view may generate an empathetic response to the plight of those that work with trauma patients in Nigeria, and thereby, bring about social change.

Furthermore, shedding light on the lived experiences of minor victims of BHI service providers expresses the need for the public and especially, the Nigerian government, to acknowledge the existence of mental illness, and subsequently, make provisions on the national budget for the training of clinical mental health professionals in the country. The culture in Nigeria towards psychology and psychological issues is unwelcoming. They are trained psychologists to the highest level of education in the country; however, because there is little or no recognition or acceptance of clinical work, most psychologists resort to the teaching professions. The Nigerian Psychological Association (NPA) is the highest professional regulatory body in the country (www.npass.org). The organization describes its services to the public as providing psychosocial services, among others. However, there is no mention of delivery of clinical or psychological services to the public.

Another factor to consider as one reviews the implication of the findings of this study is the treatment modality used in working with trauma victims. The results from this study may shed light on the need for mental health professionals to be trained specifically in trauma-focused interventions, such as cognitive behavioral trauma-focused therapy, dialectical therapy, mindfulness-based psychotherapies, eye movement desensitization reprocessing (EMDR), to name a few, for trauma patients and service providers working with the population. Many participants expressed the need to be trained in evolving therapies and treatment protocols, which they thought would be beneficial to their clients. This can be achieved if all entities, including the Nigerian

government and professional organizations, share a common goal of mental health awareness and destigmatize mental illness in the society.

Conclusion

This study sought to explore the lived experiences of service providers to minor victims of Boko Haram insurgencies in Nigeria with the goal of understanding the extent to which the impact of their work had on them on different levels of functioning. The participants of the study heartedly shared their experiences of being in the frontline as providers to children victimized by the activities of Boko Haram. The findings collaborated with existing empirical studies on the psychological impact of providing care to victims of terrorism (Franza, et al., 2020; Shaw, 2014, Thomas, 2013). The findings indicate that providers of services to trauma patients of Boko Haram insurgencies suffer from vicarious or secondary trauma, compassion fatigue, anxiety, and burnout resulting from their long exposure to their clients' narratives of trauma. However, these symptoms of mental health may be mitigated if they are addressed immediately in a therapeutic environment. The therapeutic setting may not necessarily be clinical in nature or provided by qualified clinical mental health professionals. Additionally, the findings also found that confiding in friends, family, colleagues, or confidants helped to alleviate some symptoms of mental health. This finding supports the background literature that highlighted the prevalence of the impact of trauma-related work amongst service providers.

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Appendix A: Pre-Interview Telephone Screening Questions

Hello ___:

My name is _____. I am pursuing a doctoral degree at Walden University, Minnesota, USA. I am conducting a studying to understand the experiences of individuals that provide care or assistance to children who are victimized as a result of the activities of Boko Haram in Nigeria. I am looking for people who have directly worked with this population for my study.

I want to thank you for indicating interest in the study. I will interview you about your experiences in working with minor victims of Boko Haram insurgencies in Nigeria. The study will assist health care practitioners in the area to understand the effects of working directly with victims such as the population you work with. Additionally, the findings will help to contribute to literature and subsequently, identify ways to support the care providers emotionally and mentally. Please note that you are voluntarily opting to participate in the study. Before we schedule an interview, I would like to ask you a few questions to confirm your eligibility to participate in the study. Do I have your permission to proceed with the screening questions?

1. Are you at least 20 years of age?
2. Do you speak English?
3. Do you currently reside in Nigeria?
4. Do you currently or in the past work with children who are victims of Boko Haram?

Thank you for answering my screening questions.

[Proceed to Question A or B depending on if the participants meet the inclusion criteria]

A.) I would like to proceed with scheduling an interview. Please note that the interview will be conducted in a safe and confidential location to facilitate a candid and honest discussion of your experiences relating to your work with minor victims of Boko Haram.

B.) I am unable to proceed with scheduling the interview. All the inclusion criteria were not met. I appreciate your interest and I know that you have valuable insight to provide in future studies. Unfortunately, it is not within the scope of my current work. I wish you much luck on your future endeavors and I appreciate your time and patience.

Appendix B: Interview Questions

Demographics:

Name:

Age:

Religious Affiliation:

Educational Training:

Are you a licensed clinician or para-clinician?

Number of Years Working with the population:

1. Please describe what your experience has been like working with children victim of the Boko Haram insurgency.
2. To what extent does your work with the victims affect your life socially, psychologically, physically, and spiritually?
3. In your work with the children, do you sometimes force yourself to avoid certain thoughts, feelings, places, or activities, that remind you of a frightening personal experience or stories from your clients or from repeated exposure to your clients' experiences?
4. Do you sometimes have difficulties falling and staying asleep, or lose sleep over a client's and their family's traumatic experiences?
5. Do you sometimes feel trapped by your work as a caregiver and/or feel less concerned about the welfare of your clients?

6. Do you sometimes find yourself feeling emotionally and physically tired, depleted, and rundown as a result of your work as a caregiver?
7. Do you sometimes have a sense of worthlessness, discouragement, and resentment associated with your work?
8. Do you feel you have the support you need to perform your job well from your colleagues, supervisor, and the company you work for?
9. Do you feel adequately prepared and trained by your organization for this work?
10. In your opinion, how can your company support you?
11. Do you sometimes feel that you cannot do this work anymore? What do you do to help you unwind or relax?
12. What support system do you have in place to assist you with the emotional and physical tiredness stemming from work?
13. Does your company support you or value your work as their employee? In your opinion, how can your company encourage you more as a caregiver?
14. Do you have a sense of fulfilment in what you do, or do you feel sometimes that you are a failure as a caregiver?
15. How easy is it for you to access mental healthcare resources when you need them?

Appendix C. Recruitment Flyer

Research Participants Needed

Research Purpose: To explore the experiences of providing care to children victims of Boko Haram insurgency in Nigeria.

You are eligible to be part of his study if you meet the following criteria:

1. You are at least 20 years of age.
2. You work directly with children who have been displaced, traumatized, and are victims as a result of the Boko Haram activities in Nigeria.
3. You live and provide care in Nigeria .

In this study, participants will:

Participate in a 1:1 interview for 45 – 60 minutes

This endeavor is in partial fulfilment of a doctoral degree in Clinical Psychology at Walden University.