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Relationship Between Attachment Style, Childhood Trauma, and Psychosocial Health in Adult Nigerians Raised in Kinship Homes

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Walden University

College of Social and Behavioral Health

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Kenneth O. Ekekwe

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Walden University
2023

Abstract

Relationship Between Attachment Style, Childhood Trauma, and Psychosocial Health in Adult Nigerians Raised in Kinship Homes

by

Kenneth O. Ekekwe

MS, Walden University, 2018

MD, Urbania University, 2000

BPh, Urbania University, 1996

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Counselor Education and Supervision

Walden University

November 2023

Abstract

Kinship care is a common phenomenon in Nigeria and one form of raising a child outside their biological homes. But some children who are removed from their biological homes face various challenges like attachment style, childhood trauma, and psychosocial health risks, which have lifetime consequences. A quantitative, correlational study was conducted to determine whether there is a predictive relationship between, attachment type, childhood trauma, and psychosocial health in adult Nigerians raised in kinship homes and whether attachment type mediates the relationship between childhood trauma and psychosocial health as measured by scores on the Attachment Style Questionnaire-Short-Form, Adverse Childhood Experience Questionnaire, and Psychosocial Screening Instrument for Physical Trauma Patients. A cross-sectional data collection method was used to collect data through surveys. Data analysis methods encompassed multiple linear regressions and mediation with regression analysis. The overall results showed that there is a statistically significant predictive relationship between attachment type, childhood trauma, and psychosocial health. This study contributes to a greater understanding of the Nigerian kinship system and its effects on the psychosocial functioning of adult Nigerians that experienced kinship placement as a child. The result of the study may assist counselors who work with adult Nigerians and contribute to clinical counseling training programs and services.

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Chapter 1: Introduction to the Study

Kinship is one of the alternative care environments where children are fostered outside their organic or biological families (Adeboye et al., 2019; Ariyo et al., 2019). Kinship is a well-known phenomenon in Africa, where children are sent to live with their relations, extended families, or close friends of their families (Chukwudozie et al., 2015). Approximately 15.8% of African children live outside their biological families, whereas 0.002% accounted for formal alternative care (Chukwudozie et al., 2015). These statistics imply almost 16% of African children experience kinship care. Because Nigeria is the most populous country of the African continent (World Population Review, 2021), and Nigerians are the largest African immigrants in the United States(Gramlich, 2020), Nigerian immigrants may account for the significant number and percentage of African children raised outside their biological families in Africa. However, children both in kinship care and foster care are more likely to suffer mental health issues than children living with their biological parents (Xu & Bright, 2018). Researchers note that a biological family environment is the best place to nurture children to adulthood (Adeboye et al., 2019; McCormick & Thomson, 2017). Children raised outside their organic homes experienced much trauma and are particularly vulnerable to psychological and developmental problems (Bell & Romano, 2014).

Childhood trauma among Nigerians who experienced kinship placement has not been well-researched to understand their psychosocial health later in life. My study was centered on adult Nigerians who were raised in kinship homes to assess for attachment style, childhood trauma, and their current psychosocial health. Attachment style is a

widely used paradigm for understanding human affective development and adaptive psychosocial competencies, including forming healthy relationships during adult life (Iwanaga et al., 2018; Zdankiewicz-Scigala & Scigala, 2020). Childhood trauma has been associated with insecure attachment and increased risk of psychosocial health (Kendall et al., 2015). Therefore, there is need to investigate the attachment style and psychosocial functioning of this population after kinship placement and exposure to childhood trauma. My research provides understanding of the kinship care system and the relationship between childhood trauma and psychosocial health of adult Nigerians. The findings may be used to inform clinical counseling training programs and counseling program outcomes, improve counseling services, and multicultural sensitivity. The social change implications of the research include literacy awareness and societal empowerment to improve or reform the system and make it better.

In this chapter, I will discuss the background of the study, the problem statement, and the purpose of the study. I will also discuss the theoretical framework, limitations of the study, and significance of the study. I will end with a summary of the chapter.

Background

A traumatic incident is a dangerous or distressful experience that can result in intense emotional and physical reactions, feelings of helplessness and terror, and may hinder healthy development and lead to mental or psychological problems, including personality disorders (Fratto, 2016; Scheffers et al., 2019; Whittingham, 2017). It is estimated 5 million children experience some type of traumatic event each year in the United States (Fratto, 2016). Further, 34.8 million children in the United States are

exposed to trauma or adverse childhood experiences (National Institute for Children's Health Quality, 2022). I found no literature on the estimated population of children exposed to trauma in Nigeria, but an available data on "punitive violence against children" showed that 84.9% of children in Nigeria (aged 1-14) experienced harsh or violent discipline (Ofoha & Ogidan, 2020, as cited in National Bureau of Statistics and UNICEF, 2014).

Childhood trauma has been found to have a significant relationship with a number of psychosocial and mental health problems in adulthood (Foster et al., 2015; Jansen et al., 2016; Lee et al., 2017; Masson et al., 2015; McCormack & Issaakidis, 2018; McCormick & Thomson, 2017; Stolzneburg et al., 2018). Survivors of childhood sexual trauma experience attachment insecurity, and low self-esteem, which may lead to problems in adult romantic relationships (Barnum & Perrone-McGovern, 2017). Another lifelong effect of traumatic experience is depressive symptoms and later life depression (Butcher et al., 2014; Powell & Davis, 2019).

Childhood traumatic experience not only exposes individuals to psychosocial risk but can impact the attachment quality. Three attachment patterns are secure, avoidant, and ambivalent (Mallinckrodt et al., 1995; Reisz et al., 2018). Childhood trauma has been associated with insecure attachment and increased anxiety symptomology in adults (Kendall et al., 2015). Children tend to deal with emotional trauma when they are separated from their biological parents (Hong et al., 2011). Attachment quality primarily designates patterns of beliefs and behaviors deep through connections to primary caregivers that can affect people through their lives (Lawson, 2019). Growing up in a

family environment allows children to develop a secure or healthy attachment with a consistent caregiver (Fratto, 2016). Children, when removed from their biological homes, experience attachment disruption or disorder (Howe & Fearnley 2003; Rushton Hong et al., 2003, as cited in Hong et al., 2011). Children in kinship homes are likely to experience childhood adversity or trauma and its associated psychosocial problems in adult life (Ariyo et al., 2019; Chukwudozie et al., 2015). For example, previous childhood traumatic experience due to neglectful care has resulted in problematic eating behavior and unhealthy lifestyle behaviors, which are hurdles toward behavior modification and healthy lifestyle of the children in their care (Green et al., 2021).

Studies were conducted to improve community-based kinship care and youth traumatic experiences (Adeboye et al., 2019; Chukwudozie et al., 2015). Adeboye et al. (2019) studied the experiences or problems of young Portuguese and Nigerian children in foster care, respectively. They explored lived experience of young adults (19-30 years old) and assessed three stages or phases: as children before being admitted and while in care, as young people in care, and as adults in the society. The study revealed the paucity of literature on the subject, and poor outcomes in different domains of the well-being of participants including adjustment and psychosocial issues. Chukwudozie et al. (2015) conducted research on increasing an understanding of kinship care from the perspective of children and caregivers. They discovered that children in kinship care face increased risks of discrimination, abuse, and exploitation as well as not being allowed to express their views in public or ask adults questions because of traditional, social, and cultural attitudes toward children. Such conditions can intensify attachment problem, childhood

trauma, and psychosocial risks.

Despite the research that has been conducted, there are still extensive gaps and a lack of literature on the impact of childhood adversity on adult Nigerians raised outside their biological families. Nigerians comprise the largest African immigrant population in the U.S., findings from the study may contribute to knowledge and understanding of childhood adversity and the effects with this group, which could inform clinical counseling training programs and the development of treatment plans. In turn, this could increase awareness on the best treatment practices for professional counselors by enriching their multicultural social justice competence when counseling Nigerian Americans who experienced childhood trauma. My investigation in this study is to examine the predictive relationship between attachment style, childhood trauma, and psychosocial health in adulthood Nigerians raised in kinship care.

Problem Statement

Childhood traumatic experiences have been linked to serious and persistent long-term physical, psychological, and substance abuse issues (Fratto, 2016). Children raised outside their biological parental care experience much trauma and are more vulnerable to negative psychosocial health in life (Bell & Romano, 2014). They tend to be susceptible to emotional trauma and more likely to suffer mental health issues than children raised in biological homes (Hong et al., 2011; Xu & Bright, 2018). Thus, the impact of childhood trauma and its associated psychosocial problems in adult life are applicable to children in kinship homes (Ariyo et al., 2019; Chukwudozie et al., 2015). Children in kinship care face increased risks of discrimination, traumatic experiences, and exploitation

(Chukwudozie et al., 2015). Such traumatic experiences may have implication to attachment quality (Kendall et al., 2015). Given the potential for early childhood attachment to influence psychosocial functioning in adulthood (Iwanaga et al., 2018), it is relevant to see if attachment type mediates the relationship between childhood trauma and psychosocial health.

I was unable to find current research on attachment style, childhood trauma, and psychosocial health in adult Nigerians after their kinship placement. There are is a lack of literature on the impact of childhood trauma on adult Nigerians raised outside their biological families in Nigeria. According to the Pew Research Center (2020), 348,000 Nigerians were living in the United States as of 2017; thus, Nigerian immigrants may account for the significant number of the percentage of African children raised outside their biological parents. With the growing population of Nigerian immigrants in the United States, it is important to investigate this population's attachment style, childhood trauma, and current psychosocial health after the kinship care placement as a child. There is possibility of many counselors working with this population without understanding the Nigerian kinship system and its effects on psychosocial functioning of adult Nigerians, which could inform clinical counseling training programs and services.

Purpose of Study

The purpose of this quantitative correlational study was to examine whether attachment type and childhood trauma are statistically significant predictors of psychosocial health in Nigerian adults raised in kinship homes and whether attachment type mediates the relationship between childhood trauma and psychosocial health.

Specifically, I examined the relationship between attachment style, childhood trauma, and psychosocial health in this population. It is unknown how childhood traumatic experiences during their kinship placement may have affected their attachment style and psychosocial health, and counselors are more likely to work with Nigerians whose traumatic experiences are unknown. This study may help counselors working with adult Nigerians better understand variables that may be related to their overall psychosocial health. In addition, the findings of the study will not only ensure that these adults are served in a manner reflective of cultural sensitivity but will enrich counseling programs and development, including the body of literature in counseling profession.

Research Questions and Hypotheses

RQ 1: Are attachment type and childhood trauma statistically significant predictors of psychosocial health in Nigerian adults raised in kinship homes, as measured by scores on the Attachment Style Questionnaire (ASQ)-Short-Form, Adverse Childhood Experience (ACE) Questionnaire, and Psychosocial Screening Instrument for physical trauma patients (PSIT)?

$H_0$1: Attachment type and childhood trauma are not statistically significant predictors of psychosocial health in Nigerian adults raised in kinship homes, as measured by scores on the ASQ-Short-Form, ACE Questionnaire, and PSIT.

$H_1$1: Attachment type and childhood trauma are statistically significant predictors of psychosocial health in Nigerian adults raised in kinship homes, as measured by scores on the ASQ-Short-Form, ACE Questionnaire, and PSIT.

- Independent Variables (IVs): Attachment type and childhood trauma

- Dependent Variables (DV): Psychosocial health
- Statistical Analysis: Multiple linear regression

RQ 2: Does attachment type mediate the relationship between childhood trauma and psychosocial health in Nigerian adults raised in kinship homes, as measured by scores on the ASQ-Short-Form, ACE Questionnaire, and PSIT?

$H_0$2: Attachment type does not mediate the relationship between childhood trauma and psychosocial health in Nigerian adults raised in kinship homes, as measured by scores on the ASQ-Short-Form, ACE Questionnaire, and PSIT.

$H_1$2: Attachment type does mediate the relationship between childhood trauma and psychosocial health in Nigerian adults raised in kinship homes, as measured by scores on the ASQ-Short-Form, ACE Questionnaire, and PSIT.

- Independent variables (IV): childhood trauma
- Mediating variable: attachment type
- Dependent variable (DV): psychosocial health
- Statistical analysis: mediation with regression analysis

Theoretical Foundation

Attachment theory is the theoretical framework that grounded this study. John Bowlby primarily formulated attachment theory in 1969, which emphasized the influence of the mother-child relationship on later psychological development (Haney, 2021). Bowlby (1982) noted that an early environment influences the development of character, and the first 6 years are the most impactful in attachment bonding or quality. Essentially, early childhood experiences are the building foundations of psychosocial well-being of a

person, which determine the formation of healthy relationships during adulthood (Iwanaga et al., 2018; Zdankiewicz-Scigala & Scigala, 2020). For example, early insecure attachment to a caregiver corresponds to insecure adult attachment patterns (Ainsworth et al., 1978, as cited in Kendall et al., 2015). An invalidating environment contributes to emotional dysregulation, and early childhood experiences shape schemas that guide appraisal of self, others, and the world that may impact psychosocial issues (McElroy & Hevey, 2014). The theory suggests that attachment and adverse childhood experiences influence psychosocial resources, as problems in early life hinder healthy development (Whittingham, 2017). Attachment quality determines the development of adaptive psychosocial competencies (Iwanaga et al., 2018) and continues throughout the individual lifespan. Individuals' connections with a primary caregiver shapes beliefs and behaviors, which form patterns of behavior (Bowlby, 1982; Lawson, 2019).

The attachment bonding and early environmental influence of the children in kinship care may help to determine the understanding and interpretation of their exposure to trauma. Children in kinship homes could establish some attachment quality with their biological families before the age of going into kinship care. How these early attachments may mediate the outcomes of childhood trauma or psychosocial health is not well understood. The attachment quality may have influence in the outcomes of childhood trauma and psychosocial health of this population. I will discuss further in Chapter 2.

Nature of the Study

In this quantitative study, the specific research design for addressing the research questions was a correlational design. The correlational design addresses a relationship

between two or more variables as well as makes predictions (Houser, 2015). It indicates if there is a relationship and the strength and direction of the relationship (Warner, 2013; Williams et al., 2013). I examined if two independent variables (attachment type and childhood trauma) predict a dependent variable (psychosocial health). I also investigated if attachment type mediates the relationship between childhood trauma and psychosocial health.

Multiple regression is an extension of simple linear regression with additional predictor or independent variables (Frankfort-Nachmias & Leon-Guerrero, 2018). The use of multiple regression determines the influence of multiple predictors/independent variables (IV) on the outcome/dependent variable (Warner, 2013). RQ 1 indicates the use of multiple regression because of two predictors (attachment and childhood trauma) on the outcome (psychosocial problems). Mediation is introduced in RQ 2 as an intervening variable (mediator) through which the independent variable passes to impact the dependent variable. The focus was to see whether attachment type mediates the relationship between childhood adversity and psychosocial issues. I adopted the Baron and Kenny approach using a four-step technique in performing a multiple regression analysis (Stolzenburg et al., 2018). This helped to interpret how attachment quality may intervene in childhood traumatic experience and determine psychosocial health or functioning of this population. For instance, if the coefficient of attachment type is statistically significant, it may indicate that the closer the relationship, or more secure attachment an individual had to the caregiver as a child, the higher chances of better well-being and fewer psychosocial issues as an adult.

I used the ASQ-Short-Form, ACE Questionnaire, and PSIT to answer the research questions. The ASQ-Short form is a self-administered inventory questionnaire that allows participants to rate items on a 6-point Likert-type scale ranging from 1 = *totally disagree* to 6 = *totally agree* (Iwanaga et al., 2020). The ACE Questionnaire is a 10-item brief rating scale used to analyze the link between multiple categories of childhood trauma (ACEs) and psychosocial health outcomes in adult life. It has provided significant knowledgeable evidence regarding the connection between adverse childhood experiences and adult mental and physical ill health (Felitti et al., 1998, as cited in Zarse et al., 2019). The PSIT is an assessment tool construct for psychosocial problems (Karabatzakis et al., 2019). Participants review a list of psychosocial problems in the PSIT that could be experienced by physical trauma individual (Hull et al., 2016; Karabatzakis et al., 2019).

Definitions

Attachment styles: Attachment styles are characterized by different forms of interacting and relating to caregivers or others in relationships (Lawson, 2019). Attachment styles will be measured using the ASQ.

Adverse childhood experiences: There is a connection between adverse childhood experiences and adult mental and physical ill health (Felitti et al., 1998, as cited in Zarse et al., 2019).

Childhood trauma: Childhood trauma is childhood maltreatment that is any act or series of acts of commission or omission by a parent or other caregiver that results in harm, potential for harm, or threat of harm to a child (Leeb et al., as quoted in Myers &

Llera, 2020). Childhood indicates that it is trauma experience younger than the age 18. It is a childhood adversity, which includes maltreatment (physical, sexual, emotional abuse, and neglect) and household dysfunction. Household dysfunction entails witnessing domestic violence, parental incarceration, mental illness, substance use, or divorce (Racine et al., 2020). Childhood trauma will be measured using the ACE Questionnaire.

Kinship home: Kinship practice is a kind of Western foster home often without official legal backings (Chukwudozie et al., 2015). It is a well-known phenomenon in Africa, especially in Nigeria, where children are sent to live with their extended families or close friends of their families. This practice is in the United Nations' Guidelines on Alternative Care for Children (Article 29c; Chukwudozie et al., 2015).

Psychosocial health: Psychosocial health refers to the psychosocial functioning that includes a person's mental, social, emotional, and spiritual functioning or well-being. Psychosocial health was measured using the PSIT.

Assumptions

There are many assumptions to this study. First, it was expected that respondents are adult Nigerians and lived in kinship care or outside their parental homes as a child. The second assumption was that participants have likely experienced some type of childhood trauma as a result. I also assumed that respondents participated in this study out of their own volition without experiencing unusual level of stress or psychological distress when taking the survey. Another assumption was that participants in this study would be able to recall and convey the true nature of their attachment style levels, childhood trauma experience levels, and levels of their psychosocial health when taking

the survey. I assumed that participants understood the survey questionnaire, answered truthfully, and avoided social desirability behaviors.

Scope and Delimitations

The scope of this inquiry encompassed Nigerian participants recruited through social media, listservs, emails, and Nigerian community platforms. This study did not include people who are not from Nigeria or have not experienced kinship care. This study excluded people younger than 18 years or adult Nigerians whose mental illness is not under control or of a severity that could not allow them to read, write, or comprehend the survey without increasing their stress or trauma. Therefore, the respondents to the research questions were Nigerians raised in kinship homes in Nigeria, currently residing in the United States or Nigeria, and 18 years or older. In a situation of an insufficient number of respondents in the United States, the recruitment of participants would extend to Nigeria. Participants provided the data from the survey through the Qualtrics questionnaire.

Limitations

The first limitation is the recruitment of participants in the study, which is exclusively adult Nigerians raised in kinship homes in Nigeria. Based on my experience, Nigerians do not like to self-disclose their issues, and some may find it uncomfortable recalling and talking about kinship. The issue of recall may be another limitation and potential roadblock to reporting childhood trauma or adversity. A recall is one of the challenges because the participants may feel like they are reliving the trauma. Other challenges are numbing the childhood traumatic experience or putting it far behind their

mind that it is hard to remember (McCormack & Issaakidis, 2018). The problem of recall can constitute a minimal risk and a barrier in generating the population to respond to the questionnaire.

Further, given that a convenience sampling method was used in the study, it may create low reliability. A strength of convenience sampling is that it is easier for researchers to access members of the target population; thus, researchers commonly use this sampling method (Houser, 2015). However, it relies on available subjects without any control over the respondents of a sample. Another limitation was using a nonprobability sampling technique, which may not represent the population well (Research Methods Knowledge Base, 2020). Nonprobability sampling relies on available subjects without any control over the respondents of a sample. The use of a convenience sample affects generalizability to the wider population. Convenience sampling impacts the generalizability of the study due to uncontrolled and real-world settings (Babbie, 2017). The fact that generalizability cannot be assumed is a threat to external validity (Houser, 2015). It can lead to poor quality or tainted data and influence the results, including statistical significance and meaningfulness. However, the strength of convenience sampling is that it is easier for researchers to access members of the target population; thus, researchers commonly use this sampling method (Houser, 2015).

Significance

This dissertation study contributes to the understanding of the relationship between attachment style, childhood trauma, and psychosocial health of adult Nigerians and counseling in general. The results can help in identifying other mediating factors like

attachment type in diminishing or promoting the effects of childhood adversity on adult life. The study has social change implications through literacy awareness of the effects of childhood adversity and psychosocial issues in adulthood, particularly in adult Nigerians who comprise the largest immigrant population in the United States. Social change is a global issue for social justice, social action, equity, and respect for an individual's worldview (Hipolito et al., 2016; West-Olatunji & Wolfgang, 2017). Increasing awareness on this topic can empower fostered children to speak out against any ills experienced under the system and empower their families and the public to reform the system in Nigeria. I will also share the findings with Nigerian parents using social media and meeting platforms to enlighten families for a better understanding of kinship care system and practice. I would also like to discuss my research findings with the Federal Ministry of Women Affairs (FMW) child department and an agency like the Child Rights Awareness Creation Organization. The FMW in Nigeria is responsible for implementing the Child Rights Acts adopted into law in 2003 (Adeboye et al., 2019). Such social actions could generate further discussion and research on the deficiency and improvement of kinship care, leading to government interest and policies that will safeguard children in kinship care.

The findings may also contribute to knowledge and understanding of childhood trauma and its effects with this group, which could inform clinical counseling training programs and development. In turn, this could increase awareness of the best treatment practices for professional counselors by enriching their multicultural social justice competence when counseling Nigerian Americans who experienced childhood trauma.

The awareness that attachment styles and childhood trauma may be used to predict adult psychosocial health provides significant and clinically valuable knowledge in terms of assessment, interventions, and enrichment of counseling professional literacy.

Summary

This chapter discussed childhood trauma in relation to adult Nigerians raised outside their biological families. From the literature review, there is little or no significant research on the current psychosocial health of this group that experienced childhood trauma. The findings will add to the body literature, inform clinical counseling programs, and generate social change beyond the United States. It will contribute to the understanding of the relationship between the attachment style, childhood trauma, and psychosocial health of adult Nigerians and counseling profession in general. The awareness of childhood trauma and its possible vulnerability to psychosocial health in adulthood may lead to a better understanding and improvement of kinship practice, including the need for social change. In the next chapter, I will expound on the theoretical framework applicable to this study in further details. I will also provide a comprehensive and thorough review of the appropriate existing literature that highlights childhood trauma, kinship practice, and psychosocial health or functioning.

Chapter 2: Literature Review

According to the Center for Disease Control (2016), more than 250,000,000 Americans have been exposed to childhood trauma in their lifetime. Moreover, children raised in alternative care environments, such as kinship homes, are liable to experience childhood trauma and psychosocial health risks in adult life (Ariyo et al., 2019; Chukwudozie et al., 2015). Much literature has focused on childhood traumatic experience and its effects throughout a person's life, especially in the counseling field and services (Jansen et al., 2016; Lee et al., 2017; Masson et al., 2015; McCormack & Issaakidis, 2018; Stolzneburg et al., 2018). Some studies focused on childhood trauma from the perspectives of the theoretical framework of attachment theory, attachment experiences, and mediation (Kendall et al., 2015; Maas et al., 2018; Rholes et al., 2016), and some provided a meta-analysis assessing the neuropsychological profile from childhood to adulthood of individuals who suffered childhood trauma (Masson et al., 2015; McCormack & Thomson, 2017). Similar to the current study, Melkman (2017) focused on the relationship between childhood adversity and adult well-being among vulnerable young adults who formerly experienced foster and residential care. However, there appears no research dedicated to the relationship between attachment style, childhood trauma, and psychosocial health, particularly with adult Nigerians after their kinship placement. It is relevant for counselors to become informed about the needs of adult Nigerians who may be suffering from toxic stress exposure like childhood trauma (Powell & Davis, 2019) through the kinship care system.

With the growing population of Nigerian immigrants in the United States, the aim

of this quantitative correlational study was to determine if attachment type and childhood trauma are statistically significant predictors of psychosocial health in Nigerian adults raised in kinship homes. In addition, I examined whether attachment type mediates the relationship between childhood trauma and their psychosocial health. The study may help counselors working with adult Nigerians to better understand variables that may be related to their overall psychosocial health and enrich counselor training programs and services. Further, the awareness of variables that may predict the overall psychosocial health of this population may offer significant and clinically valuable knowledge in terms of assessment, interventions, and enrichment of professional counseling literature.

In this chapter, I will present the literature search strategy and expand on attachment theory, which constitutes the framework of this study. I will also include the review of essential current literature relevant to foster care, kinship practice, and the Nigerian population, including attachment style, childhood trauma, and psychosocial health. I will end the chapter with a summary.

Literature Search Strategy

This section presents the literature search strategy relating to attachment styles, childhood trauma, and psychosocial health or functioning in adulthood. Most of the research and literature reviewed in Chapter 2 came from peer-reviewed journals. I engaged the Walden Library using EBSCOhost to retrieve peer-reviewed journals from the APA PsycInfo, APA PsycArticles, SAGE Journals, PsychEXTRA, and SocINDEX databases. Others are Taylor and Francis Online and Academic Search Complete with Full Text. I also used external databases like Google Scholar, APA PsycNET,

MEDLINE, ProQuest, and PsycCRITIQUES. In addition to the online search engines used to retrieve the majority of cited scholarly journals, I reviewed the principal work of John Bowlby (1982), *Attachment,* including a book and seminar paper relating to attachment theory written by the theory's proponents (Krumwiede, 2001; Lawson, 2019). The keywords searched in these databases were *attachment theory*, attachment quality, attachment styles, attachment and resilience, attachment questionnaires, childhood adversity*, childhood trauma*, childhood trauma and adulthood*, consequences of childhood trauma, psychosocial resources, psychosocial health, psychosocial functioning, psychosocial risk, foster care*, kinship*, foster care or kinship care, kinship care or kinship practice in Nigeria, Nigeria Population, kinship care or kinship practice in Africa,* and *benefit or challenges of kinship practice.*

My target included peer-reviewed journals within 5 years of publication. Nevertheless, some scholarly articles beyond 5 years old were used in my work due to their relevancy and historical significance. I utilized citation chaining to ensure that all the relevant literature on my topic was consulted. No peer-reviewed journals from 2000 to the present were found that combined the terms *attachment type, childhood trauma,* and *psychosocial health*. I used Google Scholar to locate works that were not found in the Walden Library. After reviewing large numbers of articles for the literature review and information on my dissertation topic, I was unable to find relevant evidence that investigated the relationship between attachment type, childhood trauma, and psychosocial health of adult Nigerians after their kinship placement. Additionally, filling this gap in the literature would be beneficial to the counseling profession and services,

due in part to the large and increasing population of Nigerians in the United States who may present for counseling.

Theoretical Foundation

Attachment theory (AT) holds that healthy relationships between infants and their early primary caregivers are essential for the development of adaptive psychosocial competencies and the formation of healthy relationships during adulthood (Iwanaga et al., 2018). AT highlights the critical works of John Bowlby and Mary Ainsworth (Haney, 2021). I will present Bowlby's early theory first and discuss later the expansion of AT by Ainsworth.

Origins of Attachment Theory

Bowlby formulated attachment theory in 1969, emphasizing the influence that the mother/figure–child relationship has on the later psychological development of the child (Bowlby, 1982). He was inspired by the works of Charles Darwin and Sigmund Freud and worked at the London Child Guidance clinic, a school for emotionally disturbed children, from 1937 to 1940 (Bowlby, 1982). He stated that early environment influenced character development and solicited broader studies on how attachment bonds between infants and mothers (Bowlby, 1982; Hazan & Shaver, 1987). Bowlby (1982) investigated how the loss of a mother-figure impacted children between 6 months to 6 years of age, and developed theories about maternal separation and concluded that children in secure relationships with their mothers would show a predictable behavior series. The series or phases are detailed in the following sections.

Predictable Maternal Separation Behavioral Phases

Protest Phase. The protest phase is the initial stage that a child appears acutely distressed at the loss of its mother and seeks to recapture by exercising all their limited resources (Bowlby, 1982). A child will cry loudly, have temper tantrums, and look eagerly toward any sight or sound that might be their missing mother. At this point, the child is full of expectation that the mother will return and rejects all the alternative or substitute figures, though some children will cling desperately to a nurse.

Despair Phase. The phase reflects the child's preoccupation with the missing mother and increasing hopelessness (Bowlby, 1982). The child's tantrums and crying are diminished or come to an end. It is a quiet stage and sometimes many erroneously presume that the child's distress has diminished. The child becomes withdrawn, inactive, and appears to be in a state of deep mourning.

Detachment Phase. In the detachment phase the child shows more interest in their surroundings, accepts the nurses and whatever gifts and food that they give them, and may even smile and act sociable (Bowlby, 1982). The child seems to lose all interest in its mother and turns away from the mother as if she is not there. The child becomes transiently attached to nurses. The experience is equivalent to the loss of the child's mother.

Ainsworth and Colleague's Expansion of Attachment Theory

Bowlby's (1982) foundational AT paved the way for other developmental researchers to further their inquiry on theory. Mary Ainsworth pioneered the study of AT following Bowlby's groundbreaking findings in this area (Mallinckrodt et al., 1995;

Reisz et al., 2018). She identified three patterns of attachment that can develop based on the children's early experiences with parents: secure, avoidant (dismissive), and ambivalent (preoccupied) attachments (Haney, 2020; Mallinckrodt et al., 1995; Reisz et al., 2018). In Ainsworth et al.'s study, children explored a novel play environment in a laboratory observation in the presence of their mother, exposure to a stranger, and reunion with their mother (Mallinckrodt et al., 1995; Reisz et al., 2018). The secure attachment infant displayed distress on separation from the caregiver, pleasure on a reunion, and utilized the caregiver's comfort to readily return to play. These findings align with Bowlby's work on healthy attachment where primate infants sought physical proximity and attention from their caregiver/attachment figure when they perceived threat or discomfort (Reisz et al., 2018). The insecure-avoidant or anxious-avoidant was characterized by infants' little interest in their mother and little strong affect throughout the observations (Mallinckrodt et al., 1995; Reisz et al., 2018). The anxious-ambivalent or resistant-ambivalent infants were excessively anxious, distressed, and angry at the prospect of caregiver unavailability, such that they were often unable to return to play after reunion (Mallinckrodt et al., 1995; Reisz et al., 2018).

Application of the Theory Similar to Present Study

Based on Bowlby's attachment theory, Van IJzendoorn and Bakermans-Kranenburg (2010) conducted a study with diverse participants, using the Adult Attachment Interview (AAI), to determine whether attachment in adulthood is associated with gender, age, culture, or socioeconomic status. After coding, the following themes emerged: secure-autonomous, insecure dismissing, and insecure-preoccupied, which

represented Ainsworth's secure, insecure-avoidant, and insecure-resistant attachments, respectively (Van IJzendoorn & Bakermans-Kranenburg, 2010). Though there were no differences due to gender and culture, there were notable differences among SES and attachment type, which implied an effect of poverty, as the mothers from low SES showed more dismissing attachment. The findings imply that attachment remains crucial across the entire lifespan and is a universal characteristic of human beings as it is rooted in evolution (Van IJzendoorn & Bakermans-Kranenburg, 2010). By implication, AT is relevant in understanding social, psychological, and biological development and functioning for adult Nigerians after their kinship placement experience.

Other research using AT showed that attachment plays a critical role when dealing with childhood trauma (Maas et al., 2018; Sandberg, 2010). Traumatic experiences alter expectations, beliefs about the world, self, and others, whereas attachment experiences help develop schemas that affect how children learn to cope with stress and trauma and may lead to neurobiological changes. The implication is that the unavailability of attachment figures during traumatic events may lead to neurobiological changes and psychosocial problems with my population understudy. Adult attachment is significantly related to posttraumatic stress and dissociation (Sandberg, 2010).

In this study I examined if attachment type has a mediating effect on childhood trauma and psychosocial health of adult Nigerians after their kinship placement. Based on Bowlby and other researchers' positions on caregiver-infant secure attachment and the problem of maternal separation, attachment theory served as my theoretical foundation. There is no study addressing this perceived secure attachment relationship between the

primary caregiver (mother-figure/parent) and maternal separation with kinship care. Using AT as my theoretical lens for my study helped me see if attachment type and childhood trauma are statistically significant predictors of the psychosocial health of this population. Given that these children in kinship care experienced parental separation after the age of 6, I examined whether attachment type mediates the relationship between childhood trauma and psychosocial health.

Literature Review

There is a lack of literature on the relationship between attachment type, childhood trauma, and psychosocial functioning of adult Nigerians raised outside their biological families. Approximately 15.8% of African children live outside their biological families, and 0.002% of it accounted for formal alternative care (Chukwudozie et al, 2015). Most parents or guardians in rural areas place their children with rich relations and non-relatives (close friends of the family) in urban areas for economic prospects, giving them opportunities for western education and apprenticeship, and, in some cases, to babysit and engage in other domestic chores. Previous studies indicated that children raised by non-biological parents are particularly vulnerable socially and developmentally (Adeboye et al., 2019; Bell & Romano, 2014; Chukwudozie et al., 2015; Ushie et al., 2016). Fear, neglect, and protracted abuse are common for many of these children in non-biological homes, including suffering from the hands of unscrupulous adults and their guardians (McCormack & Issaakidis, 2018). Moreover, many of these children fall prey to traffickers (Ariyo et al., 2019; Nnama-Okechukwu et al., 2018).

There is no formal and standardized assessment of the child's needs; emphasis is

placed on what the caregivers consider to be suitable for the child (Ushie et al., 2016). Maltreatment is prevalent in Nigerian society that encourages harsh discipline or punitive violence. Some children in kinship face basic deprivation of needs and a continuous cycle of abuse or trauma from their caregivers (Iorfa et al., 2021; Ofoha & Ogidan, 2020). Children in kinship care often present challenging behavior like reduced attention and concentration, more overactive and aggressive, and engaged in attention-seeking behavior (Cunningham & Lauchlan, 2010). Children in kinship homes are involved more in domestic work or labor than children in parental care. They are 4.17 times more likely not to attend school than children in parental homes and have fewer educational materials and lower school attendance than their mates in orphanage care. However, they achieve better or similar academic outcomes than their biological siblings or host siblings (Ariyo et al., 2019).

For my study, I focused on kinship care and adult Nigerians after kinship placement experience. To conduct an in-depth literature review, I looked at the general perceptive or understanding of the attachment type, childhood trauma, and psychosocial health. I will provide a more thorough review of kinship care in the Western world and Africa (Nigeria), including implications for attachment type and psychosocial functioning of the targeted population, followed by research specific to adult Nigerians after their placement. Additionally, I include crucial findings regarding factors necessitating kinship practice.

Attachment Type

As mentioned earlier, Bowlby's AT emphasized the importance of healthy

relationship between a child and a primary caregiver for development of psychosocial competencies in life (Iwanaga et al., 2018). Ainsworth pioneered the study of Bowlby and identified the three aforementioned patterns of attachments; namely, secure, avoidant, and ambivalent attachments (Haney, 2020; Reisz et al., 2017). Her study was known as Strange Situation Procedure, whereby a caregiver leaves the child twice in a new environment with attractive toys, initially with a stranger, and then alone, before returning (Reisz et al., 2017). Main and Solomon introduced an additional disorganized classification for the Strange Situation that encompassed a range of behavior reflecting disruption in coherence (Reisz et al., 2017). A study revealed that infant disorganized attachment transforms into controlling forms of attachment at kindergarten age and dismissive as adults (Van IJzendoorn & Bakermans-Kranenburg, 2010). Ainsworth et al.'s Strange Situation Procedure work is the gold standard assessment for attachment in infancy (Reisz et al., 2018). Attachment patterns or styles become hallmark measures in the attachment theory. Attachment studies focus on the construct of attachment styles or types of secure, dismissive-avoidant or anxious-avoidant, and anxious-ambivalent or resistant ambivalent (Haney, 2020; Mallinckrodt et al., 1995; Reisz et al., 2018).

Importance of Early Attachment

Secure early attachment gives way for later psychosocial development (Broderick & Blewitt, 2015). Children with secure attachment type are fortified with positive attitudes toward self and others. They portray trust and engage in interpersonal relationships with mutual understanding and respect. The quality of the relationship could be truncated if their positive expectations are betrayed or violated, particularly with their

caregivers or partners. Such experience could lead to behavior modifications and incorporating more negative expectations. Caregivers may experience significant increases in their life stressors leading to disruption in family life (Broderick & Blewitt, 2015). Broderick and Blewitt (2015) report the findings of several studies on securely attached children. Some of these studies indicated secure children make their positive expectations come true by their choice of partners. The secure attachment could be in danger or be modified when caregivers violate the expectations or if there are things (distraction, depression etc.) that happen later in life to the caregiver or disruption of family life. Thus, the quality of care that an infant continues to gain can either strengthen the positive attitudes toward self and others or redirect to negative expectations or insecure attachment. Broderick and Blewitt (2015) further state that securely attached children have the best outcomes, especially when they have secure attachments with both parents than with one of the parents, and their outcomes are better with one parent than if insecurely attached to both parents. At the age of 16, securely attached children are more likely to trust a best friend, and at 20 or 21, many securely attached individuals are better able to resolve conflicts with a love partner (Broderick & Blewitt, 2015).

Attachment and Cultures

Across cultures, the majority of children studied displayed secure attachment with their mothers (Broderick & Blewitt, 2015). Nonetheless, there are significant cross-cultural disparities in views of ideal caregiver-child attachment relationships (Butcher et al., 2014). The distribution of attachment patterns differs from one country to another. Children in Japan are more likely to form ambivalent attachments and less likely to

display avoidant attachments than children in the United States, while German children are more often likely to display avoidant attachments than the secure (Broderick & Blewitt, 2015). I found no studies indicating the attachment type categorization of infants in Nigeria. However, research has shown that the tenets of attachment theory are universally applicable (Broderick & Blewitt, 2015), and cultural differences in parenting may be related to group differences in the relative proportions of securely and insecurely attached infants (Lopez et al., 2000). Moreover, Ainsworth's observation and description of the healthy attachment behavior of Ganda mothers and infants in her book *Infancy in Uganda* (Ainsworth, 1967) (Sieben & Yildirir, 2020) brings the universality of AT home to Africa (Crittenden, 2017). Mary's study highlighted the anthropological observation of mother-child behavior in its ecological environment. It humanized attachment to include all humans from laboratory observation to an anthropological study (observing families where they live their lives). Her work helped to expand attachment studies to frontiers of other cultures and peoples and their use of a non-western population (Crittenden, 2017). Bowlby's AT permits for adaptation to local conditions, while Ainsworth's procedure cater for cultural differences between Ugandan and US mothers and infants (Morelli, 2015).

Attachment Theory in African Culture

Mary Ainsworth utilized longitudinal home observations (with home visits every three weeks for the first-year life) to study the 'primitive' African families in her 1967 published work, *Infancy in Uganda* (Crittenden, 2017). Mary's experimental observations firmly put Africa in the inception of attachment theory (Tomlinson et al., 2010). She

identified three patterns of attachment; secure, avoidant, and ambivalent attachments, parallel to her Baltimore standardized laboratory observations and assessment, the Strange Situation (Crittenden, 2017; Haney, 2020). Attachment patterns become a sound empirical basis for research on attachment and individual differences in the attachment (Crittenden). The work of Mary on Ugandan families provides essential evidence for the practical understanding of attachment theory in African culture. Tomlinson et al. (2010) reported various studies relating to attachment theory in some African environments and cultures (Hausa, Gusii, !Kung, Efe, Dogon, & Khayelitsha).

In polygamous Nigerian Hausa families with 18 infants between ages 6 months and 14 months, the observatory study reported that the children appear to be attached to multiple caregivers (Tomlinson et al., 2010). However, many were primarily attached to the principal figure. The principal figure may not be the mother but the individual who mostly holds and interacts with the child. Caregivers' responsibility is strictly limited to social and playful interaction (Tomlinson et al., 2010). At the same time, biological mothers are responsible for most of the physical care and health of the child, such as feeding, bathing, and other routine physical activities. The Gusii of Kenya was done with a modified Strange Situation Procedure (SSP) with the roles of the caregivers and biological mothers as described in the Nigerian Hausa situation (Tomlinson et al., 2010). The results showed 61% similar patterns of secure attachments and similar rates of security in relation to the mother as found in developed world samples. In terms of care for child needs, 54% of similar rates of security were in relation to nonmaternal caregivers (Tomlinson et al., 2010). For !Kung (or Bushmen) of Botswana, a forager

population, their children are in physical contact with their mothers 70% to 80% of the time in the first year of life (Tomlinson et al., 2010). Thus, they experience less attachment relationships than the Hausa or the Gusii. The Efe people of Zaire employ a system of multiple caregivers like Hausa and Gusii but not like !Kung (Tomlinson et al., 2010). The Efe children spend half of their time in social contact other than with their mothers, and physical care is the shared responsibility of their mothers and caregivers, unlike in the cases of Hausa, Gusii, and !Kung people (Tomlinson et al., 2010).

The traditional Strange Situation Procedure assessment was used in the attachment relationships study of the Dogon ethnic group (Tomlinson et al., 2010). Participants were 42 mother-infant pairs. These mothers nurse their children in the first year, frequently breastfeeding and on demand. The result showed 69% secure attachment, 23% disorganized attachment, 8% resistant/ambivalent attachment, and 0% avoidant classification. When disorganized attachment (23%) was converted into three patterns or styles of attachment, the outcomes were 88% secure attachment, 12% resistant/ambivalent attachment, and the avoidant was completely absent (Tomlinson et al., 2010). The Dogon findings indicated consistent associations between the quality of care and attachment patterns. The Khayelitsha people of South Africa study report was unique due to poor socioeconomic status, lack of partner support, trauma and losses that may impact parental competence to be responsive to their kids (Tomlinson et al., 2010). Despite the extreme levels of social adversity of Khayelitsha people, there was an unexpectedly significant rate of secure attachment (61.9%), and 4.1% of infants were classified as avoidant (Tomlinson et al., 2010). The high secure attachment rate could be

explained by the protective contribution of Xhosa social and cultural organization (community spirit). The community spirit in Africa enhances family structures and community cohesion leading to the notion of community spirit and compassion for others in Africa, known as *Ubuntu*. The implication is that cultural practice can impact attachment quality (Tomlinson et al., 2010).

Trauma

Trauma is a word used by physicians to describe physical injuries resulting from a sudden insult to the body like head trauma, and in psychiatry to refer to injuries of an emotional variety. The sense of an emotional variety denotes events capable of producing intense acute distress that may persist over the years like posttraumatic stress disorder-PTSD (Jones & McNelly, 2022). The latter is a psychological trauma which is a metaphorical extension of the medical term applied to emotional harm that metamorphosed into PTSD (Jones et al., 2022). The meaning of trauma expanded to exceed initial medical and psychological usages, which were only extremely terrifying and rare events that are capable of producing PTSD to other types of harm like bullying, aggression, abuse, and prejudice (Jones & McNelly, 2022). The diagnostic understanding of trauma maintains the relatively strict definition of "exposure to actual or threatened death, serious injury, or sexual violence" (APA, 2013, p. 271; Jones et al., 2022). Despite the diagnostic standpoint of trauma, individuals may expand their personal definitions of trauma, which continue to expand the concept of psychological harm. Personal concepts are often impacted by general exposure to life adversity either directly or through one's social group (Jones & McNelly, 2022).

The World Mental Health (WMH), a mental health arm of the World Health Organization (WHO), identifies trauma as common globally. Many people who experienced trauma respond with resilience, while a substantial minority may develop posttraumatic stress disorder, which is the cardinal trauma-related mental disorder (Koenen et al., 2017). In the WHO trauma study of 21 countries, more than 10% of respondents reported witnessing violence (21.8%) or exposure to interpersonal violence (18.8%), accidents (17.7%), war (16.2%), or trauma to a beloved (12.5%) (World Health Organization, August 2013). Approximately 3.6% of the world's population experienced PTSD (World Health Organization, August 2013). According to the WHO (2017) global report, 23% experienced physical abuse, 36% experienced emotional abuse, and 16% accounted for physical neglect in the previous year. The report also showed that 8% of boys and 18% of girls experienced sexual abuse during the same period (WHO, 2017). Studies in African countries indicated systematically that years of wars, genocide, poverty, and natural disasters are the root of trauma on a monumental scale. (Neuner et al., 2004; Njenga et al., 2003). An estimated 5.8 million people experience traumatic injuries annually. Regardless of the devastating effects of trauma on African citizens, the study of PTSD and CPTSD is rare (Palgi et al., 2021).

Many trauma admissions in Nigeria are from road traffic accidents and falls (Okereke et al., 2022). A study to explore the relationship between the experience of traumatic events and suicidal outcomes in Nigeria by Uwakwe et al. (2012) reported at least one exposure to a traumatic experience in 63% of the sample. The implication is that exposure to traumatic life events is common in the general population. Sixty-eight people

per 100,000 in Sub-Sahara Africa (SSA) die of trauma (Okereke et al., 2022). Some of the recommended interventions for individuals suffering from traumatic life events or PTSD are the Composite International Diagnostic Interview (CIDI) version 3.0. to assess the traumatic event, and cognitive-behavioral therapy (CBT) and eye movement desensitization and reprocessing (EMDR) for treatment (Koenen et al., 2017; World Health Organization, August 2013). Other treatment interventions include trauma-focused counseling (T-FC) and social effectiveness skills training (SEST) (Lawrence & Falaye, 2020). The WHO warned against using benzodiazepines for trauma treatment since they slow down the time to recover from potentially traumatic events, develop tolerance to their effects, become dependent on them, and generate withdrawal syndrome problems (World Health Organization, August 2013). There are three types of trauma (physical, emotional, and sexual), with each of them as lethal in causing devastating effects on the quality of life (Toof et al., 2020). I will give a brief explanation of the three types of traumas below.

Physical Trauma

Toof et al. (2020) expressed physical trauma, as quoted in SAMHSA (2017), as physical abuse, experiencing an accident or life-threatening illness, physical assault, natural disasters, terrorism, experiencing being in a refuge camp, war experiences, and experiencing community or school violence. Physical trauma may be visibly noticed. Early childhood exposure to physical trauma could result in a lifelong experience with trauma, including physical and psychological problems later in life (Banker et al., 2019). Banker et al. (2019) discovered that exposure to physical trauma within the first eight

years of life could resurface many years later.

Physical abuse or trauma is prevalent in Nigeria as its culture allows physical chastisement, physical punishment, or corporal punishment. Physical punishment is passed on through generations as a form of parenting, contributing to child abuse (Ogidan & Ofoha, 2019). A study showed that 84.9% of children in Nigeria (aged 1-14) experienced harsh or violent discipline, which is punitive violence against children. Although many caregivers are unaware of the harms or impact the practice may have on the children (Ofoha & Ogidan, 2020). Another study revealed that six in ten children experience one or more child abuse or violence (physical, sexual, and emotional abuse) in Nigeria, and less than 5% report receiving help (Iorfa et al., 2022).

Emotional Trauma

Emotional trauma encompasses psychological abuse, witnessing domestic violence, neglect, living far away from parents or family, having a parent who is sick or injured, grief and loss, military deployments, experiencing parental divorce, and experiencing the loss of a loved one (SAMHSA, 2017, as quoted in Toof et al., 2020). Emotional traumas are not always seen. Emotional trauma equally comprises being bullied by caregivers, family members, and individuals in the community. It may be more harmful than physical and sexual trauma since it is not often noticed (Toof et al., 2020). Banker et al. (2019) noted that children with emotional trauma often have difficulty regulating their emotions and maintaining healthy relationships and attachments as they get older. Children who experience neglect are more likely to develop autoimmune disorders or diabetes as adults (Banker et al., 2019).

Emotional abuse is prevalent in Nigeria, which can emanate from physical chastisement or corporal punishment. Chronic child abuse may result in severe emotional and psychological underdevelopment (Makinde, 2016). Other areas that can lead to emotional abuse are life events such as sexual abuse and unwanted pregnancy (which put children at risk of being sexually exploited as they look for shelter, food, and protection). These events undermine their psychological and emotional health and make these children highly vulnerable to the commercial sexual exploitation of children-CSES (Hounmenou, 2016).

Sexual Trauma

Sexual trauma consists of sexual assault, sexual abuse, and sexual exploitation (SAMHSA, 2017, as quoted in Toof et al., 2020). Over 70% of people that sexually violate children experienced sexual abuse in their childhood (Van der Kolk, 2017). Early childhood exposure to sexual trauma often makes children not to understand what is physically or emotionally happening to them, and they tend to establish incongruent and inappropriate relationships with others later in life (Toof et al., 2020). Banker et al. (2019) noted that exposure to a single sexual abuse as a child is equivalent to experiencing a lifetime of chronic stress and may cause a higher risk for psychosocial health issues later in life.

Child sexual violence (CSV) is the most common child abuse and trauma, which are reported all over the world, and Nigeria is no exception (Hounmenou, 2016; Iorfa et al., 2022). Some of the reported information of child sexual abuse in Nigeria occurred in homes, young waitresses in outdoor drinking bars [child labor], and CSES [child

prostitution, child pornography, child sex tourism, child trafficking] (Aborisade, 2022; Makinde, 2016; Nlewem & Amodu, 2017). With traumatic sexual experiences, children become susceptible to severe physical, psychological, and social harm (Aborisade, 2022). Nlewem & Amodu (2017) gave an account of a raped case of a female (aged 8) in Nigeria by a neighbor. After a few days of arrest, the perpetrator was released, and the case closed, leaving the girl with a deep feeling of hurt and regret for speaking up, accentuating the culture of silence due to fear and shame. In a study conducted by Iorfa et al. (2022) on the lived experiences of child sexual violence (CSV) survivors in Nigeria, aged 14 to 17, the researchers found that survivors exhibit symptoms of psychological distress in their voices and the possibility of trauma later in life. Other findings observed by the researchers were survivors' low quality of life, poor CSV survivors' services, and ignorance of the limited resources. Lastly, the survivors living with the abusers and vulnerable to revictimization, and a significant percentage of the survivors have already become perpetrators.

Childhood Trauma

Childhood trauma is childhood maltreatment that is any act or series of acts of commission or omission by a parent or other caregiver that results in harm, potential for harm, or threat of harm to a child (Leeb et al., as quoted in Myers & Llera, 2020). Childhood indicates that it is a trauma experience younger than 18 years. It is childhood adversity, including maltreatment (physical, sexual, emotional abuse, and neglect) and household dysfunction. Household dysfunction entails witnessing domestic violence, parental incarceration, mental illness, substance use, or divorce (Racine et al., 2020).

According to Ebigbo et al. (2017), in Nigeria, child maltreatment is common, and he referenced UNICEF 2015 report of the National Population Commission in partnership with the Centre for Disease Control and other development partners, which stated that 6 out every 10 Nigerian children experience some form of physical, emotional, and sexual violence before the age of 18 years with less than 5% engaging in treatment.

Childhood trauma is a catalyst for future mental health and physical health problems (Toof et al., 2020). The after-effects of early childhood trauma can lead to character problems, anxiety disorders, psychotic thinking, dissociation, eating disorders, and increased risk of violence by others and by self. Others are suicidal ideation and behavior, drug abuse, self-mutilation, and disastrous interpersonal relationships in adulthood (James & Gilliland, 2017). In a study by Banker et al. (2019), traumatic childhood experiences put children at high risk for coping and managing life stressors without involving in dysfunctional behavior. Some researchers have gone further to classify childhood trauma into two categories, namely, Type I and Type II. Type I is one distinct traumatic experience characterized by fully detailed, etched-in memories, omens like retrospective rumination, cognitive reappraisals, misperception, and mistiming. Type II analogous to complex PTSD) is longstanding and results from repeated traumatic ordeals. Massive denial and psychic numbness are primarily linked to Type II (James & Gilliland, 2017).

Childhood Trauma and Development of Mental Health Disorders. Trauma has a devastating effect on mental wellness, accompanied by biological changes that occur in the brain. These changes have an adverse impact on the physical and mental

health (psychosocial health) of a person, especially childhood trauma, because the traumatic individuals are more likely to experience reactive thinking rather than rational thinking (Toof et al., 2020). For example, childhood trauma is considered an etiologic factor of borderline personality disorder (BPD). Some meta-analysis studies indicated that people diagnosed with BPD were more likely to report childhood traumatic experiences than people with other types of psychiatric disorders (Peng et al., 2020). In another study, Scheffers et al. (2019) conducted a longitudinal study of 125 girls (average age of 19.4) who transitioned out of residential care in Canada. The purpose of the study was to explore the association between child maltreatment (trauma) and personality disorder symptoms. The results showed that symptoms of maltreatment were most prevalent for emotional (31.2%) and emotional neglect (26.4%), with one-quarter of women reporting severe symptoms of depressive personality disorder, while one-third reported symptoms of paranoid personality disorder. Emotional abuse was statistically significantly related to paranoid, schizoid, schizotypal, histrionic, avoidant, dependent, obsessive-compulsive, passive-aggressive, and depressive personality disorder. Emotional neglect was statistically significantly associated with borderline personality disorder and paranoid personality disorder.

Attachment Type and Childhood Trauma. In a study by Maas et al. (2018), the researchers investigated whether childhood stressful life events or traumas were associated with psychopathological symptoms in adulthood, particularly in individuals with autonomy-connectedness (AC). AC is developed during childhood and adolescence. Attachment experiences play a major role in the development of AC. Favorable or secure

attachment experiences will yield to a well-developed healthy self and capacity for self-governance while being connected to others. The results of their findings indicated an association of childhood stressful life or trauma and low AC to more psychopathological symptoms later in life, as well as childhood trauma related to higher sensitivity to others. Scoring high on sensitivity to others shows that individuals with traumatic experiences have the tendency to think of someone before thinking of themselves or to continually cross their own boundaries (Maas et al., 2018). Higher sensitivity behaviors reflect insecure attachments of anxious/ambivalent others before self) and avoidant/dismissive (cross their own boundaries) (Broderick & Blewitt, 2015; Haney, 2020; Maas et al., 2018).

Psychosocial Health

Many scholarly works of literature have established the association between childhood trauma and various mental health problems in adulthood. Psychosocial health is a psychosocial factor, a combination of psychological and social influences on an individual or a group's mental or behavioral health or well-being (Washington et al., 2018). Psychosocial health or well-being encompasses social networks and the support that have been recognized as a central factor for individuals exposed to childhood trauma (Melkman, 2017). A study by Melkman (2017) indicated that children's history of long-term out of biological home care or substitute placement often limits the development of a support network, which corresponds to their needs in coping with the abrupt transition to adulthood.

A study by Villodas et al. (2016) researched the importance of long-term

permanency for children in the child welfare system. The researchers' findings indicated that youth with unstable placement patterns experienced more adverse childhood experiences (ACEs)/childhood trauma and higher posttraumatic stress (PTS) levels by late childhood than those with stable placement patterns. The study implies that irregular placement patterns in foster care or kinship care can result in more childhood trauma and more severe PTS by late childhood, which is a precursor to later psychosocial problems. The account of the current and former foster care youth in a qualitative study that examined their trauma experiences showed their exposure to trauma events appeared intense, composite, and cumulative (Riebschleger et al., 2015), making them susceptible to significant distress and psychosocial risk in life.

Childhood Trauma and Psychosocial Health

The traumatic experience of children and disruptions of their families, social networks, and environment coupled with heightened vulnerability due to out-home placement or kinship care are evident in many scholarly studies. Childhood and adolescence developmental stages are identified as a period in which they are substantially susceptible to behavioral problems and heightened vulnerability of children in kinship homes (Washington et al., 2018). Children in kinship homes are more likely to live in poverty, which may be instrumental to academic difficulties as well as social and behavioral problems. Besides the history of trauma, they experience high-risk conditions like socioeconomic hardship, exposure to violence, parental substance abuse, and incarceration, including mental illness (Washington et al., 2018). These issues have serious consequences on children's and families' lives and a risk to their psychosocial

health or functioning.

Attachment Type, Childhood Trauma, and Psychosocial Health

Attachment plays an essential role when dealing with childhood trauma. As trauma changes expectations and beliefs about the world, self, and others, attachment experiences help the individual the development of schemas, which is the availability of and reliance on parents or caregivers impact how children cope with stress and trauma. The unavailability of attachment figures may lead to neurobiological changes (Maas et al., 2018). Attachment theory describes the psychosocial life of a child in relation to their mother-figure or caregiver, which forms a crucial influence on adult psychosocial relationships (Broderick & Blewitt, 2015; Iwanaga et al., 2019).

Kinship Care

Kinship care encompasses the full-time care, nurturing, and protection of a child by someone other than a parent who is related to the child biologically, by legal family ties, or by a significant prior relationship (Leinaweaver, 2014). More than 163 million children worldwide are estimated live outside their parental home or out-of-care-home (OoCH) (Leinaweaver, 2014), and kinship care accounts for one of the OoCH. Kinship practice or placements are increasing in many Western countries, with little attention paid to families in kinship care and a lack of evidence-based interventions addressing their unique needs (Pasalich et al., 2021). Child removal and placement is a serious decision that results from their parents struggling to meet their needs (Dorval et al., 2019). In a study to explore and profile the characteristics of children placed in formal kinship care and their mothers, Dorval et al. (2019) found that out of 172 children participants (aged

0-12 years); the first profile accounted for 25% of high rates of child functioning difficulties (ADHD), learning problem, mental problem, developmental delay, while the second profile had 55% of the youngest children with a small number of reported psychosocial difficulties of all three profiles. The third profile recorded the highest prevalence of attachment problems, history of maltreatment, and a high probability of permanent placement. In summary, Dorval et al.'s (2019) study showed needs or psychosocial problems prevalent in the life of these children and their mothers before the placements. These needs are Child Needs, Early Placement, and Relational Difficulties representing the first profile, second profile, and third profile, respectively. Child needs or first profile consist of the oldest cohort members that reported overall high levels of child difficulties and maltreatment with the exception of attachment issues. From the study, there was no specific report on the characteristics of mothers of first profile due to possibility of being Early Placement children who grew older and had more people around them. The stage in Attachment theory Bowlby classified as Detachment Phase (Bowlby, 1982). Early placement or second profile comprised the youngest cohort members that reported lower levels of child difficulties and lower risk mothers (i.e., lower risk of psychosocial difficulties) than the other two profiles. Relational problems or third profile showed significantly higher levels of attachment issues than the other profiles, and their mothers were significantly more likely to experience childhood maltreatment than mothers in the other profiles. The study is relevant to my dissertation topic. Some adult Nigerians may present such psychosocial difficulties before their kinship placements, which with childhood traumatic experience could compound their

needs or psychosocial difficulties.

Kinship care is divided into formal and informal care. Formal kinship care is initiated by a governmental agency like Child Protective Services or Juvenile Justices. Informal kinship care is voluntary or private kinship care without the intervention of a governmental entity (Lianekhammy et al., 2019). The distinguishing mark is that formal kinship-based fostering implies the involvement of child welfare professionals, that is, the protection plan put in place by child protection services (Dorval et al., 2019; Leinaweaver, 2014). Informal care does not involve child welfare professionals and governmental entity (Leinaweaver, 2014). The kinship care that will be investigated in my study is informal kinship care. Before delving into the detailed informal kinship care, I will distinguish kinship care in the United States and Nigeria below.

Distinguishing Kinship Care in the United States and Nigeria

Kinship care is children being brought up by their relatives or family friends when their parents, for whatever reasons, cannot look after them (Farmer et al., 2012). In the United States, an estimated 2.7 million children are under the kinship care of their grandparents, with increasing numbers of other relatives stepping into caregiving roles (Gomez, 2021). However, there are two types of kinship practices: formal and informal (Gomez, 2021). Formal kinship practice involves monitoring by child welfare agencies, legal documentation, and government oversight on the welfare of a fostered child and continually monitoring the child welfare system (Gomez, 2021; Smith & Devore, 2004). The formal kinship practice is common in the United States. There are many levels of influences on the developmental outcomes of children under kinship care (Hong et al.,

2011). Although study showed that African Americans' representation in the child welfare system is disproportionate to whites (Smith & Devore, 2004).

On the other hand, informal kinship practice does not involve monitoring by child welfare agencies and government oversight on the welfare of the fostered child (Gomez, 2021). In the United States, informal kinship placements are negotiated privately within families or "voluntarily" by child protection services (Gomez, 2021). Increasing mental health problems, inadequate access to mental health services and financial barriers to access mental health services are prevalent in informal kinship care (Gomez, 2021). In Africa, It is simply an arrangement between the child's family and their relatives or friends for the child's upbringing and is commonly practiced in Africa, particularly Nigeria (Chukwudozie et al., 2015). The informal care arrangements have insignificant documentation or regulatory frameworks (Chukwudozie et al., 2015). Nonetheless, there is insufficient data collection and research on kinship care in Nigeria. However, some studies revealed that children living with their relatives and family friends might face increased risks of discrimination, abuse, and exploitation (Chukwudozie et al., 2015). Basically, kinship practice whether formal or informal is better structured in the United States than in Africa, particularly Nigeria.

Kinship Care and Foster Care

Kinship care, whether formal or informal, is different from the foster care system. Kinship care makes it possible for the child to maintain family connections and cultural ties since the placement arrangement is between individuals related to the child biologically, culturally, or legally (Stene et al., 2020; Swanke et al., 2016). About

140,675 American children were reported living in kinship foster care in 2017, which was 32% of all foster care placements (Stene et al., 2020). Kinship caregivers may not be required to meet monitoring and licensing agreement standards as non-relative foster care parents, including being provided with the same financial support or training (Stene et al., 2020). There is a likelihood of continued contact with biological parents in kinship care placement than occurs in non-kinship placements (Swanke et al., 2016). Kinship caregivers vary in demographic characteristics, needs, different attitudes about childrearing, children in their care, and their role as caregivers. There are insufficient resources for child protection services (CPS) workers to assess the quality of kinship care (Stene et al., 2020).

Meanwhile, foster care is the state agency placement and care responsibility that is a non-relative substitute home for babies, children, and youth placed away from their parents or guardians. It is a temporary service the state provides for children who cannot live with their families or whose parents cannot care for them (Child Welfare Information Gateway, n.d.). Institutional care, residential care, children's institutions, orphanages are residential facilities for foster care in Nigeria (Nnama-Okechukwu & Okoye, 2019). Both children in kinship and non-kinship care placements suffer varying degrees of emotional and behavioral challenges, but children in kinship homes are less likely to utilize mental health services than children in non-kinship homes (Swanke et al., 2016). An estimated 25% of about 70 million children in Nigeria are vulnerable with a need for alternative care (Nnama-Okechukwu & Okoye, 2019).

Kinship Care in Western Culture

Kinship care has recently increased exponentially worldwide, including in the United States, the United Kingdom, Scandinavia, and Canada, particularly formal kinship care. Formal kinship care in the sense that it is part of the protection plan put in place by child protection services (Dorval et al., 2019; Stene et al., 2020). Kinship care is essentially similar to other parts of the world, including Africa (Xu & Bright, 2018). The benefits of kinship care (e.g., maintaining close ties with loved ones for healthy development, family preservation, mobilizing family resources, and building social networks) have resulted in its growing recognition (Dorval et al., 2019).

Informal Kinship Care in African

Kinship care is common practice in Africa due to macrosystemic influences like migratory labor practices and microsystemic influences like the relationship status of the child's birth parents (Goldschmidt et al., 2019). Grandparents (often among the poorest of social groups) are more likely to accept responsibility for kinship care (Goldschmidt et al., 2019). Thus, children in kinship homes are more likely to face financial constraints, academic difficulties, and poor social network support (Goldschmidt et al., 2019). Contrary to eminent challenges present in kinship care, children living with grandparents are more likely to enjoy stability due to the familiarity of these caregivers with the children (Goldschmidt et al., 2019). There is a commitment to caring for the children and shared culture, including background experiences that foster strong emotional bonds (Pasalich et al., 2021). All the characteristics of informal kinship care are prevalent in Nigeria. However, traditionally, every member of the community is involved in the

disciplining of a child besides parents and siblings. Consequently, an average Nigerian child experiences high levels of harsh discipline in different contexts (home, school, community, and the care settings). Harsh discipline is justified based on the cultural beliefs that children behave well after being severely punished. Moreover, caregivers who do not apply an "iron hand" (harsh punishment) are viewed as negating the childrearing process (Ofoha & Ogidan, 2020). The cultural understanding of harsh disciplining of children further exposes the individual to childhood trauma and heightens the likelihood of trauma experiences of children in kinship care.

Kinship Care and Childhood Trauma

Children in kinship care are pruned to trauma. Informal kinship-based fostering can challenge a child's attachment to his or her caregivers, causing a situation in which birth and foster kids are treated differently or leading to exploitation of foster children (Leinaweaver, 2014). Such a situation can be harmful and traumatic and heightens the risk of psychosocial health of the foster child. Leinaweaver (2014) believed that this kind of kinship is problematic for children's development since it exposes them to relationships with multiple caregivers. Fostered children are more likely than birth children in the same household to be malnourished, to be severely punished, and to die. With wealthier relatives, they are exposed to a relationship that is sometimes experienced as a form of labor exploitation and may not be given apprenticeship or educational opportunities (Leinaweaver, 2014).

Nigeria Kinship Care and Psychosocial Well-Being

Nigerian society emphasizes learning to be obedient and responsible in

childrearing, including teaching their children to behave correctly. Children at an early age are expected to do what they are told without asking for an explanation, while parents take the lead as they are seen to be more experienced and knowledgeable (Buns & Radford, 2008). The above understanding may lead to harsh disciplining of children described earlier (Ofoha & Ogidan, 2020), with more likelihood of children in kinship care bearing more of such punitive violence than those in their parental care. Additionally, challenges (e.g., financial constraints and social support) presented by kinship care factor in escalating childhood trauma and the risk of psychosocial health. The fear of being deprived of food/nutrition may lead to the child receiving a continuous cycle of abuse or trauma from the caregiver. Such situations without social services to cope with the abuse or trauma may likely exacerbate depression and mental disturbance or illness (Iorfa et al., 2021).

Attachment, Childhood Trauma, and Psychosocial Health Study Application

From the ongoing discussion, I have been able to illustrate issues related to attachment, trauma and childhood trauma, psychosocial health or functioning. Children tend to experience emotional trauma and attachment disruption or disorder due to separation from their families (Hong et al., 2011; Howe & Fearnley, 2003; Rushton Hong et al., 2003). Separation from their biological parents exposes many of these children to narratives of fears, neglect, protracted abuse, and other forms of childhood trauma (McCormack & Issaakidis, 2018). Also, out-of-biological home care (such as kinship care) often limits the development of a support network and psychosocial functioning, which are essential for an individual or a group's mental or behavioral health or well-

being (Melkman, 2017; Washington et al., 2018). In Nigeria, some children in kinship care face increased risks of discrimination, abuse, and exploitation (Chukwudozie et al., 2015). In other words, some of these children experience childhood trauma. Childhood trauma has been associated with insecure attachment and increased psychosocial health risks (Kendall et al., 2015). Six in ten children experience one or more child abuse or violence in Nigeria, and less than 5% report receiving help (Iorfa et al., 2022).

According to Nnama-Okechukwu and Okoye (2019), children develop secure attachment with caregivers when they are provided with their basic and psychosocial needs, and insecure or strange toward their caregivers when they are deprived of their basic and psychosocial needs. Growing up in a family environment allows children to develop a healthy attachment with a consistent caregiver (Fratto, 2016). When children are separated from their families, they tend deal with emotional trauma (Hong et al., 2011). Many studies show that children who experienced childhood trauma have difficulties developing strong and healthy attachments and lack skills for effective interpersonal behaviors (Fratto, 2016; Zarse et al., 2019).

In a study by McClure and Parmenter (2020), the researchers conducted a study using similar related variables (childhood trauma, trait anxiety, and anxious attachment as predictors of intimate partner violence in college students) as in my study. Both intimate partner violence (IPV) perpetration and victimization were significantly related to four forms of childhood trauma, and anxiety predicted IPV perpetration, anxious attachment styles well explained victimization, and there were no gender difference in their findings. Another study by Peng et al. (2020) explored the relationships between childhood trauma,

insecure attachment, maladaptive emotional regulation (ER), and borderline personality disorder (BPD) in 617 participants (aged 18-83) from China. The researchers' findings indicated a direct effect of childhood trauma on BPD features and three mediating pathways through which childhood trauma increased the severity of borderline features.

The implications of these researchers' studies are that individuals with childhood trauma are less likely to experience secure attachment and may encounter constant fear of interpersonal rejection or abandonment (Ariyo et al., 2019; Peng et al., 2020), therefore, leading to adverse effects on adult psychosocial health. A study by Ushie et al. (2016) assessed the quality of caregiver-child relationships and their association with child abuse in foster (kinship) and residential care in Nigeria with participants aged 7-17. Researchers' findings showed that children in foster homes experienced more maltreatment than those in residential care. And children in foster care (kinship) tend to experience poor quality of relationships and attachments to their caregivers than those in residential care (Ushie et al., 2016). Ushie et al.'s (2016) study showed that caregivers' maltreatment weakens or reduces the promotion of positive and healthy caregiver-child relationships or secure attachment. But it does not look at the consequences of childhood traumatic experiences on adulthood attachment style and psychosocial health (Ushie et al., 2016).

I found no studies investigating my variables and their application to my study population. Unfortunately, most of studies relating to childhood trauma in Nigeria were masked as childhood maltreatment, abuse, and neglect (Ariyo et al., 2019; Ebigbo et al., 2017; Ushie et al., 2016). In fact, mental health problems carry a lot of stigmatizations,

cultural expectations, and humiliation among Nigerians (Ezeobele et al., 2019). Ezeobele et al. (2019) conducted qualitative study to explore the perspectives of 18 adult Nigerian immigrant participants from Houston, Texas, on their experience with depression. Depression is one of the major mental health issues with immigrants (Ezeobele et al., 2019; Sue & Sue, 2013). Many of participants denied the existence of depression, and the participants that admitted experiencing depressive symptoms considered a spiritual problem rather than mental issue that required contemporary treatment for fear of rejection and shame (Ezeobele et al., 2019).

Summary

Adults exposed to childhood trauma have a greater likelihood of developing mental illness and other psychosocial risks, including making appropriate decisions or gaining insights into their illness (Zarse et al., 2019). This population that experienced childhood trauma often has trust issues, either trusting themselves or others and decreased emotional control, increased aggressive actions, and deficient in adapted coping skills (Buckley, 2013). In other words, these adults exposed to childhood trauma may be unable to overcome the trauma and experience some psychosocial and mental health problems in adulthood. Studying the relationship between attachment type, childhood trauma, and psychosocial health of adult Nigerians exposed to kinship placement is paramount since Nigerians form a significant population of immigrants in the U.S. Additionally, it is important that counselors become well-informed to ensure that these adults are served in a manner that will increase the quality of life for this population. In Chapter 3, I will present my research design and rationale, including the

methodology. I will talk about my population, expound on my sample and sampling procedures, and explain my procedures for recruitment, participation, and data collection. I will discuss my instrumentation and operationalization of constructs, followed by data analysis plan. Finally, I will present threats to validity of my study, ethical procedures, and summary.

Chapter 3: Research Method

This quantitative inquiry addressed the relationship between attachment type and childhood trauma and psychosocial health in Nigerian adults raised in kinship homes. Specifically, the purpose of this correlational study was to examine whether attachment type and childhood trauma are statistically significant predictors of psychosocial health in Nigerian adults raised in kinship homes and examine whether attachment type mediates the relationship between childhood trauma and psychosocial health. In this chapter, I will describe the research design and rationale, which explains the study variables, the research design in connection to the research questions, and the methodology. The methodology highlights the target population, sampling and sampling procedures, recruitment procedures, participation, and data collection, and the data analysis plan. The threats to validity follow after the data analysis plan. Validity threats describe external and internal validity threats to the study. Lastly, I will describe the ethical procedures, ehivh provide insights relating to the agreement to gain access to participants, informed consent and confidentiality, treatment of participants, and IRB permission.

Research Design and Rationale

I tested two hypotheses in this quantitative correlational study to examine the predictive values of attachment type and childhood trauma on the psychosocial health or functioning of adult Nigerians after kinship placement as children and determine whether the attachment type mediates the relationship between and childhood trauma and psychosocial health. The first hypothesis has two independent variables (IVs): attachment type, as measured by scores on the ASQ-Short-Form, and childhood trauma, as measured

by scores on the ACE Questionnaire. The dependent variable (DV) is the psychosocial health of adult Nigerians after kinship placement, as measured by scores on the PSIT. In the second hypothesis, attachment type is the mediator on childhood trauma (IV) and the psychosocial health (DV) of adult Nigerians after kinship placement.

The application of a correlational design assisted in answering my research questions. The correlational design addresses a relationship between two or more variables and allows one to make predictions (Houser, 2015). I found the design appropriate since I examined if two independent variables (attachment types and childhood trauma) predict or influence a dependent variable (psychosocial health). Childhood trauma significantly correlates with multiple disorders and dysfunctional patterns of behaviors that can impair psychosocial health or function in adulthood (Bell & Romano, 2014; Maas et al., 2018; Martin et al., 2016; Melkman, 2017). Childhood trauma has been associated with insecure attachment and increased anxiety symptomology in adults (Kendall et al., 2015). Additionally, attachment anxiety has been a mediator when anxiety, avoidance, and disorganized attachment styles were examined as simultaneous mediators in adults who experienced childhood trauma (Rholes et al., 2016). Thus, I aimed to determine whether attachment type has a mediating influence on their psychosocial health or functioning with the second hypothesis.

I used multiple linear regression to determine whether there is a predictive relationship between attachment type, childhood trauma, and psychosocial health (Frankfort-Nachmias & Leon-Guerrero, 2018). I also examined whether attachment type mediates the relationship between childhood trauma and psychosocial health. Testing for

mediation provides the extraordinary capability to move beyond straightforward models and to determine if the direct or indirect effect exists or the influence of an IV to a DV (Creswell & Creswell, 2018; Warner, 2013). I used Baron and Kenny's framework for mediation, which is a four-step approach in performing analysis of multiple regression (Gleeson et al., 2016; Stolzenburg et al., 2018). I assumed some form of mediation is supported if the effect of attachment type remains significant after controlling for childhood trauma (a predictive variable or predictor). If childhood trauma is no longer significant when attachment type (mediator) is controlled, the finding supports full mediation. If childhood trauma is still significant (i.e., predictor and mediator both significantly predict psychosocial health), the finding supports partial mediation. For instance, when the attachment is secured, the less impact of childhood trauma, which in turn means less psychosocial risk. It indicates that IV (childhood trauma) influences the mediator variable (attachment type), which in turn affects the dependent variable (psychosocial health).

Methodology

Population

For this study the population of interest is adult Nigerians who experienced kinship homes as children. A sample of adults was recruited from this population to serve as participants. They are expected to have lived in Nigeria during the time of kinship placement. The targeted sample size was 75 participants.

Sampling & Sampling Procedures

For this study, I used nonprobability sampling of convenience and snowball

samplings. Convenience sampling is a sampling technique that allows the researcher to select participants who are willing and available to be studied (Houser, 2015). The problems with convenience sampling are the presence of selection/response bias. A big portion of the population is neglected, and limits the potential for generalizing the results back to the population, which affects population validity (Babbie, 2017; Houser, 2015). Convenience sampling encourages collecting samples from a homogenous sampling frame and curtails the generalizability of the study's outcomes to the population (Valerio et al., 2016). A snowball sampling technique helps a researcher to discover variables with rare characteristics, which includes research participants assistance in recruiting other participants for the study (Babbie, 2017). The disadvantage of snowball sampling is that it results in samples with questionable representativeness (Babbie, 2017). However, these nonprobability sampling methods (convenience and snowball samplings) support the nature of my research since there are no available lists of participants to choose from. It is efficient, inexpensive, and supports faster data collection (Babbie, 2017).

Participants of this study comprise adult Nigerians 18 years and older who experienced kinship placement as a child. Potential participants consist of those living in the United States and in Nigeria. There are no limitations concerning demographic information other than age restriction. The participants should be able to read, write, recall, and comprehend the survey without increasing their stress or trauma. It is assumed that respondents will participate in this study willingly and freely and without experiencing an unusual level of stress when taking the survey.

Sample Size

I used the Free Statistics Calculator to conduct a priori power analysis to obtain the required number of participants to test the hypotheses when applying multiple linear regression. It is vital to perform the statistical power to determine the size of a sample or required participants in a study with a good decision criterion of statistical significance of alpha threshold .05 and conventional power level of .80 (Frankfort-Nachmias & Leon-Guerrero, 2018; Murphy et al., 2014). Murphy et al. (2014) stress that a power level of .80 or higher indicates that the success of a null hypothesis rejection is four times greater than failure. I set the power at .80, and the effect size set at a moderate medium level (0.15), where alpha = .05. The obtained total sample size for the study following a priori power analysis is 68. To account for possible attrition, I planned to obtain a sample size of 75.

Procedures for Recruitment, Participation, and Data Collection

Following approval of my dissertation study by Walden's Institutional Review Board (approval # 02-27-23-0527588), I started to recruit participants for the study through social media (Facebook, WhatsApp). I posted a recruitment flyer on Facebook seeking participants for the study. I also put up a recruitment flyer advertising the study and soliciting participants in Nigerian community WhatsApp platforms. The recruitment flyers had brief information about the study, participant and eligibility criteria, along with my contact information (name, email address, and phone number). The recruitment flyers also included a link to the survey in Survey Monkey for individuals who meet the eligibility criteria and choose to participate. For further questions, participants could

contact me.

I also asked participants for their help to recruit others. I asked them if they know any family, friends, or acquaintances who were also raised in Nigerian kinship placements. If so, I asked that they share with them the link to the survey questionnaire on the flyer. As a snowball sampling technique, it becomes a chain-referral sampling that picks up more participants along the way and gets bigger and bigger as each additional participant is added to the study (Burkholder et al., 2016).

I used the SurveyMonkey for data collection, which allowed participant information to remain anonymous during the study while collecting data (surveymonkey.com). When a participant clicked the link to the survey, the survey included an electronic informed consent, instructions about the research study, and a demographic questionnaire (Appendix A). The informed consent form appeared on the first page of the survey and detailed the respondents' risks and benefits, including the eligibility to participate in the study. There was a caveat or disclaimer stating that the topic being researched relates to childhood trauma, and by consenting to respond, participants are aware of the nature of the study. I reiterated in the consent disclosure that a trauma is a dangerous or distressing experience that can result in intense emotional and physical reactions, feelings of helplessness and terror, and capable of leading to serious injury or death (Scheffers et al., 2019). Participation is voluntary, and a participant can withdraw at any time without penalty. Before beginning the survey, participants will give their consent and acknowledge that their participation is voluntary by selecting the button that says, "Yes." Participants then proceeded with the survey, which included the ASQ-

Short-Form, ACE Questionnaire, and the PSIT. I retrieved all the collected data and downloaded it to SPSS for analysis after reaching the targeted sample size.

Instrumentation and Operationalization of Constructs

Demographic Questionnaire

I included a demographic questionnaire (Appendix D) that I administered to all participants. It comprised information regarding the participants' age, gender, tribe, marital status, employment status, education, household income, and number of household members. The questionnaire included three questions concerning the family attachment/bond before and after kinship placement and the participants' age going into kinship home.

Attachment Style Questionnaire-Short Form

Attachment style questionnaire is developed from Attachment Theory that helps to explain individual differences in the affective ties formed with the parent or primary caregiver (Iwanaga et al., 2018; Rom & Mikulincer, 2003). I administered the Attachment Style Questionnaire (ASQ)-Short Form by Iwanaga et al. (2020). It is a revision of the Attachment Style Questionnaire (ASQ) by Feeney et al. 1994 (Iwanaga et al., 2020). This ASQ short form was formulated to scientifically reduce the length of existing ASQ scales while maintaining their psychometric properties (Iwanaga et al., 2018). The ASQ is a 40-item, self-report measure with three subscales: secure attachment, anxious attachment, and avoidant attachment. There are 8 items in secure attachment subscale, 15 items in anxious attachment subscale, and 17 items in avoidant attachment subscale. For instance, under secure subscale there are items like "Overall I

am a worthwhile person" and "I am easier to get to know than most people." Two example items in anxious subscale are: "It's important that others like me" and Sometimes I think I am no good at all" (Iwanaga et al., 2020). Participants will rate each item using a 6-point Likert-type agreement scale ranging from 1 (totally disagree) to 6 (totally agree). Each ASQ subscale will be reported and evaluated separately (Iwanaga et al., 2018). Validity is demonstrated by intercorrelations among scales. Secure and avoidant are negatively correlated (r = -.49), secure and anxious are negatively correlated (r = -.29), and avoidant and anxious are positively correlated (r = .35). It has test-retest reliability coefficients .74 and .80 with internal consistency reliability coefficients from .83 to .85 (Iwanaga et al., 2018).

I did not find any journal articles that previously made use of the ASQ-SF assessment tool except the authors' preliminary validation. Iwanaga et al. (2018) conducted a test-retest preliminary validation of ASQ-SF using individuals with disabilities. The goal of their study was to develop an ASQ measure that will provide strong evidence for the psychometric properties similar to the long-form ASQ. The result showed that short-form was as reliable as the long-form and found to correlate with hope, sense of coherence, and subjective well-being in the study, including strong evidence of similarities in the psychometric properties. The authors of ASQ-SF allow the use of the measure for non-commercial research and educational purposes without seeking written permission (Iwanaga et al., 2020).

Adverse Childhood Experience Questionnaire

The Adverse Childhood Experience Questionnaire (ACE-Q) is a 10-item brief

rating scale used to analyze the link between multiple categories of childhood trauma (ACEs) and psychosocial health outcomes later in life. It has provided significant knowledgeable evidence regarding the connection between adverse childhood experiences and adult mental and physical ill health (Felitti et al., 1998, as quoted by Zarse et al., 2019). The questionnaire checks for subject recall of pre-adult exposure to psychological, physical, and sexual abuse. It includes household dysfunction, domestic violence, substance use, and incarceration (Zarse et al., 2019).

For instance, the participants responded Yes or No to statements such as 1. Did a parent or other adult in the household often Swear at you, insult you, put you down, or humiliate you? Or Act in a way that made you afraid that you might be physically hurt? 2. Touch or fondle you, or have you touch their body in a sexual way? Or Try to or actually have oral, anal, or virginal sex with you? The yes answers are ranted at 1 point, while no answers get 0 points. After the questionnaire, the total is calculated. A total score of 0 means no trauma, and 10 means trauma in all categories. Higher scores signify a greater exposure to childhood trauma, while lower scores signify a fewer exposure to childhood trauma.

The scale demonstrated a favorable level of reliability (Alpha = .81) by applying Cronbach's rating (Schmidt, 1996). The ACE-Q was used on the adult population of 13,494 Kaiser patients resulting in a 70.5% response sample with a mean age of 56.1 years. The outcome showed that higher ACE scores corresponded to a greater degree of adult illness burden or psychosocial risk (Felitti et al., 1998). To determine childhood trauma outcomes, the ACE-Q has served as an assessment tool for adult populations in

social services, healthcare, education, justice, and legislator studies (Zarse et al., 2019). Mendel et al. (2021) reported a study of first-time mothers conducted in 2014-2015 to examine the pathways between maternal childhood health and well-being and pregnancy-related stress in the population. The 99 participants were 29 years old on average, and one of the instruments administered to them was the ACE-Q. The result indicated that more than a third (35.4%) of the participants had experienced four or more ACEs, indicating a high-risk category for adverse health and behavioral health outcomes (Felitti et al., 1998). The questionnaire is not copyrighted, and there are no fees for its use. A researcher is requested to send a copy of the subsequent questionnaire to dvpinquiries@cdc.gov.

Psychosocial Screening Instrument for Physical Trauma Patient

I included the PSIT questionnaire, which is an instrument for screening patients or individuals surviving a physical trauma or injury (Karabatzakis et al., 2019a). It was developed in Dutch to help screen patients' several psychosocial problems like social and self-image, anxiety, and depressive symptoms after the trauma or injury (Karabatzakis et al., 2019). According to Karabatzakis et al. (2018), the development of the PSIT was prompted by lack of comprehensive psychosocial screening instrument for survivors of physical trauma or injury that will help to assess for psychological problems (depression, anxiety, or post-traumatic stress symptoms-PTSS) and other psychosocial problems like impaired social life. The PSIT is a 15-item self-report assessment tool with three subscales: subscale 1 (Negative affect), subscale 2 (Anxiety PTSS), and subscale 3 (Social and self-image). It is scored 0 (not at all), 1 (a little), 2 (quite a lot), or 3 (very

much). Subscale 1 consist of seven items; example is item 2 = depressed mood, subscale 2 has 3 items; example is item 1 = anxiety, feeling tensed, whereas 4 items are in subscale 3, example is item 3 = problems with intimacy/sexuality. Item 16 (other problem or problems, namely:) is optional open-ended question and not considered a subscale (Karabatzakis et al., 2019b). I did not find any previous study that used the instrument except the developers. The developers used the PSIT instrument to assess psychosocial health of all adult trauma patients without severe cognitive disorders (n = 1448) in a Dutch level I trauma center from October 2016 through September 2017. The purpose was to finalize and psychometrically examine the PSIT (Karabatzakis et al., 2019a). The instrument has a good test-retest reliability (intraclass correlation Coefficient .86). The tool reported a favorable internal consistency for the three subscales, including area under the curve (AUC). Subscale 1 has (alpha 0.91; AUC = 0.92), subscale 2 (alpha 0.77; AUC = 0.88), and subscale 3 (alpha 0.79; AUC = 0.92) (Karabatzakis et al., 2019a). The authors of PSIT allow the use of the measure for non-commercial research and educational purposes without seeking written permission (Karabatzakis et al., 2019). Therefore, I will not need special permission to use this measure.

Data Analysis Plan

I used the Statistical Package for the Social Sciences (SPSS) to perform the statistical analysis of the data collected, particularly SPSS Version 28. Data analysis involved both descriptive statistics and inferential statistics, which means describing the statistical data and inferring from the sample data what the population might think (Research Methods Knowledge Base, 2020). Specifically, I used the descriptive statistics

to report demographic and categorical data. For example, I used descriptive statistics to describe demographic data on how the age, location, gender, and economic status of participants are distributed. I used inferential statistics to test my hypotheses. With the multiple linear regression, I analyzed the predictive relationship between my variables and investigate the mediating variable. The current research questions and hypotheses aligned with the correlational and multiple regression analyses, as shown below.

Research Questions and Hypotheses

RQ 1: Are attachment type and childhood trauma statistically significant predictors of psychosocial health in Nigerian adults raised in kinship homes, as measured by scores on the Attachment Style Questionnaire (ASQ)-Short-Form, Adverse Childhood Experience (ACE) Questionnaire, and Psychosocial Screening Instrument for physical trauma patients (PSIT)?

$H_0$1: Attachment type and childhood trauma are not statistically significant predictors of psychosocial health in Nigerian adults raised in kinship homes, as measured by scores on the ASQ-Short-Form, ACE Questionnaire, and PSIT.

$H_1$1: Attachment type and childhood trauma are statistically significant predictors of psychosocial health in Nigerian adults raised in kinship homes, as measured by scores on the ASQ-Short-Form, ACE Questionnaire, and PSIT.

- Independent Variables (IVs): Attachment type and childhood trauma
- Dependent Variables (DV): Psychosocial health
- Statistical Analysis: Multiple linear regression

RQ 2: Does attachment type mediate the relationship between childhood trauma

and psychosocial health in Nigerian adults raised in kinship homes, as measured by scores on the ASQ-Short-Form, ACE Questionnaire, and PSIT?

$H_0$2: Attachment type does not mediate the relationship between childhood trauma and psychosocial health in Nigerian adults raised in kinship homes, as measured by scores on the ASQ-Short-Form, ACE Questionnaire, and PSIT.

$H_1$2: Attachment type does mediate the relationship between childhood trauma and psychosocial health in Nigerian adults raised in kinship homes, as measured by scores on the ASQ-Short-Form, ACE Questionnaire, and PSIT.

- Independent variables (IV): childhood trauma
- Mediating variable: attachment type
- Dependent variable (DV): psychosocial health
- Statistical analysis: mediation with regression analysis

Threats to Validity

Internal Threats to Validity

Internal validity shows that evidence in the study resulted in the outcome. There are a few threats to the internal validity of this research, namely, researcher bias, participant maturation, research design and sampling technique. The researcher bias encompasses my understanding of the subject matter and principal concepts such as attachment type, childhood trauma, and psychosocial health to influence the study's design (Burkholder & Crawford, 2016). For instance, if I manipulated the systemic investigation or introduced a systematic error into the sample data to arrive at certain outcomes. Maturation is a potential threat to the validity. It is more than age-related

biological changes to encompass participant worldview, understanding, insights, and biological changes such as recall, becoming hungry, tired or fatigued, impatient, which may occur during the intervention or while answering the questionnaire (Flannelly et al., 2018). The above mentioned conditions in maturation can impact the participants' focus or concentration in answering the questionnaire, which invariably reflect in the quality of their responses. Another threat to this study is the possibility of mortality. Mortality accounts for participant dropout or attrition in a study (Flannelly et al., 2018). Burkholder and Crawford (2016) held that participants dropout or attrition may indicate that they differ from those who completed the survey in a meaningful manner. The obtained sample may limit the correct representation of the population of interest, include limiting generalizability of results as an external validity threat.

The use of nonprobability sampling could be a threat to the study. Convenience sampling, for example, makes selection or response bias much more likely (Babbie, 2017; Burkholder et al., 2016). Snowball sampling may lead to a potential sampling bias and margin of error because of participants' shared similar traits, which also poses a threat to the study's internal validity (Babbie, 2017; Burkholder et al., 2016). Social desirability bias is a possible internal threat to this study. Some participants may answer the questionnaire in manners that make them look favorable or appealing to others, considering that snowballing technique is involved.

External Threats to Validity

External validity demonstrates the capability of the study findings to be generalized. It shows the degree to which the findings in the study would support other

persons in other areas at different times (Babbie, 2017; Burkholder et al., 2016; Houser, 2015). External threats to validity are embedded in nonprobability sampling. A big portion of the population is neglected. Responses are more likely from less busy people, higher in agreeableness, extraverted, and educated. Responses come from easily available people. It does not reflect the position of the general population. In addition to the sampling technique, the G*Power provided a sample size of 75 for the study. The sample size is a miniature representation compared to the population of adult Nigerians exposed to childhood trauma after their kinship placement. Thus, the study lacks generalizability.

Ethical Procedures

Ethical considerations are vital in the counseling profession and scholarly research. I got the Walden University Institutional Review Board (IRB) approval before collecting any data. I ensured that I obtained the participants' informed consent and addressed the issue of confidentiality and privacy. The American Counseling Association [ACA] (ACA, 2014) in *2014 Code of Ethics* dedicated whole Section G to research and publication, including the rights of research participants (Standard G.2.). The ethical guidelines copiously stated what a researcher should observe in the process. To ensure that respondents' identity is not in jeopardy, I addressed the issue under confidentiality and informed consent. I assured them of maintaining their privacy and confidentiality.

I addressed confidentiality in the voluntary informed consent disclosure at the beginning of the survey. All the information provided in the questionnaire will remain secure and confidential. I did not ask at any time for the participants to provide their names or address while completing the survey, or any other identifiable information, to

ensure confidentiality. Individual responses will not be disclosed in order to protect the participants' personal identification and information. It is strictly for scholarly inquiry and academic purposes. At the end of the informed consent, the respondents chose to acknowledge their participation was voluntary by selecting the button that says, “Yes or No.” This last action indicates that participants understand their rights, expectations, and willingness to participate in the study. Part of participants' rights was to participate freely and exit from participation at any time without penalty. Agreements to the stipulated conditions in the informed consent disclosure authenticate participants' access to the survey questionnaire. I ensured the protection of confidentiality and information through data storage using initials or pseudonyms and an encrypted password known to me.

Regarding the treatment of participants in the study, participants were informed about the possible advantages and disadvantages of serving as research participants. These potential benefits and risks contained in the informed consent disclosure. While taking the survey, the recall and retrospective report may arouse negative feelings and emotions. Participants can withdraw at any time. At the end of the survey was my statement of appreciation to all the participants, including the advice to seek help if they are experiencing any emotional or mental health discomfort as a result of participating in my study. Additionally, I have the obligation of reporting any errors that might make the results misleading to my readers (Babbie, 2017). The study has to reflect on what it purports to study and inform my readers' possible limitations or errors.

Summary

In this chapter I focused on the research design and methodology for the proposed

study. A non-experimental quantitative correlational design used to examine the predictive relationship between attachment type, childhood trauma, and psychosocial health of adult Nigerians after kinship placement experience. Additionally, the study examined if attachment type mediates the relationship between childhood trauma and psychosocial health. A convenience sample of participants were recruited. I used the ASQ, ACE, PSIT, and a short demographic questionnaire to collect data for the study. In the following chapter, I explained the data collection process and data analysis. It also comprised answers to my research questions derived from the analysis of the data.

Chapter 4: Results

This quantitative correlational study was conducted to examine whether attachment type and childhood trauma are statistically significant predictors of psychosocial health in Nigerian adults raised in kinship homes and whether attachment type mediates the relationship between childhood trauma and psychosocial health. The research questions addressed whether attachment type and childhood trauma are statistically significant predictors of psychosocial health in Nigerian adults raised in kinship homes and whether attachment type mediates the relationship between childhood trauma and psychosocial health in Nigerian adults raised in kinship homes. The primary goal of this study was to contribute to a greater understanding of the Nigerian kinship system and its effects on the psychosocial functioning of adult Nigerians who experienced kinship placement as a child. The results of the study may assist counselors who will work with adult Nigerians, and may contribute to clinical counseling training programs and services.

Data Collection

Walden University Institutional Review Board approval was granted on February 27, 2023. On March 09, 2023, I opened up the survey I created in SurveyMonkey to allow anyone with the survey link to access and complete the survey. The survey comprised the informed consent, my demographic questionnaire, the ASQ-Short Form, the ACE Questionnaire, and PSIT. The demographic questionnaire had 12 questions in SurveyMonkey. Question 14 was the ASQ that contained 40 items of the questionnaire, Question 15 contained 10 items of the ACE Questionnaire, and Question 16 had 15 items

in the PSIT. The 16th item of the PSIT, which was optional and not part of the subscales, was designed as Questions 17 and 18 (Q17 & Q18) to fit the pattern of the question.

I posted the poster announcement in the various Nigerian WhatsApp groups in the States, particularly in Chicago, Illinois, and the Facebook group. I sent out the first round of poster announcements on March 09, 2023. I received three responses during the first week of data collection, March 09–March 12, 2023. I sent out the second round of poster announcements on March 13, 2023. In the second week, March 13–March 19, 2023, I received 31 responses. I sent out the third round of poster announcements on March 20, 2023. During the third week, March 20–26, 2023, I received 44 responses. After adding all the responses at the end of the third week of data collection, I met and exceeded my sample size requirements. Per the a priori analysis discussed in Chapter 3, I needed a minimum of 68 respondents. I oversampled by 10% to account for possible attrition resulting in an intended plan to obtain a sample size of 75. By the end of week 3, I had 78 responses, with 72 of those responses being eligible for data analysis.

Seventy-seven participants consented to answer the survey. However, six participants discontinued after consent. Important to note is that one participant who lives in Nigeria completed and submitted the survey without consent. The participant was included in the data analysis because the survey was completely anonymous and no identifiable information was obtained. Additionally, participants had to consent in order to have access to the survey. It is possible the individual initially consented in order to have access to the survey and later unchecked the box before submission. An approximation of 92% of 78 respondents who opened the survey completed and

submitted it. The median time respondents spent completing the survey was 12 minutes. I closed the survey in SurveyMonkey on March 30, 2023. There were no notable discrepancies in data collection from the initial plan discussed in Chapter 3, except for the participant who completed and submitted the survey questionnaire without consent.

I examined the data for missing values and found six missing values in the demographic, six in the ASQ data, two in the ACE-Q data, and eight in the PSIT data. The missing values were randomly missing and were addressed through mode imputation during data cleaning. Mean/mode imputation is completed by replacing missing values with a variable's mean or mode of observed values (Silva-Ramirez et al., 2011). Mean/mode imputation can be used in cases such as this, where less than 5% of the data is missing (Aljuaid & Sasi, 2016). I also cleaned data to exclude the six participants who discontinued after consenting and to prepare the data for multiple regression and mediation analyses in the SPSS.

After data cleaning, the database was transferred to the SPSS application for analysis. Preliminary arrangements and organization of items according to the ASQ and PSIT's subscales were performed in line with the requirements of their authors (Iwanaga et al., 2018; Karabatzakis et al., 2019). I computed the variables to fit into the model for the regression analyses. I used reverse *Key* (i.e., 6 = 1, 5 = 2, 4 = 3, and so on) to score the participant attachment responses according to the authors' instruction (Iwanaga et al., 2018; Mallinckrodt et al., 1995). The 16th item in the PSIT (designed in SurveyMonkey as questions 16 & 17) was optional. According to the questionnaire authors' instructions, it did not belong to any subscale in the PSIT (Karabatzakis et al., 2019).

Results

Demographics and Other Variables

The survey collected demographic information: gender, tribe, residence (currently lives in), age, marital status, household number, and education. Other information was employment, annual income, kinship age, and family relationship before and after kinship care. The highest number of Participants (N = 18) was in the age range of 45-54, contributing 25% of the participation. Most participants identified themselves as Igbo (79.71%). The overall demographic information showed that majority of participants were single (29.17%), held a bachelor's degree (54.17%), were employed (26.39%), and earned an annual income of $26,000-$50,000. Twenty-five participants, which accounted for 35.21% (the highest percentage), reported going into kinship placement between the ages of 7-12. Thirty participants, who accounted for 41.67%, indicated "a very good" family relationship before kinship placement. Table 1 provides participant demographic characteristics of the survey.

Table 1

Participant Demographic Characteristics as a Percentage of the Sample

Characteristic	*n*	Percentage
Gender		
Male	21	29.17%
Female	24	47.22%
Non-binary	7	9.72%
Prefer not to answer	10	13.89%
Tribe		
Hausa/Fulani		1.45%
Igbo		79.71%
Yoruba		8.70%
Other Nigeria tribe		10.14%
Residence		
United States	60	85.71%
Nigeria	10	14.29%
Age		
18-24	9	12.50%
25-34	15	20.83%
35-44	11	15.28%
45-64	18	25.00%
55-64	8	11.11%
65-74	6	8.33%
75+	5	6.94%
Marital status		
Single	21	29.17%
Married	17	23.61%
Separated	9	12.50%
Divorced	9	12.50%
Widowed	9	12.50%
Prefer not to answer	7	9.72%
Household		
1-3	23	31.94%
4-6	25	34.72%
7-9	16	22.22%
10+	8	11.11%
Education		
Less than primary school	5	6.94%
Primary school	1	1.39%
Secondary school	3	4.17%
Tertiary school	12	16.67%
Bachelor's degree	23	31.94%
Master's degree	19	26.39%
Doctorate	7	9.72%
Other professional degree	2	2.78%
Employment		
Unemployed	14	19.44%
Employed	39	54.17%
Self-employed	19	26.39%

Characteristic	*n*	Percentage
Annual income		
Under $10,000	9	12.50%
$10,000-25,000	6	8.33%
$26,000-50,000	19	26.39%
$51,000-75,000	15	20.83%
$75,000+	6	8.33%
Prefer not to answer	17	23.61%
Age kinship care began		
0-2	11	15.49%
3-6	22	30.99%
7-12	25	35.21%
13-17	13	18.31%
Family relationship before kinship		
Very good	30	41.67%
Good	18	25.00%
Not so good	16	22.22%
Bad	5	6.94%
Very bad	3	4.1%
Family relationship after kinship		
Very good	13	18.06%
Good	16	22.22%
Not so good	27	37.50%
Bad	10	13.89%
Very bad	6	8.33%

Test of Assumptions

Preliminary analyses were conducted to assess the assumptions of the absence of multicollinearity, outliers, normality, linearity, homoscedasticity, and residuals' independence before the analysis. I tested the normality assumption by examining the P-P plot and ensuring that data points did not strongly deviate from the normal line (see Figure 1). I assessed for homoscedasticity by visually inspecting a scatter plot of standardized residuals versus unstandardized predicted values (see Figure 2). I assessed multicollinearity using tolerance values and variance inflation factors (VIFs). All tolerance values were greater than 0.1, and variance inflation factors (VIFs) were less than 10 (see Table E1 in the Appendix E). The assumptions were met, and no violations were noted.

Figure 1

Normal P-P plot for the Research Question 1

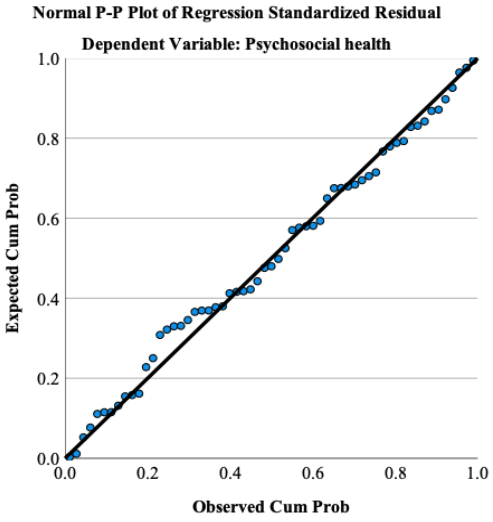
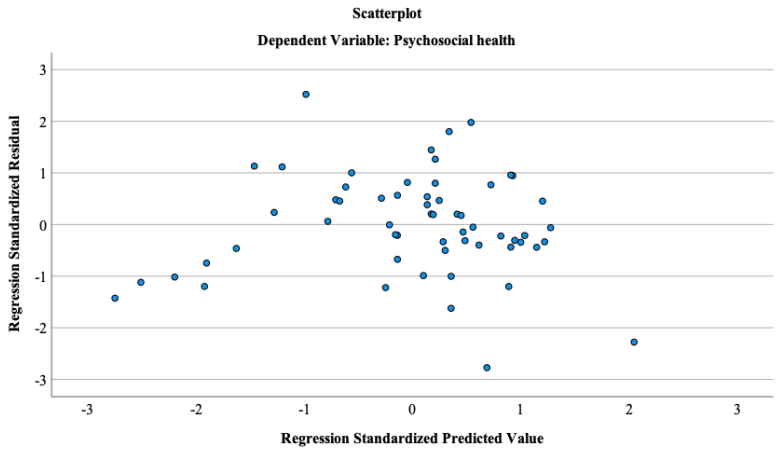


Figure 2

Scatterplot of Residuals Versus Predicted Values for Research Question 1



Null Hypothesis 1

A multiple linear regression analysis was conducted to evaluate the prediction of psychosocial health from attachment type and childhood trauma. The results of the overall multiple linear regression analysis revealed statistically significant predictors to the model F (2,56) = 12.729, p< .001, R^2_{adj} = .29. However, controlling for attachment type, the regression coefficient (ß = 1.727, t = 4.787, p < .001) associated with childhood trauma at 95% Confidence Interval (CL, 1.004 to 2.449) suggests that for every increase in childhood trauma, the psychosocial health risk increases on average by approximately 1.73. Conversely, the regression coefficient (ß = -.079, t = -1.122, p = .267) associated with attachment type at a 95% Confidence Interval (CL, -.219 to .062) shows a statistically nonsignificant to psychosocial health risk in the model. Thus, an assessment of the individual contribution of each predictor shows that childhood trauma contributes to psychosocial health risks in this population. The adjusted R2 value of approximately

0.29 associated with this regression model suggests that predictors account for 29% of the variation in psychosocial health. The adjusted R2 reported to provide a more precise view of that correlation or overall goodness-of-fit index (Warmer, 2013). The confidence interval associated with the regression analysis does not contain 0, which means the null hypothesis can be rejected (see tables in Appendix E).

Null Hypothesis 2

A mediation with linear regression analysis was conducted to evaluate whether attachment type mediates the relationship between childhood trauma and psychosocial health outcome. I carried out a series of regression analyses using Baron and Kenny's (1986) four steps approach to test for these hypotheses. In Step 1, I conducted a simple regression analysis with childhood trauma predicting psychosocial health to test for the pathway. The result of the regression analysis revealed a statistically significant predictor of psychosocial health (ß = 1.812, t = 5.091, p < .001). In Step 2, I conducted a simple regression analysis with childhood trauma predicting attachment type to test for the pathway. The result of the regression analysis revealed a statistically nonsignificant predictor of attachment type (ß = -.610, t = -.904, p = .369). In Step 3, I conducted a simple regression analysis with attachment type predicting psychosocial health to test for the pathway. The result of the regression analysis revealed a statistically nonsignificant predictor of psychosocial health (ß = -.111, t = -1.374, p = .175). In Step 4, I conducted a multiple regression analysis with childhood trauma and attachment type predicting psychosocial health. The results of the multiple linear regression analysis were statistically significant, F (2,56) = 12.729, p< .001, R^2_{adj} = .29. The regression analysis

coefficients scores revealed a statistically significant predictor of childhood trauma (ß = 1.727, $t = 4.787$, $p < .001$) and statistically nonsignificant predictor of attachment type (ß = -.079, $t = -1.122$, $p = .267$) at 95% Confidence Interval.

The findings show that childhood trauma directly and positively predicts psychosocial health (ß = 1.812, $t = 5.091$, $p < .001$) in Nigerian adults raised in kinship homes. Analyzing the indirect effects, the results reveal that attachment type does not significantly mediate the relationship between childhood trauma and psychosocial health (ß = -079, $t = -1.122$, $p = .267$) in this population. Childhood trauma does not significantly affect attachment type (ß = -.610, $t = -.904$, $p = .369$), and attachment type, in turn, does not significantly affect psychosocial health (ß = -.111, $t = -1.374$, $p = .175$). The findings do not support that attachment type is a statistically significant mediator in the relationship between childhood trauma and psychosocial health. Therefore, the null hypothesis is accepted (see tables in Appendix E).

Summary

In this chapter, I presented the multiple regression analysis of the data collected from adult Nigerian participants who experienced kinship placement as a child. I aimed to determine whether attachment style and childhood trauma were statistically significant predictors of psychosocial health risk in the participants. Additionally, the goal was to see if attachment style statistically mediates or influences the relationship between childhood trauma and psychosocial health in this population. All the assumptions were met. The overall results of the findings showed that attachment type and childhood trauma were statistically significant predictors of psychosocial health risks in this population.

However, looking at the unique individual contributions of the predictors, the coefficients result shows that attachment type was a statistically nonsignificant predictor of psychosocial health and a statistically nonsignificant mediator between childhood trauma and psychosocial health. Conversely, childhood trauma positively and directly contributes statistically significantly to predicting psychosocial health risks in adult Nigerians who experienced kinship placement as a child. The general outcomes of the two research questions led to the rejection of the null hypothesis in RQ1 and the acceptance of the null hypothesis in RQ2.

Chapter 5 will be a summary with discussions on the study, including a restatement of the purpose of the study with findings. I will interpret these findings, explore possible explanations and rationales for the outcomes, and discuss limitations, implications for social change, and recommendations for future research. Finally, I will conclude with closing thoughts on the need for social support on increasing government oversight or policy regulation for kinship care placement.

Chapter 5: Discussion, Conclusion, and Recommendations

The purpose of this quantitative correlational study was to determine whether attachment type and childhood trauma are statistically significant predictors of psychosocial health in Nigerian adults raised in kinship homes and whether attachment type mediates the relationship between childhood trauma and psychosocial health as measured by scores on the ASQ-Short-Form, ACE Questionnaire, and PSIT. The primary goal of this study was to contribute to a greater understanding of the Nigerian kinship system and its effects on the psychosocial functioning of adult Nigerians that experienced kinship placement as a child. The result of the study may assist counselors who work with adult Nigerians and contribute to clinical counseling training programs and services.

An assessment of the individual contribution of each predictor variable showed that though attachment type was not a significant predictor of psychosocial health risks in adult Nigerians who experienced kinship care, childhood trauma was a predictor of psychosocial health risks among adult Nigerians in the study. Next, I investigated if there was a mediating effect of attachment type on the relationship between childhood trauma and psychosocial health. The findings did not support statistically significant mediating effect of the attachment type on the relationship between childhood trauma and psychosocial health. The goal of contributing to a better understanding of the psychosocial health of adult Nigerians after their kinship placement as a child was met.

In this chapter, I will discuss interpretations of the results and compare the current study findings with those of previous similar studies. Interpretations of the results are presented in order of null hypotheses. Finally, I will discuss the study's limitations,

recommendations, and implications.

Interpretation of the Findings

Many assumptions were made in this study based on previous research, and not all were supported by the findings. There is a cultural perception among Nigerians that physical discipline and corporal punishment are necessary for the good upbringing of children. Otherwise, individuals are believed to misbehave, and their actions worsen. On the contrary, this culture that allows physical chastisement, physical punishment, or corporal punishment, which is passed on through generations as a form of parenting, contributes to child abuse and trauma (Ogidan & Ofoha, 2019). Similarly, emotional abuse or trauma prevalent in Nigeria can emanate from physical chastisement, sexual abuse, and unwanted pregnancy and may result in severe emotional and psychological underdevelopment (Makinde, 2016). Some studies showed that children in kinship care are more likely to experience all forms of abuse and maltreatment that can result in more childhood trauma and more severe posttraumatic stress (PTS) and social and behavioral problems (Villodas et al., 2016; Washington et al., 2018).

In this study, with a childhood trauma questionnaire, out of 70 participants who completed the questionnaire, the result indicated that more than 75% of the participants had experienced five or more ACEs, indicating a high-risk category for childhood trauma (Felitti et al., 1998). This study result corroborates the National Center on Early Childhood Health and Wellness' (n.d.) research that indicates that children who are exposed to four or more ACEs are at a greater risk of developing various psychosocial problems, including attempted suicide, learning and behavioral challenges. Furthermore,

eight out of 10-leading causes of death in the United States are linked with exposure to four or more ACEs (National Center on Early Childhood, n.d.). Childhood traumatic experiences adversely affect health outcomes later in life. Thus, students who are victims of trauma are at increased risk for academic failure or poor performance in the classroom (National Center on Early Childhood Health and Wellness, n.d.). Hence, the assumption or culture of physical or corporal punishment, which some kinship care children are more likely to experience (Leinaweaver, 2014; Lorfa et al., 2021), contributes to abuse and childhood trauma (Ofoha & Ogidan, 2020). Childhood trauma is a catalyst for future mental health and physical health problems (Toof et al., 2020). The profound lifespan impact of childhood trauma on the mental health and psychosocial well-being of the victims will be explored next through the interpretation of this research findings.

Research Question 1

The results in the current study showed a statistically significant predictive relationship between attachment type, childhood trauma, and psychosocial health. Attachment experiences play a major role in the development of autonomy-connectedness, with childhood trauma leading to low autonomy-connectedness and more psychopathological symptoms (Maas et al., 2018). In addition, youth with unstable placement patterns experience more adverse childhood experiences or childhood trauma and higher posttraumatic stress (PTS) levels by late childhood than those with stable placement patterns (Villodas et al., 2016), which is a precursor to later psychosocial problems. Exposure to trauma events is intense, composite, and cumulative (Riebschleger et al., 2015), making children susceptible to significant distress and psychosocial risk in

life. The results indicated that childhood trauma was a significant predictor of psychosocial health. This study's statistically significant relationship between childhood trauma and psychosocial health corroborates similarly with previous findings (see Peng et al., 2020).

Analysis of the results also indicated that attachment type was not a significant predictor of psychosocial health. The overall finding in my research regarding the attachment type is that it is statistically nonsignificant in the relationship between childhood trauma and psychosocial health, which differs from previous findings (Ariyo et al., 2019; Peng et al., 2020). From the weighted average (grand mean) of secure (3.54), anxious (3.39), and avoidant (3.24) attachment types, the majority of the participants in my study reported secure attachment perception of themselves, followed by those with anxious attachment perceptions of themselves. Participants with avoidant attachment perception are fewer in number. The probable factors that could explain the findings are the participants' reported age of entry into kinship care and relationships with their families before kinship placement. About 53.52% of participants (38) entered kinship care between 7 and 17 years old. Attachment theory holds that the early environment influences character development, and the first six years are the most impactful in attachment bonding or quality (Iwanaga et al., 2018; Zdankiewicz-Scigala & Scigala, 2020). Additionally, 66.67% of study participants reported "good" or "very good" relationships with their families before kinship placement. Based on the results of this study, adult Nigerians who lived in kinship placement as a child and experienced childhood trauma struggled with psychosocial health risks, and attachment type was not a

statistically significant predictor in their psychosocial health.

Research Question 2

Attachment is essential when dealing with childhood trauma, as trauma changes expectations and beliefs about the world, self, and others (Maas et al., 2018). Attachment experiences help the individual in the development of schemas. It means that the availability of and reliance on parents or caregivers impacts how children cope with stress and trauma. The unavailability of attachment figures may lead to neurobiological changes. Childhood trauma has been associated with insecure attachment and increased psychosocial health risk (Kendall et al., 2015). Given the potential for childhood attachment experiences to influence adult psychosocial functioning (Iwanaga et al., 2018), I wanted to see whether attachment type mediates the relationship between childhood trauma and the psychosocial health of this population using Barron and Kenny's (1986) four steps approach. The findings showed that the attachment type was statistically nonsignificant mediation in the relationship between childhood trauma and psychosocial health. Some possible reasons for the lack of observed mediation of attachment, which is incongruent with previous findings, could be participants' social desirability bias, self-perception error, false inference (overinterpretation/misunderstanding), and memory problem or recall during the survey (Groves et al., 2009; Warner, 2013).

There was neither full nor partial attachment-type mediation in the relationship between childhood trauma and the psychosocial health of the population. This finding is partially consistent with a similar study by Sandberg (2010) on whether K.

Bartholomew's (1990) self-report dimensions of adult attachment mediate or moderate links from victimization/abuse to posttraumatic stress and dissociation. He found that adult attachment was significantly related to posttraumatic stress and dissociation. However, there were no significant mediation effects for attachment, although dismissing attachment type indicated a moderate link between victimization/abuse and posttraumatic stress. In my finding, there is also no attachment-type mediation effect that is statistically significant in the relationship between childhood trauma and the psychosocial health of these participants who experienced childhood kinship placement. Exposure to childhood trauma has direct and statistically significant effects on their psychosocial health.

Overall Analysis

This research was prompted by the researcher's observation of social problems in the kinship care system in Nigeria, especially attachment type, childhood trauma, and psychosocial health. I set up two research questions and their corresponding hypotheses. After the data analysis, the null hypothesis of the first research question was rejected. The results showed that childhood trauma statistically significantly predicts psychosocial health risks of adult Nigerians who experienced childhood kinship placement. However, attachment type was not a statistically significant predictor of their psychosocial health. Nonetheless, there is useful information about attachment type observed from the results. More participants have a secure attachment perception of themselves than those with anxious and avoidant insecure attachments. As indicated above, the possible explanation as to why the findings differ could hinge on participants' reported age at the beginning of kinship and relationship before kinship placement.

Given that some studies have linked childhood trauma to insecure attachment and its influence on adult psychosocial health, I investigated its mediating effect on the relationship between childhood trauma and psychosocial health in the second research question. I used Baron and Kenny's (1986) three-step approach for mediation analysis to ensure zero-order relationships and the fourth step to prove complete mediation across the variables (MacKinnon et al., 2007). My findings showed no statistically significant mediation effect on the relationship between childhood trauma and the psychosocial health of the participants. The null hypothesis was accepted. Attachment type presents a statistically nonsignificant effect in the relationship between childhood trauma and the psychosocial health of this population. These findings provide some evidence that Nigerians who experience kinship placement are more likely to suffer childhood trauma and its lifelong consequences or psychosocial health. There are three subscales of psychosocial health showing different cut-off mean scores: negative affect/mood disturbances ≥ 7, anxiety symptoms and posttraumatic stress symptoms (PTSS) ≥ 3, and social and self-image ≥ 4 (Karabatzakis et al., 2019b). Worth noting is that participants in my study reported mean scores higher than the cut-off score on each of the three subscales (affect 9.49, anxiety/PTSS 5.63, & social/self-image 5.54). Consequently, they are more likely to experience psychosocial health risks such as mood disturbances, anxiety symptoms and PTSS, and social and self-image (social or sexual problems, negative body image, and/or decreased self-confidence).

To the best of my knowledge, this is the first study that investigated adult Nigerians who experienced childhood kinship placement in relation to attachment type,

childhood trauma, and current psychosocial health. My research findings may assist counselors who will work with adult Nigerians and may contribute to clinical counseling training programs and services, including adding to counseling literature. Counselors may learn more about the kinship care system in Nigeria and some of the inherent social problems intrinsic to the system. Firstly, the kinship care system is not structured like in the United States, heightening the likelihood of child trauma in kinship care. Secondly, counselors can better understand the Nigerian concept of disciplinary measures or harsh discipline, which can intensify childhood trauma and assess this population in this area. In six out of ten exposed to childhood trauma, less than 5% receive help or treatment (Lorfa et al., 2022). Furthermore, counselors may need to use words like maltreatment, abuse, and neglect instead of childhood trauma when exploring and assessing their Nigerian clients for a better counseling outcome, as found in most Nigerian literature (Ariyo et al., 2019; Ebigbo et al.; Ushie et al., 2016). My study reveals that exposure to childhood trauma in this population results in statistically significant psychosocial health risks in adulthood. Lastly, the findings would be shared with organizations, institutions, government agencies, and parastatal for gainful insights and social change.

Limitations of the Study

This study has its limitations. The first limitation is the use of Baron and Kenny's (1986) four-step approach for mediation analysis, which is the general approach many researchers use, the significance of the indirect pathway is not ever really tested and tends to miss some true mediation effects (Type II errors) (Mackinnon et al., 2007). Secondly, the participants in the study were adult Nigerians. In Nigerian culture, something like

trauma or depression symptoms is seen by the collective ethos of the community as a failure of the family or group rather than just a failure of the person (Ezeobele et al., 2019). The cultural understanding of mental health could implicitly generate social desirability bias in some participants' responses. Selection bias may equally be an issue in the sense respondents who self-selected to participate in the study may have differed in some way from nonparticipants. For instance, individuals who were feeling extremely overwhelmed may have decided not to participate. Based on the researcher's experience, Nigerians do not like to self-disclose their issues, and some may find it uncomfortable recalling and talking about kinship. Ezeobele et al. (2019) noted that Nigerians have different cultural beliefs regarding mental illness, and they fear being associated with mental problems because of stigmatization, cultural expectation, and humiliation. For instance, in this study survey, six participants discontinued after consent.

The recall issue may be another limitation and potential roadblock to reporting attachment type or childhood trauma. Recall is one of the challenges because the participants may feel like they are reliving the trauma. For example, there were missing values randomly spread in all the measures, including the demographic questionnaire, and there was no way of ascertaining the reasons due to the anonymity nature of the survey. Other challenges are numbing the childhood traumatic experience or putting it far behind their mind that it is hard to remember (McCormack & Issaakidis, 2018). The recall problem can constitute a minimal risk and a barrier in generating the population to respond to the questionnaire.

Given that a convenience sampling method was used in the study, it may create

low reliability. The majority of participants identified themselves as Igbo (79.71%), while the remaining identified as Other Tribes (10.14%), Yoruba (8.7%), and Hausa/Fulani (1.45%). As the sampling name implies, it is more convenient than other sampling techniques. A strength of convenience sampling is that it is easier for researchers to access members of the target population; thus, researchers commonly use this sampling method (Houser, 2015). However, it relies on available subjects without any control over the respondents of a sample. As a nonprobability sample, convenience sampling may not represent the population well (Research Methods Knowledge Base, 2020). In this study, 55 participants were Igbo, 6 Yoruba participants, 1 Hausa/Fulani, and 7 participants from other Nigerian tribes. The sample participants' distributions across ethnic groups or tribes did not equitably reflect the groups.

The use of a convenience sample affects generalizability to the wider population. Convenience sampling impacts the generalizability of the study due to uncontrolled and real-world settings (Babbie, 2017). It is difficult to tell if the researcher has represented the population well. The fact that generalizability cannot be assumed is a threat to external validity (Houser, 2015). It can lead to poor quality or tainted data and influence the results, including statistical significance and meaningfulness.

Recommendations

Although this study is a quantitative research design method a sample size of 72 is small for generalization when compared to the Nigerian population, in addition to demerits of convenience and snowball sampling techniques. Future research should focus on obtaining a larger sample of adult Nigerians who experienced kinship care placement

as a child. It should include participants with proportional and equitable distribution of Nigeria ethnic groups, a range of educational attainment, and functioning levels for a better generalization.

I also recommend further research on the mediating effects of attachment-type with this population using alternative tests (e.g. Sobel Test Calculator) rather than Baron and Kenny's approach to calculate the indirect effect and test it for significance (Mackinnon et al., 2007). Sobel's (1982) approach tends to pick the indirect effect by multiplying two regression coefficients for some actual mediation (MacKinnon et al., 1995). It is equally important to test for moderation effect of attachment type in this population since this study's mediation analysis outcomes reflected statistically nonsignificant mediating effects in the relationship between childhood trauma and psychosocial health, which differed from previous research findings. Additionally, there is a need for further research to know if children who experienced kinship placement under the age of six will give a different result on attachment styles, thereby corroborating the Attachment theory and the studies mentioned earlier. Other areas for further studies on this topic are the major contributing factors of childhood trauma in kinship placement, the effects of transitioning to their biological homes, and effective childhood trauma treatment after their placement.

Furthermore, counselors could use the findings in this study to inform how they approach adult Nigerians seeking mental health services. Another recommendation is to study this population from a qualitative research method to further explore the kinship care phenomenon, patterns, and themes and the impact kinship care has on the

psychosocial health of adult Nigerians, because little remains known.

Implications for Positive Social Change

Results showed that adult Nigerians who experienced kinship care placement struggle with psychosocial health due to exposure to childhood trauma. Results also indicated a statistically nonsignificant predictive relationship between attachment type and psychosocial health. Similarly, the findings showed statistically nonsignificant attachment mediating effects in the relationship between childhood trauma and psychosocial health for this population.

As mentioned in Chapter 2, six in ten children experience one or more child abuse or violence in Nigeria, and less than 5% report receiving help (Iorfa et al., 2022). Additionally, challenges (e.g., financial constraints and social support) presented by kinship care factor in escalating childhood trauma and psychosocial health risk. The fear of being deprived of food/nutrition may lead to the child receiving a continuous cycle of abuse or trauma from the caregiver. Such situations without social services to cope with the abuse or trauma may likely exacerbate depression, mental disturbance, or illness (Iorfa et al., 2021). Many studies show that children who experience childhood trauma have difficulties developing strong and healthy attachments and lack skills for effective interpersonal behaviors (Fratto, 2016; Zarse et al., 2019).

Given the current study's results, harsh or violent discipline should be discouraged or abolished, and proper education on the ills of harsh discipline should be given to caregivers and community members. Traditionally, every member of the community is involved in disciplining a child besides parents and siblings. Consequently, an average

Nigerian child experiences high levels of harsh discipline in different contexts (home, school, community, and care settings). Harsh discipline is justified based on the cultural beliefs that children behave well after being severely punished. Moreover, caregivers who do not apply an "iron hand" (harsh punishment) are viewed as negating the childrearing process (Ofoha & Ogidan, 2020). The cultural understanding of harsh disciplining of children further exposes the individual to childhood trauma and heightens the likelihood of children's trauma experiences in kinship care. Parents or families whose wards are in the kinship care placement should continuously check their children to help minimize maltreatment or punitive violence against children.

Unfortunately, most studies on childhood trauma in Nigeria were masked as childhood maltreatment, abuse, and neglect (Ariyo et al., 2019; Ebigbo et al., 2017; Ushie et al., 2016). Maltreatment is prevalent in Nigerian society that encourages harsh discipline or punitive violence. Some children in kinship face basic deprivation of needs and a continuous cycle of abuse or trauma from their caregivers (Lorfa et al., 2021; Ofoha & Ogidan, 2020). Children in kinship care often present challenging behavior like reduced attention and concentration, more overactive and aggressive, and engaged in attention-seeking behavior (Cunningham & Lauchlan, 2010). Children in kinship homes are more involved in domestic work or labor than in parental care. They are 4.17 times more likely not to attend school than children in parental homes and have fewer educational materials and lower school attendance than their mates in orphanage care (Ariyo et al., 2019). The above argument further indicates that some kinship care children are more at the receiving end of childhood trauma, maltreatment, or punitive violence

against children.

Available data on punitive violence against children showed that 84.9% of children in Nigeria (aged 1-14) experienced harsh or violent discipline (Ofoha & Ogidan, 2020, as quoted by the National Bureau of Statistics and UNICEF, 2014). Many caregivers are unaware of the harm or impact such a practice can have on the children. The lack of knowledge on the part of caregivers has kept the practice alive (Ofoha & Ogidan, 2020). One lifelong effect of traumatic experience is childhood trauma, one of the most noted risk factors for depressive symptoms and closely linked to later-life depression (Butcher et al., 2014; Powell & Davis, 2019). Government should be able to put some policies in place to improve kinship care. Increasing mental health problems, inadequate access to mental health services, and financial barriers to accessing mental health services are prevalent in informal kinship care (Gomez, 2021). Community organizations, town unions, and leaders of communities should call for cultural revival to eradicate harsh or punitive violence against children as a measure of discipline.

Through the suggested combined efforts of parents, caregivers, communities, government, and researchers, positive social change is possible at every level – individual, organizational, and global, and it begins with sharing the results of this study. It is essential to highlight the notion and nature of childhood trauma instead of maltreatment and identify maltreatment or punitive violence against children as a precursor to childhood trauma. Furthermore, it is vital to stress that childhood trauma has a lifelong psychosocial health risk or consequence.

This research study could aid various human endeavors, particularly supervisors,

educators, researchers, and advocates. Supervisors and educators should continue to explore multiculturalism, background, and other cultural dynamism of the supervisees, clients, teachers, and students by engaging them in formal or informal discussions. For instance, a participant in the study who is a counselor or teacher may not find anything wrong with corporal or harsh punishment. The individual sees it as a normal and valuable corrective measure because of their cultural mindset without knowing its traumatic effects or harmfulness to a child's psychosocial functioning and health. Supervisors and educators should be aware of this mindset and be able to guide such individuals. Researchers should do more research on kinship care and childhood trauma, maltreatment, or punitive violence against children. For instance, 95% of kinship arrangements in the UK are informal (instituted outside the formal child welfare system) and unstructured (Farmer et al., 2012).

Further research studies could be done on kinship placement and childhood trauma and harsh or punitive punishment in Nigerian households in America. The idea is to create more awareness and enlightenment, address the ills of the kinship system, and gain insightful knowledge or empowerment to break any cycle of trauma. Advocates could help discontinue the circle of trauma and normalization of punitive violence against children. Advocacy entails an action that promotes human rights, health, wellness, and dignity, which involves knowledge of social justice as a tool of social action (Vera & Speight, 2003). This study can provide informed knowledge on the kinship system for advocates of social change, as well as gainful insights toward enhancing the kinship system and promoting human rights, health, wellness, and dignity.

Conclusion

Researchers noted that a biological family environment is the best place to nurture children to adulthood (Adeboye et al., 2019; McCormick & Thomson, 2017). According to Bell and Romano (2014), children raised outside their organic homes experience much trauma and are particularly vulnerable to psychological and developmental problems. Hong et al. (2011) argued that children deal with emotional trauma when separated from their biological parents. Dealing with emotional trauma after the separation can impact the attachment style. Children that are removed from their biological homes experience attachment disruption or disorder (Howe & Fearnley, 2003; Hong et al., 2011). Childhood trauma may hinder healthy development that could lead to mental or psychological problems (Jansen et al., 2016; Lee et al., 2017; Masson et al., 2015; McCormack & Issaakidis, 2018; Stolzneburg et al., 2018). Kinship is one of the alternative care environments where children are fostered outside their organic or biological families (Adeboye et al., 2019; Ariyo et al., 2019). According to Chukwudozie et al. (2015), kinship is a well-known phenomenon in Africa, whereby children are sent to live with their relations, extended families, or close friends of their families. Kinship care is a common phenomenon in Nigeria, and Nigerians are the largest African immigrant population in the U.S. (Gramlich, Feb. 3, 2020). Children in kinship homes are liable to experience childhood trauma, which may result in later-life depression or lifelong psychosocial problems (Butcher et al., 2014; Powell & Davis, 2019).

The results of this study indicated that adult Nigerians who experienced kinship care struggle with psychosocial health issues due to exposure to childhood trauma. Given

the outcomes of this research, increased childhood trauma is much more prevalent in kinship homes than in biological family homes. Suppose an improvement or positive social change in kinship care is to be within the system. In that case, it begins with every community member (government inclusive) and cultural revival to eradicate harsh or punitive violence against children as a measure of discipline.

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Appendix A: Demographic Questionnaire

Dissertation Study Demographic Questionnaire

Please indicate your response by checking on one answer appropriate to you on each question below:

1. Gender:

   O Male

   O Female

   O Non-binary

   O Prefer not to answer

2. Tribe in Nigeria:

   O Hausa/Fulani

   O Igbo

   O Yoruba

   O Other Nigerian tribes

3. Currently lives in:

   O USA

   O Nigeria

   O Other

4. Current age range:

   O 18-24 years

   O 25-34 years

O 35-44 years

O 45-54 years

O 55-64 years

O 65-74 years

O 75 years or older

5. Marital Status:

O Single

O Married

O Separated

O Divorced

O Widowed

O Prefer not to answer

6. Household number (How many people live in your household, including you):

O 1-3

O 4-6

O 7-9

O 10 or more

7. Education:

O less than primary school

O Primary school

O Secondary school

O Tertiary school

O Bachelor's degree

O Master's degree,

O Doctorate

O Other professional degree e.g. J.D. or M.D. or D.D.S. etc.

8. Employment Status:

O Unemployed

O Employed

O Self-employed

9. Annual Income:

O Under $10,000

O $10,000-25,000

O 26,000-50,000

O 51,000-75,000

O 75,000 or above

O Prefer not answer

10. Age kinship care began:

O 0-2

O 3-6

O 7-12

O 13-17

11. Relationship with immediate family before kinship care:

    O Very good

    O Good

    O Not so good

    O Bad

    O Very bad

12. Relationship with immediate family after kinship care:

    O Very good

    O Good

    O Not so good

    O Bad

    O Very bad

Appendix B: Permission and ASQ-Short Form

Attachment Style Questionnaire–Short-Form

PsycTESTS Citation:
Iwanaga, K., Blake, J., Yaghmaian, R., Umucu, E., Chan, F., Brooks, J. M., Rahimi, M., & Tansey,, T. N. (2020). Attachment Style Questionnaire--Short-Form [Database record]. Retrieved from PsycTESTS. doi: https://dx.doi.org/10.1037/t75708-000

Instrument Type:
Inventory/Questionnaire

Test Format:
Participants rate items on a 6-point Likert-type scale, ranging from 1) "totally disagree" to 6) "totally agree.".

Source:
Iwanaga, Kanako, Blake, John, Yaghmaian, Rana, Umucu, Emre, Chan, Fong, Brooks, Jessica M., Rahimi, Maryam, & Tansey, Timothy N. (2018). Preliminary validation of a short-form version of the Attachment Style Questionnaire for use in clinical rehabilitation counseling research and practice. Rehabilitation Counseling Bulletin, Vol 61(4), 205-216. doi: https://dx.doi.org/10.1177/0034355217709477, © 2018 by SAGE Publications. Reproduced by Permission of SAGE Publications.

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Attachment Style Questionnaire (ASQ)-Short Form

Participants rate the 40 items on a 6-point Likert-type scale. Response options range from totally disagree (1), disagree (2), slightly disagree (3), slightly agree (4), agree (5), and totally agree (6). Please indicate your response by checking on the option appropriate to you below:

	Items	totally disagree	disagree	slightly disagree	slightly agree	agree	totally agree
Secure Attachment Subscale							
1	Overall I am a worthwhile person						
2	I am easier to get to know than most people						
3	I feel confident that other people will be there for me when I need them						
4	I find it relatively easy to get close to other people						
5	I find confident about relating to others						
6	I often worry that I do not really fit in with other people.						
7	If something is bothering me,						

	others are generally aware and concerned.						
8	I am confident that other people will like and respect me.						
Anxious Attachment Subscale							
9	It's important that others like me.						
10	It's important to me to avoid doing things that others won't like.						
11	I find it hard to make a decision unless I know what other people think.						
12	Sometimes I think I am no good at all.						
13	I find that others are reluctant to get as close as I would like.						
14	I worry that others won't care about me as much as I care about them.						
15	I worry that I won't measure up to other people						
16	I wonder why people would want to be involved with me.						
17	It's very important to me to have a close relationship.						
18	I worry a lot about my relationships.						
19	I wonder how I would cope without someone to love me.						
20	I often feel left out or alone.						
21	When I talk over my problems with others, I generally feel ashamed or foolish.						
22	I get frustrated when others are not available when I need them.						
23	Other people often disappoint me.						
Avoidant Attachment Subscale							
24	I prefer to depend on myself rather than other people.						
25	I prefer to keep to myself.						
26	To ask for help is to admit that you're a failure.						

27	People's worth should be judged by what they achieve.						
28	Achieving things is more important than building relationships.						
29	Doing your best is more important than getting on with others.						
30	If you've got a job to do, you should do it no matter who gets hurt.						
31	My relationships with others are generally superficial.						
32	I find it hard to trust other people.						
33	I find it difficult to depend on others.						
34	I find it easy to trust others.						
35	I feel comfortable depending on other people.						
36	I worry about people getting too close.						
37	I have mixed feelings about being close to others.						
38	While I want to get close to others, I feel uneasy about it.						
39	Other people have their own problems, so I don't bother them with mine.						
40	I am too busy with other activities to put much time into relationships						

Appendix C: ACE-Q

Adverse Childhood Experience (ACE) Questionnaire

Finding your ACE Score

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often** ...
Swear at you, insult you, put you down, or humiliate you?
or
Act in a way that made you afraid that you might be physically hurt?
Yes No If yes enter 1 _____

2. Did a parent or other adult in the household **often** ...
Push, grab, slap, or throw something at you?
or
Ever hit you so hard that you had marks or were injured?
Yes No If yes enter 1 _____

3. Did an adult or person at least 5 years older than you **ever**...
Touch or fondle you or have you touch their body in a sexual way?
or
Try to or actually have oral, anal, or vaginal sex with you?
Yes No If yes enter 1 _____

4. Did you **often** feel that ...
No one in your family loved you or thought you were important or special?
or
Your family didn't look out for each other, feel close to each other, or support each other?
Yes No If yes enter 1 _____

5. Did you **often** feel that ...
You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
or
Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
Yes No If yes enter 1 _____

6. Were your parents **ever** separated or divorced?
Yes No If yes enter 1 _____

7. Was your mother or stepmother:
Often pushed, grabbed, slapped, or had something thrown at her?
or
Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?
or
Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
Yes No If yes enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street

drugs?
Yes No If yes enter 1 _____
9. Was a household member depressed or mentally ill or did a household member attempt suicide?
Yes No If yes enter 1 _____
10. Did a household member go to prison?
Yes No If yes enter 1 _____

Now add up your "Yes" answers: _____ This is your ACE Score

Appendix D: Permission and PSIT

Psychosocial Screening Instrument for physical Trauma patients

PsycTESTS Citation:
Karabatzakis, M., Den Oudsten, B. L., Gosens, T., & De Vries, J. (2019). Psychosocial Screening Instrument for physical Trauma patients [Database record]. Retrieved from PsycTESTS. doi: https://dx.doi.org/10.1037/t77257-000

Instrument Type:
Inventory/Questionnaire

Test Format:
Participants review a list of psychosocial problems which can be experienced by physical trauma patients, responding to items on a 4-point Likert scale. Response options range from 0 (not at all) to 3 (very much). In addition to the response scale options, the last item also has an open-ended option, to describe psychosocial problems not on the list.

Source:
Reproduced by permission from: Karabatzakis, Maria, Den Oudsten, Brenda Leontine, Gosens, Taco, & De Vries, Jolanda. (2019). Psychometric properties of the psychosocial screening instrument for physical trauma patients (PSIT). Health and Quality of Life Outcomes, Vol 17. doi: https://dx.doi.org/10.1186/s12955-019-1234-6

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Psychosocial Screening Instrument for Physical Trauma Patients (PSIT)

Participants rate the 16 items on a 4-point Likert-type scale. Response options range from not at all (0), a little (1), quite a lot (2), and very much (3). Please indicate your response by checking on one option appropriate to you below:

	Items	Not at all	A little	Quite a lot	Very much
1	Anxiety, feeling tensed				
2	Depressed mood				
3	Problems with intimacy/sexuality				
4	Feeling less attractive				
5	Inadequate social support				
6	Decreased self-confidence				
7	Recurring memories, nightmares, and/or				

	images (flashbacks) of the trauma				
8	Feeling upset when thinking about the trauma increased watchfulness				
9	Increased watchfulness				
10	Less social/leisure activities than desired				
11	Frustration				
12	Disappointment				
13	Feeling powerless				
14	Anger				
15	Relationship issues				

Do you experience other psychosocial problems than those listed above? If so, please describe them below and state to what extent you experienced this problem in the past week?

		Not at all	A little	Quite a lot	Very much
16	Other problem or problems, namely: ……..				

Thank so much for participating in the survey.

Appendix E: Tables

Table E1

Statistical Table

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.	95.0% CI for B		Collinearity Statistics	
		B	SE	Beta			Lower	Upper	Tolerance	VIF
1	(Constant)	22.560	10.293		2.192	.033	1.941	43.179		
	Attachment type	-.079	.070	-.125	-1.122	.267	-.219	.062	.991	1.009
	Childhood trauma	1.727	.361	.533	4.787	<.001	1.004	2.449	.991	1.009

a. Dependent Variable: Psychosocial health

Table E2

Model Summary

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.559[a]	.313	.288	6.449

a. Predictors: (Constant), Childhood trauma, Attachment type

Table E3

ANOVA Table

ANOVA[a]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	1058.770	2	529.385	12.729	<.001[b]
	Residual	2328.959	56	41.589		
	Total	3387.729	58			

a. Dependent Variable: Psychosocial health

b. Predictors: (Constant), Childhood trauma, Attachment type

Table E4

Statistical Table

Coefficients

Model		Unstandardized Coefficients		Standardized Coefficients		
		B	Std. Error	Beta	t	Sig.
1	(Constant)	22.560	10.293		2.192	.033
	Attachment type	-.079	.070	-.125	-1.122	.267
	Childhood trauma	1.727	.361	.533	4.787	<.001

a. Dependent Variable: Psychosocial health

Table E5

Step 1: Childhood Trauma Predicting Psychosocial Health

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients		
		B	Std. Error	Beta	t	Sig.
1	(Constant)	10.734	2.115		5.076	<.001
	Childhood trauma	1.812	.356	.543	5.091	<.001

a. Dependent Variable: Psychosocial health

Table E6

Step 2: Childhood Trauma Predicting Attachment Type

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients		
		B	Std. Error	Beta	t	Sig.
1	(Constant)	145.274	4.046		35.909	<.001
	Childhood trauma	-.610	.675	-.113	-.904	.369

a. Dependent Variable: Attachment type

Table E7

Attachment Trauma Predicting Psychosocial Health

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients		
		B	Std. Error	Beta	t	Sig.
1	(Constant)	36.594	11.430		3.201	.002
	Attachment type	-.111	.081	-.177	-1.374	.175

a. Dependent Variable: Psychosocial health

Table E8

Childhood Trauma and Attachment Type predicting Psychosocial Health

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients		
		B	Std. Error	Beta	t	Sig.
1	(Constant)	22.560	10.293		2.192	.033
	Attachment type	-.079	.070	-.125	-1.122	.267
	Childhood trauma	1.727	.361	.533	4.787	<.001

a. Dependent Variable: Psychosocial health