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Psychological Consequences of the Boko Haram Insurgency for Nigerian Children

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Abstract

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MA, Coventry University, London, 2013

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Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Public Policy and Administration—Terrorism, Mediation, and Peace

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Abstract

Studies have examined the causes and impacts of terrorism in Nigeria; however, no known research has documented the psychological impacts of witnessing ongoing Boko Haram terrorist violence based on the lived experiences of Nigerian children. The purpose of this qualitative phenomenological study was to examine the psychological consequences of the Boko Haram insurgency based on the lived experience of Nigerian children exposed to terrorism in Nigeria. The study's theoretical framework combined Piaget's theory of cognitive development and punctuated equilibrium theory. The central research question examined the adverse psychological effects of the Boko Haram insurgency for Nigerian children residing in Nigeria. Data for this study were collected through interviews from a purposeful sample of 8 participants who were exposed to the Boko Haram insurgency in Nigeria and a review of literature that primarily included peer-reviewed articles and studies relevant to the psychological theories. Collaizi's method of phenomenological analysis was employed for data analysis. Results showed that all the participants reported negative symptoms of mental health disorders, which did not lead to permanent mental health illnesses. Among the participants, the primary factors that moderated the symptoms, preventing progression to permanent mental health illnesses, were fasting and religious support. Implications for positive social change include giving voice to voiceless Nigerian children and providing the Nigerian populace, multilateral and bilateral organizations, and the Nigerian government with information necessary to understand the effects of terrorism on children and promote resilience in children who have experienced terrorism.

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Dedication

It has been a long 4 years of endurance, heartache, pain, and many victories. Finally, victory is ascertained! The desire to earn a doctoral degree started from my undergraduate days, but how, where, and when I would earn it was what I did not know. However, in Jeremiah 1.5, God says, "Before I formed thee in the womb, I knew you, before you were born, I set you apart, and I appointed you as a prophet to the nations." This scripture has been my motivation and encouragement since my undergraduate school days. I thank God for choosing me to make a difference in my family and the world!

I also dedicate this page of my dissertation to my father, late Pa Gabriel Adepelumi, and my mother, Mrs. Hannah Adepelumi, who never had the opportunity to earn high school certificates but desired to farm to send me to school. Thank you for working me through the journey of life and to where I cannot regret. You worked very hard to give me the best. I thank you for raising me in the path of the Lord and being supportive. Your little boy is now a doctor! Adebusola, Adepelumi, my wife. What more can I say? I am so appreciative that God placed you in my life. I love you and look forward to renewing my love with you in the world beyond. Thank you for being there for me. No matter my anger, frustration, absence from home, and yelling, you never judge me. One love will continue to keep us together!

Finally, I want to thank my children, Omofolawe, Inioluwa, and Eriigbagbo, for enduring my struggle, frequent reading, and absence from home. I love you and thank you for being supportive.

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To Dr. Glenn Starks, thank you for being my committee member. I cannot begin to thank you enough for stepping in at the right time. Your actions and support motivated me and helped me to believe that I could still achieve this dream, so I thank you from the deepest depth of my heart.

Finally, this effort would not have been successful without Dr. Eliesh Lane, who served as my University Research Review (URR) member; thank you for providing the direction and guidance that helped sharpen the study's focus. Thank you, lady, I am grateful!

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Chapter 1: Introduction to the Study

Introduction

Since 2009, children in northeastern Nigeria have been living under prolonged armed conflict due to the Boko Haram insurgency. Boko Haram is a Jihadist terrorist organization based in northeastern Nigeria that is also active in Chad, Niger, and northern Cameroon. Founded by Mohammed Yusuf in 2002, the group has been led by Abubakar Shekau since 2009. The objectives that Boko Haram seeks to achieve include establishing Islamic Sharia law in the northern part of Nigeria and rejecting western education (Adesoji, 2010). To achieve its political, religious, and ideological aims, Boko Haram intentionally uses indiscriminate violence to create terror (Nacos, 2016). The activities of Boko Haram have a direct impact on the development of children in northeastern Nigeria (Amnesty International, 2014; Human Rights Watch, 2014; Oxfam, 2015). As of 2018, the majority of Nigerian children in the northeast still face severe hardships such as family displacement, assault, kidnapping, poverty, and death.

I formulated the research topic for four reasons. First, no study had documented the psychological consequences of the Boko Haram insurgency based on the lived experience of children who have been victims of the Boko Haram insurgency in Nigeria. Hence, this study explored the psychological impacts of Boko Haram terrorism on Nigerian children.

Second, there was a need to understand the psychological impacts of the Boko Haram insurgency on the education of Nigerian children. Third, there was a need to explore the support services that help Nigerian children to cope with the trauma of the

Boko Haram insurgency. Finally, it was necessary to determine the barriers to receiving mental health therapy for Nigerian children affected by Boko Haram attacks. The potential social implications of the study involve the generation of new knowledge to develop effective mental health policies and programs for children exposed to terrorism in Nigeria.

Chapter 1 outlines the psychological consequences of the Boko Haram insurgency for Nigerian children. The purpose of the study was to examine the psychological consequences of the Boko Haram insurgency based on the lived experience of Nigerian children exposed to terrorism in Nigeria. The research questions were developed to seek a better understanding of how terrorism has impacted the education of Nigerian children. This information was essential to this study, in that it would help to determine Nigerian children's attitudes toward schooling, as well as their school performance regarding assimilation, accommodation, and effective communication before and after being exposed to the Boko Haram insurgency. The chapter also includes a description of the assumptions, scope, and significance of the study.

Chapter 2 presents a literature review and includes a discussion of the literature search strategies as well as a brief history of the two theories that constituted the theoretical framework for this descriptive narrative and phenomenological study. The theoretical framework included Piaget's (1977) cognitive development theory and the punctuated equilibrium theory (PET; Baumgartner & Jones, 1993). The scope of the study was limited to the psychological consequences of the Boko Haram insurgency for Nigerian children exposed to the insurgency. Chapter 3 presents the study's

methodology, whereby a phenomenological approach was employed to capture individual interpretations of occurrences as lived by individuals who experienced the Boko Haram insurgency. My role as the researcher was to gather and interpret data from study participants and analyze this information into themes. Purposive sampling was used to select the eight participants for the study. The instrumentation employed in the study consisted of interviews, reflexive notes, and peer-reviewed articles. Chapter 4 presents the results of the pilot study, along with information on the study setting, a demographic description of study participants, data collection and analysis methods, and results of the study. Chapter 5 includes interpretations of the findings, recommendations, a description of the study's potential impact for positive social change, and a conclusion.

Despite the anticipated limitations, the study is significant in furthering understanding of the psychological consequences of Boko Haram terrorism on Nigerian children as well as other children in developing countries with similar challenges. This study contributes to the body of knowledge needed to address this problem. In conducting the study, I sought out the opinions, thoughts, feelings, and insights of children affected by the Boko Haram insurgency in northeastern Nigeria.

Background

Nigeria has been under siege from terrorism since 2009, with this violence engendered by an Islamic sect called *Boko Haram*. The escalation of the Boko Haram insurgency in Nigeria has had increasingly harmful impacts on the mental health of Nigerian children. A United Nations Children's Fund (UNICEF, 2016) report estimated that 7 million Nigerian children have been internally displaced and exposed to frequent

violence, which has implications for their mental health. Despite mental health concerns related to these children's experiences, they are rarely assessed and provided with mental health treatment. Events associated with the Boko Haram insurgency severely undermine the psychological and educational outcomes of children in northeastern Nigeria (Amnesty International, 2014; Human Rights Watch, 2014; Oxfam, 2015). A survey conducted by UNICEF (2016) showed that 7 million Nigerians have been displaced as a result of the Boko Haram insurgency, of which 57% are children (International Organization for Migration (IOM, 2015).

Reports from the International Organization for Migration (IOM, 2015) have shown that the mental health needs of Nigerian children who have been affected by terrorism remain largely unmet due to limited or nonexistent social programs, lack of qualified professionals, corruption, and ceaseless instability from terrorist attacks (Schininá et al., 2016). UNICEF (2016) estimated that 1,200 schools were destroyed, 319,000 child learners were denied access to safe learning spaces, and 952,029 school-aged children were displaced because of the Boko Haram insurgency. A similar report by Hawke (2015) revealed that an estimated 3.7 million children are in need of mental health support in Nigeria. Additionally, the report suggested that if the psychological requirements of these children are not met, an epidemic of chronic mental health illness may result. However, these reports from UNICEF, IOM, and Hawke were not based on the lived experience of children exposed to terrorism in northeastern Nigeria. In contrast, this study relied on the lived experience of children exposed to terrorism in Nigeria, in

order to understand the psychological consequences of the Boko Haram insurgency on Nigerian children.

In 1991, Nigeria passed the Mental Health Act (MHA) to prevent and treat mental health and neurological disorders among the Nigerian population. The September 11, 2001 terrorist attacks introduced a new wave of terrorism that has required new methods of response to and treatment for the mental health consequences of terrorism. Given that the Nigeria MHA predates the Boko Haram insurgency, it is possible that the provisions in the Act many not cater to the mental health needs of Nigerian children impacted by Boko Haram. Indeed, Adewuya et al. (2016) revealed that Nigeria had not updated its policy on mental health to meet the emerging needs of affected children. This may, in part, account for the lack of a holistic approach to the prevention and treatment of mental health illnesses in Nigeria.

The intention behind formulating national policy and enacting MHA to support mental health for the Nigerian population was a good one. Achieving the intended result, however, is another challenge that requires following trends in mental health, diagnosis, and treatment. Equally, achieving the goals of mental health policy requires establishing greater trust and accountability between the Nigerian government and its citizens.

In response to the ongoing Boko Haram insurgency in Nigeria, the Nigerian government has developed counterterrorism and postconflict recovery policies. A 2017, a report from the World Bank on northeastern Nigeria that focused on recovery and peace building covering the period 2015-2016 showed that Nigeria had recorded significant successes in the fight against Boko Haram (Quick & Demetriou, 2017). The World Bank

report also revealed that the military campaign had been stronger and better coordinated. Boko Haram is now a less potent military threat compared to 8 years ago, when the terrorist organization killed tens of thousands of people, uprooted millions, damaged local economies, destroyed cross-border trade, and spread to the Lake Chad states of Cameroon, Chad, and Niger. The Boko Haram group has in recent months carried out fewer attacks and has chosen softer targets such as remote villages, churches, and markets (Onapajo, 2017). This is a dramatic departure from December 2013, when hundreds of Boko Haram fighters overran a Nigerian air force base in the Borno state capital, Maiduguri.

Notwithstanding these remarkable military and economic achievements on the part of the Nigerian government, in 2018 Boko Haram abducted 110 students from the Government Girls' Science Technical College in Yobe State. Moreover, a UNICEF (2016) report concluded that the psychological consequences of terrorism for Nigerian children are overlooked due to lack of implementation of MHA. Ineffective psychosocial support for Nigerian children following the trauma of terrorism has long and short-term implications for all (James & Gilliland, 2013).

An assessment of Nigerian government counterterrorism and postconflict recovery policies showed that these policies did not reflect any provisions for the mental health of children affected by terrorism in Nigeria. This lack of support stems from inadequate preparedness by the Nigerian government to deal with terrorism, and there is no policy framework to cater to the mental health needs of children affected by violence. The limited services offered—which are reactive, rather than proactive—are rarely

accessible to children due to corruption (World Health Organization, 2015). A peacebuilding effort that does not cater to the mental health needs of people affected by the trauma of terrorist attacks may be counterproductive in relation to achieving sustainable peace. The traditional cultural system does not support the mental health needs of children due to stigma. Consequently, in the face of neglect and ineffective mental health treatment provided to children exposed to terrorism, parents resort to traditional methods of caring for their children. Traditional methods of care involve the sum of all knowledge and practices, in that parents rely on various forms of medicine and therapy such as herbal medicines, mind and spirit therapies, self-exercise therapies, radiation and vibration, aromatherapy, and preventive medicine for the treatment of mental disorders in Nigeria (Ebigbo, Elekwachi, & Nweze, 2017). Olagunju et al., (2017) argued that when the burden of treating children's mental health illnesses is placed on parents, it becomes an added stress for parents and may lead to posttraumatic stress disorder (PTSD) in children (Da Paz & Wallander, 2017).

The effects of mental health stressors on children arising from violence such as that perpetrated by Boko Haram include the exhibition of strange behaviors, numbing, malnutrition, fear, avoidance, and recurring flashbacks (Halevi, Djalovski, Vengrober, & Feldman, 2016; Rosshandler, Hall & Canetti, 2016). Harris et al. (2016) and Rosshandler et al. (2016) claimed that violence could have a profound long-term psychological effect on children, often resulting in the development of permanent mental health problems (Sharma, Fine, Brennan, & Betancourt, 2017). Luthar and Eisenberg (2017) revealed that in some cases, children relied on community and familial support to develop adaptive

coping mechanisms after exposure to traumatic events. The impact of violence on children's educational attainment is profound because it may impair students' learning and exam performance, in addition to having a lasting effect on human capital accumulation (Shany, 2017). Bloom and Matfess (2016) found a relationship between exposure to terrorism and poor academic performance among children exposed to violence. Qouta et al., (2007) also claimed that exposure to terrorism causes poor concentration problems and low cognitive capacity in children. Children who have experienced severe trauma from violence have weaker school performance (Miller et al., 2000a).

Understanding how terrorism has impacted the education of Nigerian children is important. It is necessary to understand how Nigerian children's experiences with Boko Haram have affected their attitudes toward schooling as well as their school performance in relation to assimilation, accommodation, and effective communication before and after being exposed to the Boko Haram insurgency. According to Piaget's cognitive development theory, when children are exposed to violence between the ages of 11 to 15 years, their assimilation and adjustment process may be impaired, and they may find it difficult to process new information (McLeod, 2015). Although children in northeastern Nigeria receive some mental health services, the mental health needs of children who have experienced the Boko Haram insurgency are not being adequately addresed, particularly through school-based mental health services. In addition, the lived experiences of children affected by the heinous crimes of Boko Haram have not been

documented. Sanchez et al., (2017) revealed that, if properly diagnosed and provided effective treatment, children may do well in their education despite exposure to terrorism.

Poppen et al. (2016) identified the incorporation of child mental health promotion and intervention into the school curriculum, particularly in poor resource settings such as Nigeria, as a well-recognized, effective strategy for child mental health treatment. However, a study conducted by Ola and Atilola (2017) showed that school-based mental health services are nonexistent in Nigeria, particularly in communities affected by Boko Haram violence. In this study, I sought to determine the educational experience of children exposed to the Boko Haram insurgency by relying on Piaget's cognitive development theory.

Halevi et al. (2016) revealed that children exposed to terrorism may develop the symptoms of PTSD. Halevi et al. investigated the effects of terrorism on 232 children exposed to terrorism in Sedat, Israel. The results showed that the children suffered anxiety disorder, hyperactivity disorder, oppositional defiant disorder, and PTSD. Studies (e.g., Bleich & Solomon, 2013; Lowe & Galea, 2015; Scrimin et al., 2006) have shown that sleeping phobia, fear, lack of appetite, depression, emotional numbing, mourning, grief, avoidance, and insecurity are common among children exposed to terrorism.

Atilola et al. (2015) and Tunde-Ayinmode et al. (2012) evaluated the effects of terrorism in Nigeria; however, no known study has documented the lived experiences of children exposed to terrorism in northeastern Nigeria in terms of the psychological effects of terrorism, the impact of terrorism on children's educational experience, and how

children cope with the trauma of terrorism. The effects of terrorism on children in Nigeria may not be the same as in other parts of the world because of differing political wills, cultural practices, and norms.

Resilience programs that include diagnosis and treatment are essential for the recovery of children exposed to terrorism in Nigeria. However, the mental health facilities and policy framework that should enhance recovery efforts for Nigerian children are not up to date (Babalola & Fatusi, 2009; Omigbodun & Bella, 2004; WHO, 2005). A report by the WHO (2014) concluded that Nigerian mental health policy remains substantially unimplemented and has not been updated to reflect the psychological health needs of people exposed to terrorism in Nigeria (Lora, Hanna, & Chisholm, 2017). The WHO (2014) also reported that public psychiatric centers for children have no admission beds and there is no extant law to regulate traditional community-based voluntary mental health hospitals to protect patients' rights. There is a shortage of mental health personnel across related professions. Further, nongovernmental organizations have paid little attention to the mental health issues of Nigerian children, and there has been no formal support for family caregivers or for the educational needs of children with mental health illnesses (Kranke, Schmitz, Der-Martirosian & Dobalin, 2016).

On the other hand, some studies (e.g., Bonnanno et al., 2005; Ciccheti, 2010; Garbarino et al. 2015; Masten & Osofsky, 2010) have demonstrated that strong social support from families, functional parenting, community attachment, and economic status are factors for adjustment for children affected by terrorism. Dobson and Dobson (2009)

argued that school-based intervention programs with 10-12 sessions per week and cognitive-behavioral therapy (CBT) provide protective and adaptive factors for the treatment of PTSD in children exposed to terrorism (Ager et al., 2010; Foa et al., 2009). At the same time, Harris et al. (2008) identified religion as one of the best means for children to achieve desirable emotional and social functioning when exposed to violence.

As stated earlier, although there have been studies (e.g., Atilola et al., 2015) related to the effects of terrorism on people exposed to it in Nigeria, no studies have documented the psychological consequences of terrorism for children's mental health and educational needs from the perspective of Nigerian children exposed to the Boko Haram insurgency. This study filled this gap by examining the psychological effects of terrorism on Nigerian children based on their lived experiences. The study (a) assessed the impacts of terrorism on the educational experience of Nigerian children, (b) examined whether programs and services available to children affected by terrorism were helpful, (c) identified programs and services that may help promote coping and adjustment for Nigerian children affected by terrorism, and (e) determined the barriers that exist to improving the mental health of Nigerian children. This study also determined what public policies are available or need to be developed to help this population to cope with mental health problems. Punctuated equilibrium theory was used to evaluate the Nigerian government policies and programs available to provide mental health support to children exposed to the Boko Haram insurgency. The study supported the development of recommendations on how to improve the mental health of Nigerian children. A comprehensive review of literature is presented in Chapter 2.

Problem Statement

The emergence of Boko Haram in 2009 in Nigeria led to an 85% increase in terrorism-related violence compared to the previous decade (IEP, 2016). The drastic increase in the rate of terrorism-related violence in turn heightened the degree of psychological distress in Nigerian children, particularly in communities affected by the Boko Haram insurgency. In northeastern Nigeria, a significant percentage of children with mental health illnesses that may be related to Boko Haram's terrorism remain undiagnosed and untreated (Alozieuwa & Oyedele, 2017; Langer, Godefroidt, & Meuleman, 2017; Ola & Atilola, 2017; Okoli & Philip, 2014; Onapajo, 2017; Olaniyan & Asuelime, 2017). Collins and Collins (2005) classified how children react to crisis into affective, cognitive, and ecosystem domains. Traditional psychologists (e.g., Bonanno, 2010; Bleich & Solomon, 2003; Collins & Collins, 2005; James & Gilliland, 2013) have categorized the psychological impacts of terrorism on children in terms of acute stress disorder (ASD) and PTSD. ASD occurs when children affected by terrorism cannot overcome their mental stress within 30 days, and PTSD develops when stress persists for more than 30 days.

The psychological consequences of terrorism for Boko Haram-affected children in Nigeria are largely unknown. It is recognized that children who are exposed to ongoing violence in Nigeria may suffer severe cognitive dysfunction, depression, panic disorder, generalized anxiety disorder, and psychiatric illnesses (Halevi et al., 2016; Pfefferbaum et al., 2016). Eseadi et al. (2016) argued that lack of effective mental health treatment for children affected by terrorism may result in an increase in the number of

children with ASD or PTSD. However, their study did not rely on the lived experience of Nigerian children to ascertain the effectiveness of mental health services provided to children exposed to terrorism. Further, they did not take into consideration that the effects of terrorism on children in Nigeria, as well as Nigerian children's methods of coping with the trauma of terrorism, may not be the same as in other parts of the world because of differing political wills, cultural practices, and norms. Consequently, relying on studies involving children exposed to terrorism in other countries to form conclusions on the effects of terrorism and methods of coping with the trauma of being exposed to terrorism on Nigerian children may be misleading, in that there are differences in values and beliefs between traditional Nigerian culture and the cultures of other countries. There is danger in relying on trauma-based interventions that may not attend to the role of cultural context.

To address the psychological consequences of terrorism for Nigerian children exposed to the Boko Haram insurgency, I conducted a qualitative phenomenological study to investigate the psychological effects of ongoing terrorist attacks and determine the type of resiliency programs that help children to cope with this trauma. With a better understanding of the lived experience of Nigerian children exposed to terrorism, policymakers may develop policies to guide coordination, management, and efficient service delivery so that children affected by terrorism can receive quality support and services.

Purpose of the Study

The purpose of this study was to examine the psychological consequences of the Boko Haram insurgency based on the lived experience of Nigerian children exposed to terrorism in northeastern Nigeria. The central phenomenon explored in this study was the lived experiences of children exposed to Boko Haram terrorist attacks in Nigeria. A qualitative case study with an interpretive phenomenological design was used to uncover the psychological factors that impact the children's responses. The study participants were children exposed to the Boko Haram insurgency (now adults) in northeastern Nigeria. The research site was Nigeria. Qualitative research methods, including face-to-face interviews, reflexive notes, and review of literature on psychological consequences of terrorism for children, were used to develop an enhanced understanding of individual study participants' perceptions, thoughts, memories, imaginations, and emotions in relation to their mental experiences with the Boko Haram insurgency. These procedures aligned with qualitative research with a phenomenological approach as it provided insight into the children's perspectives. Researchers using qualitative methods seek to "explore, explain, or describe a phenomenon" (Marshall & Rossman, 2006, p. 33).

To qualify for this study, participants needed to meet the following requirements:

1. enrolled in secondary school for at least 6 months during the Boko Haram insurgency from 2009 to 2010;
2. resided in northeastern Nigeria for at least 5 years after the insurgency began, and exposed to Boko Haram insurgency between 2009 to 2010;

3. between the ages of 15 and 18 during the Boko Haram insurgency (since this study was conducted in 2017, the age of the participants was between 22 and 25 years old);
4. able to remember the events that occurred during the Boko Haram insurgency;
5. willing to provide details about, and express and explain, their lived experience during the Boko Haram insurgency.

Bentley and O'Conner (2014) reported that people who experienced trauma could handle interviews from 5 months after their trauma. All of the study participants satisfied all of the criteria above.

Outcomes of this study may help the Nigerian government to develop a resiliency framework to address ASD or PTSD among Nigerian children. Findings yielded by this research may also be useful in developing resiliency framework programs and support focusing on prevention and treatment of mental-health-related diseases affecting children in other African countries where there is an ongoing insurgency. Relevant topics related to the psychological condition of children in Nigeria, the nature of diagnosis and treatment, and how to create short- and long-term resiliency programs for children were examined.

Research Questions

The central research question guiding this study was the following:

RQ1: What are the adverse psychological effects of the Boko Haram insurgency on Nigerian children residing in northeastern, Nigeria?

Sub questions were as follows:

RQ2: How had terrorism impacted the educational experience of children in northeastern, Nigeria?

RQ3: What programs and services were available and perceived by the interviewed children as being helpful in improving their coping with effects of terrorism?

RQ4: What programs and/or services may help promote coping and adjustment for Nigerian children affected by terrorism residing in northeastern, Nigeria?

RQ5: What are the barriers to improving the mental health of the children of Nigeria?

Theoretical Framework for the Study

The theoretical framework that I used to ground the psychological consequences of terrorism for Nigerian children consisted of Piaget's (1977) theory of cognitive development (PTCD) as well as punctuated equilibrium theory (PET; Baumgartner & Jones, 1993). Piaget described child cognitive development as the

> progressive reorganization of mental process results from biological maturation and environmental experience on the way children construct an understanding of the world around them, experience discrepancies about what they already know and what they discover in their environment and adjust their ideas. (p. 17)

PTCD was employed within an effort to elucidate the psychological effects of violence on Nigerian children and their identity formation, personality structure, neurobiology, adaptive and coping mechanisms, and regular mode of relating to others,

as a starting point toward understanding the secondary effects of exposure to terrorism (Williams & Paterson, 2009). PET was employed to explain government policies that support resiliency programs for children affected by terrorism in northeastern Nigeria. My goal in using PET in this study was to explain how changes in Nigerian government public health policies impact the psychological consequences of terrorism for children (Baumgartner et al., 2014). Thus, PET corresponds to how extended periods of large-scale changes in public policies have either improved or undermined psychosocial support for children with mental health illnesses in Nigeria. Additionally, I applied PET in an effort to determine which Nigerian government policies and programs are helpful to children in improving their ability to cope with the effects of terrorism, as well as which programs and services may help promote coping and adjustment in Nigerian children affected by terrorism. Both frameworks help in understanding how the Nigerian government deploys decision making for policy development.

The cognitive characteristics of Nigerian children, when examined in combination with their contextual environment, are key factors that shape policy processes (Baumgartner & Abel, 2006). Political institutions influence recovery policy decisions following violence. To determine the impacts of terrorism on Nigerian children, it was imperative to examine factors affecting the ways in which individuals act and behave. This study may increase public awareness of the detrimental effects of terrorism on children. A more detailed explanation of PET and PTCD is presented in Chapter 2.

Nature of the Study

This study was a qualitative study with an interpretive phenomenological approach. Interpretive phenomenology was used to uncover the psychological responses that influenced the experiences of children affected by the Boko Haram insurgency in Nigeria (Folland, 2017; Moustakas; 1994). Phenomenological study is consistent with a detailed understanding of the psychological consequences of terrorism on children in northeastern, Nigeria, which was the primary the focus of this study. Creswell (2009) defined phenomenological research design as a "research plan which describes the meaning of the lived experience of a concept or a phenomenon for several individuals" (p. 13). McConnell-Henry et al. (2009) divided phenomenological research designs into two categories: descriptive-transcendental (Husserl's) and interpretive-hermeneutic (Heidegger's and Moustakas's) phenomenology. For Moustakas, the purpose of interpretive phenomenology is to gather data based on similar experiences to uncover the sociological or psychological factors influencing responses. Interpretive phenomenology was employed to provide full stories of the study participants' experiences and traumas. It was also used to support an understanding of the psychological problems that may influence children's responses, the impacts of the Boko Haram insurgency on children's education, and barriers to children's mental health treatment.

Purposive sampling was used to select study participants from designated locations in Nigeria. The sample size for this study was eight. Nigeria is a country where individuals relevant to this study presently reside. The rationale for the purposive sampling was to concentrate on study participants who had been exposed to the ongoing

insurgency carried out by Boko Haram militants in Nigeria. Babbie (2016) recommended that people who have experience with the phenomenon of interest be used as the primary participants in a phenomenological study. Members of the sample population were identified from the the internally displaced persons (IDP) camp in Nigeria.

I conducted two studies: a pilot study and a regular case study. Some substantive study participants were also recommended to me by participants in the pilot study. The pilot study was conducted to ensure the validity of the research protocol before the substantive study. The five participants in the pilot study also participated in the regular substantive study. The purpose of the pilot study was to enable the participants to have prior knowledge of the research topic. Campbell et al. (2009) suggested that research participants should have prior knowledge about the topic of research in trauma-related studies. This study collected data using interviews from participants between the ages of 22 and 25. Face-to-face individual interviews related to the psychological impacts of terrorism on the study participants were used to gather data from the study's sample population (Axinn & Pearce, 2006; Groenewald, 2004). After the face-to-face interviews, I used Collaizi's (1978) methods of data analysis to extract, organize, and analyze the dataset (Edward, & Welch, 2011). I also reviewed data on the psychological consequences of terrorism for children. A detailed explanation of the study participants, methods of data collection, and data analysis are presented in Chapter 3.

Definitions of Terms

The operational definitions below were applied to the understanding of the

psychological consequences of terrorism for children.

Acute stress disorder (ASD): The various severe anxiety symptoms developed by individual children following exposure to an extreme traumatic stressor of violent terrorist attacks within 90 days.

Boko Haram: An Islamic terrorist organization that has been active in Nigeria since 2009.

Bracketing: "The process of identifying and holding in abeyance any preconceived beliefs and opinions about the phenomena under study" (Polit & Beck, 2012, p. 721).

Cognitive development theory: A theory developed by Jean Piaget to understand the cognitive functioning of children through a series of stages; Piaget proposed four stages of cognitive development: the sensorimotor, preoperational, concrete operational and formal operational periods.

Cognitive functioning: The cerebral activities that lead to knowledge through which information is acquired in children.

Evidence-based treatment: The "specific clinical practices that help bridge the gaps between what researchers find to be effective treatment and what is implemented at the practice level" (Bongar et al., 2007, p. 469).

Exposure therapy: Behavior therapy designed to treat anxiety-disorder-related PTSD symptoms to overcome the anxiety of fear.

Nigerian children: Individuals between 13 and 18 years of age who were born in Nigeria and live in northeastern, Nigeria.

Protective factors: Broad individual attributes, strengths, resources, and supports that are variables and/or conditions present in individuals that that may help children with ASD/PTSD to cope with and recover from stressors. Such factors include parental functioning, family attachment, religion, and tradition, as well as school-based and evidence-based therapeutic interventions that help to mitigate stressful events effectively.

Psychoeducation: "Education offered to individuals with a mental health condition and their families to help empower them and deal with their status in an optimal way" (Bongar et al., 2006, p. 471).

Psychological debriefing: The various semi structured intervention programs that aid recovery and mitigate psychological morbidity.

Sensorimotor: The first stage of cognitive development as proposed by psychologist Jean Piaget starting from age 0 to 24 months.

Schema: The last stage of psychologist Jean Piaget's cognitive development theory. Schema refers to mental representations and ideas that babies acquire.

Assumptions

Assumptions are realistic aspects of this study that I believe to be true, but for which there is no empirical evidence. The study relied on the assumption that I reviewed relevant literature on psychological impacts of terrorism on children. Another assumption was that all of the participants provided accurate information related to the mental health impacts of the Boko Haram insurgency on them. In addition, I assumed that the direct exposure of children to violence impairs their psychological wellbeing emotionally and cognitively. Finally, I also assumed that because the study participants

were already adults (between the ages of 22 and 25) when this study was conducted, there was minimal risk to them. The results of this study suggest further questions and present future implications for children experiencing the Boko Haram insurgency. Consequently, the results are presented as directions and questions for future research, programs, and services.

Scope and Delimitations

The research problem is crucial in determining the psychological consequences of the Boko Haram insurgency on Nigerian children as established in the literature review. Details on the scope and delimitations of this study are provided in this section.

The study participants included individuals who were exposed to the Boko Haram insurgency in northeastern Nigeria. The study did not include interviews with children who were exposed to terrorism outside northeastern, Nigeria.

The study focused on the psychological consequences of the Boko Haram insurgency for Nigerian children, and the findings were used to establish the perceived impacts of terrorism on Nigerian children.

As the researcher, I adopted a qualitative methodology with interpretive phenomenological approaches involving a review of literature on the psychological effect of terrorism on children and face-to-face interviews of the study participants to gather data for this study. The findings of this study may have limited transferability because its proposed impacts are limited to children exposed to the Boko Haram insurgency in northeastern, Nigeria. However, the description of the impacts should enlighten readers about psychological consequences of terrorism for children. The study findings will be

published and shared with other researchers through conferences and other channels, which will further enhance the study's transferability and usefulness.

The problem that I addressed in this study was that no known study had been conducted about the psychological impacts of the Boko Haram insurgency based on Nigerian children's lived experience, the impacts of the Boko Haram insurgency on Nigerian children's educational experience, the programs that are available to serve this population of children, and what may help members of this population to cope with the effects of terrorism. More knowledge about children's lived experience of being exposed to terrorism could inform the development of policies and programs for effective diagnosis and treatment of such children, as well as resiliency programs that may help them to cope with the trauma of being exposed to an insurgency. I relied on PTCD to determine the psychological impact of terrorism for Nigerian children, and PET to examine programs and policies that may help them to cope with trauma of terrorism.

The choice of northeastern, Nigeria was based on the convenience of the location and the cooperation of the coalition of nongovernmental organizations working with the study participants. Additionally, Nigeria was where the study participants were residing at the time of the study. The choice to work with participants who had been provided services by nongovernmental organizations was made because I sought to determine the nature and impacts of the services already rendered to study participants. I systematically provided an invitation to participate in this study to the participants who matched the criteria for this study.

This case study was based on what the study participants conveyed as their lived experience during the Boko Haram insurgency. However, the results from this study suggested additional questions and future implications; I present the results and questions as a guide to greater understanding of the psychological experience of other Nigerian children exposed to terrorism in the future. Runfola, Perna, Baraldi, and Gregori (2017) argued that the findings from case study research can be used to explain other similar situations. Falk and Guenther (2006) expressed a similar position when they stated that generalization is possible in qualitative research methods because of "future implications, theory building—that is, the 'inductive' approach, and because of the receiving audience's perceptions" (p. 8).

Limitations

Issues of trustworthiness and ethical bias related to researcher subjectivity were a challenge to this study because I was the sole instrument for data gathering, analysis, and interpretation. I was born in Nigeria and may be emotionally attached to the needs of the study participants. Studies (e.g., Creswell, 2009) have shown that researchers' subjectivity and bias in the process of data collection, analysis, and interpretation are among the limitations of a qualitative study.

The second limitation was that data were collected from residents of northeastern Nigeria, who were exposed to Boko Haram insurgency. The purposeful sample for this study consisted of eight participants, which may have affected the quality of data and transferability of the study outcomes. The qualitative approach assumes rich data to address a particular problem. Because Boko Haram activities have occurred across all six

states in the northeastern region, and in northcentral (Abuja, Nassarawa) Nigeria, and affected approximately 3.7 million children (UNICEF, 2016), it was not clear whether the experiences of these study participants reflected the lived experiences of other children affected by terrorism in northeastern and northcentral Nigeria.

To address the limitations, I used the same semistructured interview protocol for all interviewees. Participants' responses were used to confirm the accuracy of transcribed interviews through member checking and thick description of the study context (Miles et al., 2013). Qualitative studies have suggested member checking, thick description of study context, and thorough description of procedure from the beginning to the end as major critical strategies for producing trustworthy and believable findings in qualitative research (Gasson, 2004; Goulding, 2002; Morrow, 2005).

Boyd (2001) suggested two to 10 research participants to reach saturation, while Groenewald (2004) recommended between five and 10 people for a phenomenological study. Cheong, Khoo, Tong, and Liew (2016) described member checking as a means of researcher-respondent validation in a qualitative study. The purpose of member checking is to help researchers to improve the accuracy, credibility, validity, and transferability of a qualitative study (Kroening, Moore, Welch, Halterman, & Hyman, 2016). Checks relating to the accuracy of the data took place at the end of the interviews. I asked the study participants to read or listen to my readings of the transcripts of the interviews in which they participated. The focus was ensuring that my interpretations of the study participants' words matched what they intended. Additionally, member checking enabled me to recycle the study analysis back to the study participants and request their feedback

about the accuracy of research content. This also ensured that the study participants and I viewed the data and the study conclusions consistently.

In addition to member checking, I used thick description to validate the data that were gathered from the study participants. Thorne (2016) described thick description as the process by which a researcher conveys the actual situations that have been investigated and, to an extent, the contexts that surround them. I made the criteria and procedures for data gathering and analysis explicit for the study participants. I presented a thorough description of the procedures for how the data were gathered and interpreted from beginning to end. Explicit description of the data gathering procedure ensured that another researcher could follow the progression of events in this study and understand the process. This was achieved by giving an account disclosing any assumptions and suppositions that might have influenced the data gathered. I also gave a detailed account of the relationship between field notes and conclusions based upon them, indicated coding instructions, reported how the actual data gathered for this study were placed into different coding categories and linked to memoing or my reflexive notes, and described the process of keeping the data. This helped me to develop a truthful and reliable account of this qualitative study. Morrow (2007) argued that giving a detailed account of the context or setting which data are gathered and interpreted is a way to overcome researcher bias in qualitative research. For this study, I conducted preliminary interviews with study participants to identify any challenges that might affect the study participants' responses.

Significance of the Study

The effects of terrorism on children have been extensively studied and analyzed, in recognition of the critical need for research-based knowledge related to all aspects of child development (Cyr, Michel, & Dumais, 2013). Despite the abundance of studies on effects of terrorism on children, the psychological impact of ongoing terrorism on Nigerian children based on their lived experiences has not been investigated to date. In other to identify feasible solutions to the current psychological impacts of Boko Haram attacks on Nigerian children, it is necessary to understand the psychological consequences of terrorism for children, including its impacts on their education, and to examine programs and services available to them to cope with the trauma of terrorism. By offering recommendations for programs and policies to improve the mental health of Nigerian children who have experienced the Boko Haram insurgency, I hope to fill a gap in the literature toward stemming the tide of mental health illnesses among Nigerian children.

This study may have positive implications for social change because recommendations from this study may help policymakers (a) understand the psychological impacts of terrorism on Nigerian children and (b) develop programs and policies that will help children to cope with the trauma of being exposed to terrorism. Because of the complexity of the problem, finding a unified solution is challenging. Waxman (2011) revealed that the psychological suffering caused by acts of terrorism is more prevalent than physical injuries arising from terrorism. The ways in which terrorism affects children are dependent not only on individual characteristics, but also on

children's family structures and the culture in which they are raised (Bongar et al., 2007; Bowie et al., 2001; James & Gilliland, 2013).

Strategies to help children affected by terrorism elsewhere in the world may not work in Nigeria because of differences in cultural practices and norms. Intervention measures have to be peculiar to each circumstance. Understanding the psychological consequences of terrorism for children within the Nigerian context is critical to the development of intervention measures at the pre-event and postevent levels to cushion the psychological effects of terrorism.

Findings from this study may enable the Nigerian government to establish a legal framework and series of initiatives to address the psychological consequences of Boko Haram violence for Nigerian children as well as their educational experience. The study may also help the Nigerian government to develop resiliency policies and programs that help Nigerian children who have been affected cognitively by the Boko Haram insurgency to improve their concentration and school performances, as well as policies and programs to increase children's enrollment in school so as to counter Boko Haram propaganda against western education. Moreover, findings from this study may enable those in the Nigerian government to reflect on barriers to mental health illnesses among Nigerian children, re-examine government health policies and programs, develop workable policies and programs, and implement such policies and programs to address the mental health barriers that children with mental health illnesses face in Nigeria.

Discussions of terrorism in Nigeria have typically focused on counterterrorism, the tactics of Boko Haram, and the leadership of terrorism. By determining the

psychological effects of the Boko Haram insurgency on Nigerian children, this study adds a voice to cater for the Nigerian children affected by Boko Haram insurgency. Findings from the study may also make it possible for the Nigerian government to design and implement resiliency and developmental programs that will aid the recovery of children affected by both terrorism-related and natural disasters. The findings and recommendations could be used in the development and application of interventions and policies aimed at supporting children who have been traumatized by terrorism.

De La Sablonniere et al. (2013) noted that "dramatic social change is not merely a distant phenomenon of historical interest; it is one that impacts everyone on a daily basis" (p. 18). Studying the psychological impact of the Boko Haram insurgency on Nigerian children may deepen researchers' understanding of individual roles and connections between terrorism and mental health. It may also enhance researchers' understanding of the links among Nigerian government health policies and programs and the mental health and educational needs of Nigerian children exposed to violent Boko Haram attacks. Comprehensive analysis of the psychology of terrorism in Nigeria can offer researchers new perspectives, assisting them in elucidating the different ways that culture, individuals, families, and government institutions adapt to the crisis in Nigeria.

Summary

The rationale for this phenomenological study was that there is a need to determine the psychological consequences of Boko Haram terrorist attacks in Nigeria. This chapter has provided background information for this study exploring the psychological impacts of terrorist activities in Nigeria on Nigerian children.

Additionally, this study examined the nature of support services that children receive following the trauma of terrorism. Chapter 2 provides a review of the literature and theory related to psychological consequences of terrorism for children.

Chapter 2: Literature Review

Introduction

The failure to provide effective psychological support to children exposed to the Boko Haram insurgency in Nigeria endangers their mental health and reduces the opportunities these children have for educational attainment. Children affected by terrorism suffer poor assimilation and weaker school performance (Bloom & Matfess, 2016). Nigerian children affected by the Boko Haram insurgency still face the psychological effects of direct exposure to terrorism. Incidents of terrorism, family displacement, and loss of family and friends may have long-term, broad effects on children's development. In Nigeria, there is a lack of effective programs to provide resilience and recovery to address the psychosocial effects of terrorism on Nigerian children. There are gaps in research, policy efforts to respond comprehensively to the Boko Haram insurgency, especially in relation to the psychological effects of the insurgency on children as they pertain to their education.

The purpose of this study was to determine the psychological effects of terrorism on Nigerian children, as well as to identify the support programs that promote coping and adjustment for children exposed to terrorism. The literature review confirmed how terrorism is responsible for weaker educational performance in children and how early and effective diagnosis and treatment of mental health illnesses in children can reduce the impact of permanent mental health illnesses. This chapter offers a review of literature, theoretical foundations, and effects of psychological consequences of Boko Haram terrorist attacks on children. It also contains a discussion of the effects of terrorism on

the educational experience of children. Additionally, modes of assessment and treatment of trauma and strategies for coping with terrorism among children affected by terrorism are reviewed. Programs and support services that help children exposed to terrorism to deal with the resulting trauma and barriers to improving the mental health of children exposed to terrorism are also addressed to conclude the chapter.

Literature Search Strategy

In studying concepts and ideas related to the psychological effects of terrorism on children for this study, I accessed literature that consisted primarily of peer-reviewed articles and studies relevant to the psychological theories that formed the study's theoretical framework. To conduct the literature search, I used the Walden University libraries, EBSCO Academic Search Complete/Premier, ProQuest Central, PsycARTICLES, PsycBOOKS, PsycINFO, Psychology: A SAGE Full Text Collection, PubMed, SAGE Online Journals, SAGE Premier, SocINDEX, and Google Scholar.

I also searched and reviewed manifold documents and reports and studies from NGOs such as the IOM, International Rescue Committee (IRC), UNICEF, WHO, Nigeria Network of Non-Governmental Organizations (NNGOs), United Nations Office on Drugs and Crime (UNODC), and Transparency International. Though reports and research compiled by United Nations experts in the fields of psychology of terrorism and health were not from scholarly journals, revelations and suggestions from this nondescript literature added to the body of knowledge. A subject-based approach was used for the search. The terms that were used for the research included *acute stress disorder*, *affectionate domain*, *Boko Haram*, *cognition*, *children*, *consequences*, *culture*, *cognitive*

functioning, *evidence-based treatment*, *effects*, *exposure therapy*, *protective factors*, *posttraumatic stress disorder*, *psychoeducation*, *psychological debriefing*, *insurgency*, *stressor level*, *sensorimotor*, *schema*, *Nigeria*, *terrorism*, *peacebuilding*, and *resiliency*.

Bonanno et al., (2010); Halevi et al. (2016); and Lowe and Galea (2015) identified PTSD as a psychological effect of terrorism on children affected by war and terrorism. Much of what is currently known about the psychological consequences of children's exposure to terrorism has been derived from quantitative research based on the prediction that relied on previous violence, children socioeconomic status, government treatment data, social workers, gender, and previous parent and children mental history.

The outcomes from most of these studies mainly established the symptoms of PTSD. The results of these previous studies have not shown other nonpathological problems or symptoms that affect children and that may have serious health consequences.

Due to the fear that ongoing intervention should not contaminate recovery efforts and for overreliance on the international standard for treatment and recovery, there have been few studies on the effectiveness of intervention programs for children following exposure to terrorism. Previous studies relied on the knowledge of relatives, social workers, and government data to document the psychological consequences of terrorism for children.

The ways in which the Boko Haram insurgency affects Nigerian children may be different from the ways in which terrorism affects children elsewhere in the world. Furthermore, the resiliency interventions that apply in other countries may not work in

Nigeria because of differences in cultural practices and norms. Intervention measures should be particular to each circumstance. Understanding the psychological consequences of the Boko Haram insurgency for Nigerian children is critical to the development of intervention measures at the preevent and postevent levels to cushion the psychological effects of terrorism.

Children and Piaget's Cognitive Development Theory

Despite robust empirical studies on the impacts of terrorism on the Nigerian population, there is no known study about the psychological consequences of the Boko Haram insurgency for Nigerian children. Studies have shown that the cognitive functioning of children is largely determined by children's developmental stage (Balk, 2011). A notable theory for determining the developmental stage of children is the cognitive development theory propounded by Jean Piaget. My goal in applying Piaget's cognitive development theory in this study was to understand the mechanisms by which children develop and adjust to their environment. Through this, an understanding of how terrorism impacts the educational experience of children at the formal level can be reached.

Piaget's cognitive development theory is focused on two variants of thinking: assimilation and accommodation. *Assimilation* involves the adaptation process through which a child takes in and incorporates new information or experiences, and *accommodation* describes what occurs when a new experience or information causes an adjustment in an individual child's existing schemas.

Piaget categorized points of development in children into sensorimotor, preoperational, concrete operational and formal operational stages (McLeod, 2015). The sensorimotor period is the point at which children develop physical interactions with their environment and begin to develop sets of ideas and how it developed gradually, although, during the sensorimotor period, children cannot depict the appearance and disappearance of physical objects within their environments. Children's ignorance about the occurrence of events in their environment continues to the preoperational stage. At the preoperational stage (2-7 years old), children are not able to develop or form a concept of an idea and need real or solid events to understand their environments. In the formal phase (ages 11-18 years and continuing into adulthood), children begin to understand and imagine their environments. They think abstractly and can combine logical structures in a sophisticated manner. The child begins to think like an adult in the formal phase and engage in inferential reasoning (combination of schemas). Piaget's theory indicates that this is the stage during which children should be taught self-reliance, independence, and self-control as well as positive behaviors. However, if a child in the formal operational stage is out of school, is displaced, and begins to witness violence, the child may become doubtful, exhibit negative behaviors, become unconstructive, lack self-reliance become pessimistic about life and his or her environment, and begin to exhibit negative attitudes toward schooling and positive attitudes toward violence (Pedro, 2015). This position was echoed by Conway (2016) and Gonzalez, Monzon, Solis, Jaycox, and Langley (2016), who argued that the psychological consequences of terrorism for children include instability arising from confusion that affects the child's developmental stage. Moreover,

exposure to severe violence can cause concentration problems and low cognitive capacity in children (Qouta, Punamäki, & El Sarraj, 2007). Children who have experienced severe trauma that emanated from violence may have weaker school performance (Miller et al., 2000a). In addition, children who have lost their parents to terrorism through either death or displacement and who experience continuing terrorism may have poor information processing and lack creativity (Olff, Langelanda, & Gersons, 2006).

Piaget's theory of cognitive development fell within the scope of this study and was applied to determine whether the Nigerian children affected by terrorism were cognitively impaired at the formal stage. When acts of terror disrupt the formal stage of conceptual reasoning, Piaget's cognitive development theory provides guidelines on how to understand and develop programs and design interventions that will have a positive impact and facilitate the transition from doubt to trust and from instability to stability.

The goals that Boko Haram seeks to achieve are to create psychological disturbance, enthrone the Islamic Caliphate, and establish Islamic schools based on Sharia law in northeastern Nigeria (Thomson, 2012). A report by Human Rights Watch (2016) showed that Boko Haram had attacked more than 1,200 schools in northeastern Nigeria, killed 600 teachers, and forced another 19,000 teachers to avoid teaching since 2009.

Apart from over 1.6 million children displaced due to the Boko Haram insurgency, over 1,000 children have been killed in school attacks, and another 300 girls have been kidnapped from hostels in Chibok, a community in Borno state (UNICEF, 2016). Human Rights Watch (2016) has reported that since 2009, an estimated 952,029

school-aged children had fled Boko Haram violence and had little or no access to formal education. Peculiar to the Nigerian children affected by the violent attacks of Boko Haram is the effect of Boko Haram attacks on the children's school at operational and formal operational stages of the children's lives and development.

As noted above, beginning at the age of 11 to 18 years and continuing into adulthood, child's cognitive structures began to conceptualize reasoning, which they build into the adult level. At this stage, the child begins to assimilate into their cognitive level structure and maintains mental equilibrium. If a child is experiencing new environmental challenges (e.g., violence, crime, or family displacement), the child may lose stability; in this situation, the child's cognitive reasoning may become impaired and the mental processes may find it so difficult to adapt to the new environment. In this study, I sought to determine whether the Boko Haram insurgency had an adverse effect on Nigerian children's cognitive development (assimilation and accommodation) at the stage of schema in northeastern Nigeria.

Punctuated Equilibrium Theory (PET)

The ways in which children cope with the trauma of terrorism may be explained by PET (Shiffman, Schneider, Murray, Brugha, & Gilson, 2008). PET addresses how changes in government policies over a period impact service delivery (Baumgartner et al., 2014). It is known that when children are exposed to terrorism, they receive diagnosis and treatment to cope with their psychological trauma. For example, children may be provided counseling with exposure-based therapies in order to help them cope with PSTD (Nemeroff et al., 2006; Rothbaum & Schwartz, 2002; Servaty-Seib & Taub, 2010).

Central to these programs and services is the type of support and services that children who are exposed to terrorism receive from the government. In addition to functioning hospitals, researchers (e.g., Druss, 2002; Shiffman, Schneider, Murray, Brugha, & Gilson, 2008) have identified National Health Insurance (NHI) in Israel and Medicaid in the United States as examples of government policies and programs that provide financial support to children to help them cope with the economic implications of the diagnosis and treatment of mental illnesses (Druss, 2002; Shiffman et al., 2008). Medicaid provides financial support to pay for health insurance for the treatment of mental health illnesses in children, particularly for children from low-income families that cannot afford health insurance. NHI provides similar support to children exposed to terrorism in Israel. U.S. government health programs provide for 10 to 20 sessions per week of cognitive-behavioral therapy (CBT) based on an imaginal method for children with PTSD symptoms or behavioral disorders, which can help children to cope with trauma (Foa et al., 2009).

The Nigerian government has developed mental health programs and has formulated various national policies on mental health, in addition to enacting the MHA to provide for the prevention and treatment of mental health and neurological disorders among its population. The effective implementation of these policies and programs has a significant role to play in the diagnosis and treatment of children exposed to terrorism in Nigeria. PET held great appeal in the context of this research to determine which Nigerian government policies and programs were helpful to children in improving their

ability to cope with the effects of terrorism and promoting adjustment for Nigerian children affected by terrorism.

A Brief History of Nigeria's Psychosocial Situation

During the precolonial era, custodial care for the treatment of people with mental illnesses in Nigeria relied on traditional healers. Westbrook (2011) showed that during this era, gross abuses of individuals with mental health illnesses occurred. Mental health patients were abandoned, forced into hard labor without payment, and restricted to traditional mental treatment homes (Erinosho, 2007). Under the British colonial government, which took power around 1907, mental health treatment was not substantially different from what those with mental illnesses had obtained before the advent of colonialism.

A remarkable effort to improve the mental health of people in Nigeria began in 1954, when Aro Psychiatric Hospital was established in Abeokuta, followed by the establishment of other mental health hospitals across Nigeria (Erinosho, 1976). During this period, the treatment of mental health fell into the hands of both traditional healers and syncretic churches.

In order to integrate western and traditional mental health systems, community mental health centers were established as therapeutic alternatives. According to Erinosho (2007), mental health treatment in community health centers involves the use of "electroshock therapy, drug therapy, modified form of insulin … intensive care in the community programs entails active participation of families and community leaders" (p. 66). As of 2018, numerous community treatment centers still exist throughout Nigeria.

This structure, in part, has been responsible for placing the treatment, resiliency, of coping with mental health diseases of children to parents, and families until 2018. Today, both traditional healers and government hospitals provide mental health treatment in Nigeria.

In line with global practices, Nigeria enacted the MHA in 1991 and incorporated its primary care services into law. MHA provides for the scaling up of essential mental health treatment and the provision of psychotropic medications in communities where they are needed. In particular, MHA indicates that mental health services are to be delivered by trained primary health workers, with coordinated supervision provided by specialist mental health workers (Federal Ministry of Health, 1991). However, despite the enactment of MHA, 20% of Nigerians with mental health disorders are unable to receive efficient diagnosis and treatment for their mental health symptoms (Gureje & Lasebikan, 2006). A WHO (2006) report showed that 20% of people with a mental health problem in Nigeria received partial and incomplete treatment.

In 57 years of Nigerian independence, the country has witnessed 30 years of military rule and 3 years of civil war. Nigeria experienced terrorism in 1980 when Maitatsine attacked religious figures and armed clashes led to the death of 5,000 people. In 2009, the emergence of the terrorist organization commonly known as Boko Haram escalated terrorist attacks in Nigeria by 85% compared to previous decades (IEP, 2016).

The drastic increase has resulted in several studies on the effects of terrorism on the Nigerian population (e.g., Okoli & Philip, 2014 and Olaniyan, 2015). The Boko Haram attacks have led to the direct exposure of children to unimaginable violence;

horrors, bombing, killings, hardship, kidnapping, diseases, and family displacement. Daily exposure of children to Boko Haram violence, if not at addressed may lead to internalization of violence, bitterness and psychological health problems which may impact the health of Nigerian children in the long - run

Hayes and McAllister (2009) and Peredo (2015) have shown that terrorism is a way of producing psychological trauma and long term resentment, bitterness, and violence in children. When terrorism occurred children develop fear for the future, and personal conception of safety and their security becomes compromised. Comer and Kendal (2007) identified direct exposure and indirect exposure to the ways which children may be exposed to terrorism. It was indirect exposure when children family were affected by death or displacement or when children watch the horror of terrorism through television or media directly experienced terrorism in or resides in the location where terrorism occurred. A direct exposure occurred when terrorism was conducted in the presence of the children.

The rapid increase in the intensity of insurgency carried out by Boko Haram has led to the exposure of approximately 2.5 million children in Nigeria to terrorism (UNICEF, 2016). These children live in fear of the unknown, are displaced, malnourished, suffer direct injury, and experience daily kidnappings, killings, and rapes.

The childhood effect of being a direct victim of terrorist attacks could be devastating and long lasting with permanent psychological problem spanning from birth to adolescence and to the adulthood (Pine, Costello, & Masten, 2005). Extant studies on epidemiology established a direct link between children mental health problem and

various levels of posttraumatic stress disorder with direct exposure to terrorism (Hussey, Chang & Kotch, 2006; Pynoos et al., 1999, Steinberg & Avenevoli, 2000). A similar position was expressed by the WHO (2006) when it found that at least 10% of the people who experienced highly dangerous event/s would have serious mental health problems. The WHO claimed that these dangerous circumstances will hinder the ability of the individuals to function effectively (Kessler & Üstün, 2004).

However, the association of terrorism with mental health is not consistent. Studies (e.g., North & Pfefferbaum, 2002) showed that the distress that children suffered during exposure to terrorism is considered "normative response" that may not necessarily be regarded as pathological responses. North and Pfefferbaum (2002) argued that many people experienced psychological problems than psychiatric illnesses; as such psychological problems should not be missed with psychiatric illnesses. Okasha and Elkholy (2012) echoed similar position when they argued that it is unknown if children who were directly or indirectly exposed to terrorist attacks inevitably experienced deteriorated mental health and if there are available or effective resilience and coping mechanism to the children. Such simple views are questionable in Nigeria. Most of the studies that predict association of terrorism with children traumas were longitudinal designs, with scientific research designs which imposed statistical data to analyses and predict the outcome (Kano, Wood, Siegel, & Bourque, 2016; Slone & Mann, 2016).

Relying on scientific calculations to predict the psychological impacts of terrorism on children is ambiguous, fret with biases, and methodological limitations. Creswell (2009) argued that results yielded from quantitative studies are limited as they

provide numerical descriptions rather than detailed narratives that provide detailed accounts of children affected by terrorism perception. In addition, Babbie (2016) showed that answers in quantitative research are preset and does not necessarily present how people feel about a subject. To address these concerns, this study will conduct a qualitative phenomenological study that will present the lived experience of Nigerian children exposed to Boko Haram terrorism.

Equally, most of the study participants in those studies (e.g., Halevi et al. ,2016; Okasha & Elkholy, 2012; Moscardino, Axia, Scrimin & Capello, 2007) were from different cultural backgrounds and had not been directly exposed to terrorism. Therefore, the degree which terrorism affects children is ambiguous and unclear. Also, there is also a concern about the successfulness of intervention programs for the treatment of mental illnesses in children exposed to terrorism. The interventions and resilience programs applied as coping methods for children exposed to terrorism elsewhere in the world may not work in Nigeria because of cultural differences.

Social cohesion, solidarity, affection, religion, community resilience, and family support are some of the most important resilience to coping with trauma or loss of family members. A holistic understanding of the psychological consequences of terrorism on children as well as the coping methods in children should be based on the lived experiences of the children. Thus, intervention measures have to be peculiar to each circumstance. The review of selected scholarly studies relevant to impacts of terrorism on children education follows. The Piaget child cognitive development theory is

explored in the next discussion to explain the psychological functioning of children exposed to terrorism.

The Psychological Consequences of Terrorism for Children

The intentional perpetration of acts of violence on civilian noncombatant, to achieve ideological, religious, or political interest is referred to as terrorism (Borum, 2004; Bongar, 2004; McEntire, 2009). Psychological reactions are part of the standard process in the aftermath of exposure to terrorist attacks. The historical literature describes the cognitive response to terrorism as a form experience which ultimately lives injuries or traumas with lasting impacts on the victims (Collins & Collins, 2005).

Though the scars of Boko Haram terrorism may live temporary or permanent injuries and mental health problems with the victims, however, the cognitive reaction to terrorism is uniquely based on individual ecological development. Bonanno, Brewin, Kaniasty, and Greca, (2010) identified life disruption, missed school, weak academic functioning and continues life stressor as some of the adverse cognitive effects on children exposed to terrorism in the short term and the long term. Piaget cognitive development theory corroborates this believes when he argued that family displacement, adverse changes in environment, and violence affects child assimilation and accommodation at developmental stage. A longitudinal study conducted by Halevi et al. (2016) examined the maternal and child predictors of risk and resilience following extreme exposure to terrorism and the war in the children exposed to war and terrorism in Sedat, Israel. The sample size comprised of 232 children of which 148 experienced repeated acts of terrorism and 84 experienced terrorism three times. The age range of the

study participants when they were exposed to terrorism was between 1.5 years and 11 years old. The results of the study showed a statistically significant correlation between terrorism and PTSD symptoms. Anxiety disorder, less attention deficit, hyperactive disorder, was shown in the war experienced children.

Also, oppositional defiant disorders conduct was found among the children. There was no change in the prevalence of this disorder over the period of ten years that the children were exposed to terrorism and war. The result concluded that exposure to terrorism by children could exacerbate over time and lead to permanent psychopathology and externalize children profile into adulthood. The result of this study echoed the findings of Lowe and Galea's (2015) study which concluded that exposure to terrorism and war caused PTSD symptoms among children exposed to terrorism or war.

Lowe and Galea (2015) reviewed the historical literature related to the psychological effects of mass shootings on indirectly exposed populations. The study evaluated 49 peer-reviewed articles relevant to the psychological implications of the mass shooting that comprised of 27 independent variables. The reviewed articles covered 49 studies from 15 different mass shooting in high schools in the United States and Finland. A coding process with two steps was used to understand the characteristics of the study, and to understand the prevalence estimates and predictors of mental health outcome of the study. The study finds that the survivors and members of the communities where a mass shooting occurred developed different types of mental disorders symptoms which includes fear and decreased a sense of security and safety in the exposed population.

A long term psychological response was found to be required to reduce mental health impacts of the post-intervention efforts among the study population. Lowe and Galea (2015) study agreed with other literature that concludes that exposure to terrorism is a characteristic of developing mental health problems among children and that long-term post-intervention programs are required for the treatment of mental health in children exposed to terrorism. The findings from Lowe and Galea (2015) study supported the previous study conducted by Scrimin et al. (2006) where it was shown that symptoms of PTSD were found in Beslan children that were exposed to terrorism.

Scrimin, Axia, Capello, Moscardino, Steinberg, and Pynoos (2006) reported that Beslan children between the nine to 18 years of age showed high symptoms of PTSD after the children were taken a hostage in school by a group of terrorists. The aim of the research was to provide information on the impacts of terrorist attacks on the Belsian children that were taken hostage by a group of terrorists. The sample population was forty -two participants of which twenty two were children, and twenty were the children's primary caregivers. A qualitative study with the semi structured interview was used to conduct neuropsychological impacts of the terrorist's attacks on the Belsian children three months after the hostage taken of the children in school.

In addition, the qualitative study was used to examine the available resiliency within the framework of the environment in which the children live. A Wilcoxon test revealed a severe statistical exposure than their caregivers ($z = - 3.81$, $p<0.0001$). The study found a mental health condition of witnessed severe terrorist events, three months after the terrorist attack in the children. Besides, the caregivers were also found to have

similar PTSD symptoms. Likewise, behavioral problems were found in the children. The majority of the children were found having difficulties in sustaining attention for two minutes. Neurological impairments were also found in the children.

Equally, the study found that children short memory was significantly below average. The study suggested an early necessary assessment and diagnosis of the traumatized children avoid memory loss, the challenging behaviors so that the children performance in school will not be impaired by poor cognitive and behavioral functioning. Moreover, the children were unable to concentrate on their studies and exhibited signs of short memory loss. These reactions were similar to previous research studies, psychological theories, and existing literature relevant to children population affected by terrorism and followed similar trends of psychological reactions to direct exposure to terrorism (Moscardino, Axia, Scrimin & Capello, 2007).

Similarly, Moscardino et al. (2007) reported that 88% of the children that were directly exposed to the terrorist attack on their school showed aggression, defiant behaviors, problem following and accepting adults' directions, developed sleeping phobia, and lack of appetite after experiencing the traumatic events (Moscardino et al., 2007). Other reactions exhibited by the children include avoidance of people and places, avoidance of discussion related to the event, headaches, stomach ache, ear pain, emotional numbing, mourning, and grief. Furthermore, the study revealed that student exhibited fear and sense of insecurity. The students were found confused about their environment, vulnerable as a citizen and had the problem to handle social issues and school's task. The study also showed that parental support, community support,

individual children personal quality, as well as ritual and traditions are an effective coping mechanism for the children.

Previous research has reported mental health disorders and struggle to sustain attention as corresponding to exposure to a traumatic event in children (Moscardino et al., 2007). This agrees with other extant literature that identify age of the children, status, history of the children, religious practice, nature of therapeutic staff support, culture and traditions as buffer to stress following traumatic exposure to terrorism by children (Dekel, Stanger, Georgakopoulos, Stuebe, & Dishy, 2016; Pereda, 2013; Solomon and Laufer, 2005; Willis, Yeager, & Sandy, 2003). However, Masten (2016) argued that the implementation of resilience in the context of abstruse cognitive loss should be based on the individual child shared roots. In other words, the framework for developmental resiliency should be based on personal context congruence. Since proper child upbringing differs, a universal application of protective factors for children exposed to terrorism implicates the intervention.

Borge, Motti-Stefanidi, and Masten, (2016) suggested an integrated approach that includes individuals and their families background as a promising positive adaptation in personal adversity. Nevertheless, this study agrees with the focus of these study research questions of the psychological consequences of Boko Haram insurgency for children as well as determining adaptive and protective factors that will enhance their recovery following exposure to an insurgency.

The aim of the study conducted by Thiabtet et al. (2008) was to find the relationship between terrorism and trauma in children affected by terrorism and the war

in the Gaza Strip. The research participants were 499, of which the breakdown of the study includes 100 families, 200 parents and 197 children aged nine -18 years. Parents and children described the feelings of trauma, depression, loss of parent jobs, fear, depression, and anxiety following exposure to violence. The result revealed a significant statistical relevance of correlation between exposure to terrorism and PTSD among children. Also, result yielding from the study revealed that both traditional and universal intervention in the treatment of children should involve parents. This study agrees with other studies which find psychological disorder in children that experienced terrorism and identify functioning parenting as a protective factor for facilitating real recovery for children in the aftermath of suffering trauma.

Comer et al., (2010) confirmed a significant association between mental health disorders and September 9, 2011, attacks among children. The aim of the study was to examine the impacts of terrorism on the life disruptions and psychopathology of New York City preschool children. A purposeful sample of 8,236 whose ages range between 4-18years from New York public school were surveyed six months after the September 11, 2001, terrorist attacks. Cross sectional observation design and logistic regression were used to examine the connection between life-related disruption and mental health disorders among the study participants.

In addition to the statistical correlation between mental health disorders and September 9, 2011, attacks among children, the result further showed that the effects of terrorism are far more beyond proximal contact and traumatic exposure. Family displacement and loss of their parental job following the 9/11 terrorist attack in New

York were found to be the reasons why the children developed PTSD symptoms. Finally, the outcome of the research study showed that early diagnosis and treatment is significant to avert permanent mental health problem in children who are victims of terror. Similar studies conducted by Schaal et al., (2012) reported similar findings. The research methodology in Schaal et al., study was a challenge because a casual inference is not permitted in cross design observation (Patton, 2009). However, despite the limitation of this study, the findings yielded from this study is in tandem with other studies which found indirect exposure to terrorism causes PTSD symptoms in children.

Talking about the symptoms of anxiety, memory loss, and depression as the effects of terrorism on children, Schaal et al. (2012) reported that 100% of the survivors suffered from Rwanda genocide suffered from PTSD. The aim of the study was to compare the rates of mental health disorders among Rwandan genocide perpetrators and Rwandan genocide survivors (children) and to investigate the prevalence of posttraumatic stress disorder (PTSD) and depression among the two groups. Through the feelings of the participants, the severity of depression, anxiety, and symptoms related to PTSD was found among the study participants. Also, a similar survey carried Thabet, and Vosta (2008) position finds PTSD symptoms in children exposed to terrorism. It also finds that the children were malnourished, impoverished, emotionally unresponsive, and developed recurring flashbacks.

In identifying factors that may help children cope with the trauma emanated from terrorism, Thiabtet et al., (2008) recommended counseling for the treatment of trauma in children exposed to terrorism than administration of medication. Thiabet et al., (2008)

reported that 80% of children exposed to terrorism improved with counseling based therapy than 20% who were administered drugs for treatment. However, while a longitudinal study is required to establish the effect of long-term treatment for psychological trauma from an act of terrorism or disaster in children, data accessed and analyzed for this study were not derived from the longitudinal study. Equally, the majority of children and parents who participated in this study were not directly exposed to violence; rather their experience was based on the secondary effect of terrorism that includes loss of parental income. Regarding the appropriateness of the study, the chi-square deployed for statistical analysis of the study did not provide information on the strength of the relationship of children exposed to terrorism and the prevalence of PTSD.

Macksound and Aber (1996) examined the number and types of war traumas children face growing up in war or terrorism inflicted countries and the relations of such experience to their psychological development. The study sample population was 224 Lebanese children ages 10-16 years. The study administered semi-structured interviews and used multiple regression equations to determine the relation between the ages of the children and the types of trauma experienced.

The findings from this study showed that the trauma suffered by the children was positively related to PTSD symptoms, and different kinds of war traumas were differently related to PTSD symptoms, and adaptation outcomes found in the children. Nasie (2016) reinforced Macksoud and Aber's findings that chronic effects of PTSD are found in children who are involved in intractable conflicts and that the PTSD and those chronic effects of the violent dominate their lives. Thiabtet et al., (2008) expressed Macksound

and Aber (1996) position that therapeutic interventions are more suitable for the treatment of PTSD in children and should be expanded to improve social behaviors.

A similar study by Pereda (2013) reported similar findings. In developing a clear understanding of the psychological effect that terrorism may have for children, Pereda (2013) reviewed a total of 107 articles and 54 books related to the topics of psychological effects of terrorism on children, of which 77 were related to September 11, 2001, terrorist attacks in New York. Findings showed that 64% of the reviewed literature covered children that were indirectly exposed to terrorism and 14% of the articles covered studies on children that were directly exposed to terrorism. The reviewed literature was coded based on methodology, relevance, year of publication, and year of study to the topic. The result from this study showed that terrorism has psychological effects on children. Findings yielded from the study also distinguished between pathological responses to terrorism as a reasonable response to an unnatural act. In addition, the result of the study demonstrated that the impacts of terrorism could be transitory from short term to long term and may not be generalized.

Pereda (2013) categorized exposure to terrorism to direct exposure and indirect exposure. Killing of friends and families, displacement, living in a community where a terrorist act is carried out were identified as elements of direct exposure to terrorism; and exposure to terrorism through mass media as indirect exposure to terrorism. Parental response to exposure to terrorism such as crying was symptom of PTSD in children (p.192). Besides, this study suggested that though early treatment such as diagnosis and provision of therapeutic support to children in the school setting are effective in the

treatment of the psychological disorder in children, it recommends additional multimodal direct exposure and indirect exposure to treatment interventions programs are still needed.

Pereda (2013) recommended further studies on the effects of terrorism on children who are directly exposed to terrorism so at to have a better understanding of its impacts and design appropriate intervention programs. Skill building in cognitive and behavioral therapeutic support was also recommended for trained professionals who can work individually with children who are victims of terrorism. Such professionals should be able to have the knowledge to identify symptoms, harmful physical effects, psychological, social, and short –term and long –term effects of terrorism on children. In addition, community intervention that involves religious places and parents were recommended as part of the treatment plans.

The result from Pereda (2013) study is relevant to this study because it shows psychological effects of terrorism to children, diagnosis and treatments for children directly and indirectly exposed to terrorism, as well as methods to reduce barrier to treatment of mental illnesses in children exposed to terrorism. Moreover, the study suggested the use of therapeutic support for the treatment of a mental disorder in children than the prescription drug.

Pine et al. (2005) suggested that while direct exposure to terrorism is a measure of the stable outcome of PTSD in children, the totality of child and child's ecology is a risk factor that can increase mental health problem in children. Data concerning the symbiotic relationships among stress, trauma, and developmental psychopathology with

specific emphasis on long forms of trauma were reviewed in the study. In addition to parental displacement, death of friends, siblings or parents, witness of horrific events, watching graphic incidents of terrorism on television were equally identified as unsafe factors for developing trauma by children in the aftermath of terrorist attack.

Aside from the amounts of life disruption such as orphan refugee, school or home damaged, as well as social disorganizations were other associated risk factors that may increase adjustment problems for children. The study suggested that family support, school-based intervention programs and positive peer influence as factors that may mitigate the symptoms of mental health disorder in children that witnessed and experience terrorism.

McEntire (2009) pointed out that to understand how children respond to trauma after terrorism; there is a need to explore theories on child development theories to explain how children change and grow over the course of childhood. The next discussion will explore the psychological impact of exposure to terrorism on children's education.

The Psychological Consequences of Terrorism for Children's Education

There are accumulated literatures that have analyzed the impacts of terrorism on children education (Berrebi & Klor, 2008; Monteiro & Rocha, 2016; Pfefferbaum, 2001). However, very little attention has been given to explain the effect of Boko Haram insurgency on Nigerian children education and cognitive development, which are fundamental to social development. This discussion will explore literature to explain the psychological impacts of terrorism on the education of children exposed to terrorist attacks. As earlier indicated, the goal which Boko Haram seeks to achieve in the

northern Nigeria is to reject western education and stop children from going to school. To achieve this goal, Boko Haram deployed violent tactics that include forceful abduction of students from hostel, and killing of children in their hostels. They also destroy school infrastructures through bombing. Bloom and Matfess (2016) found a relationship between exposure to terrorism and poor academic performance among children exposed to violence. Likewise, Delaney-Black et al. (2002) revealed that violence exposure is associated with decreased intelligence quotient (IQ) and reading ability of children who were exposed to violence in Russia.

The goal of the study conducted by Delaney-Black et al. (2002) was to examine the relationship between violence exposure and trauma related distress, and standardized test performance among early school aged urban children who were exposed to violence and experienced trauma in the United States. The study participants consisted of 157 boys (52%) and 142 girls (48%), with a mean age of 6.9 years (age range, 5.9-7.9 years). A regression equation was employed to examine community violence exposure and trauma related distress as predictors of reading ability. The result showed that a child experiencing violence exposure and trauma related distress at or above the 90th percentile would be expected to have a 7.5-point (SD, 0.5) decrement in IQ and a 9.8-point (SD, 0.66) decrement in reading achievement. A significant challenge for this study is that this study employed quantitative statistical analysis to measure the impacts of violence on the academic performance of the students. The regression equation deployed for statistical analysis of the study was not based on the lived experience of the Russian children that experienced terrorism and did not consider the methods of

treatment and diagnosis following the children's involvement with the phenomenon to understand reasons for low IQ level among the participants. Notwithstanding, findings from the study corroborates Piaget cognitive development theory that adverse changes in an environment and violence affect child assimilation and accommodation at the developmental stage. In addition, Delaney-Black et al. (2002) findings correspond with the aim of the present research study to determine the educational experience, mainly academic performance of Nigerian children exposed to Boko Haram insurgency. Similar study conducted by Scrimin et al. (2009) confirmed Delaney-Black et al. (2002) findings when they reported that children exposed to terrorism in Russia performed significantly less well than children that are not exposed to violence.

Scrimin et al. (2009) conducted a study to report on cognitive functioning among school age children twenty months after a terrorist attack against their school. Participants included 203 directly and indirectly exposed children from Beslan and 100 non exposed children from another town of the Russian Federation. Participants were tested using nonverbal neuropsychological measures of attention, memory, and visual-spatial performance. Findings from the study revealed that overall, children that were directly and indirectly exposed to terrorism performed significantly less well than controls in all domains. Besides, direct exposure and loss of a family member were associated with reduced memory performance. Outcomes of Scrimin et al. (2009) aligned with the result from the study conducted by Ali, Mahsud, and Khan (2016) that reported exposure to terrorism decreases the capacity of learning among students.

The objectives of the study conducted by Ali, Mahsud, and Khan (2016) was to analyze the impact of war on terror on students' academic performance, and highlighted the impact of terrorism on students' behavioral and personality modification in Swat, a district in Pakistan. The study respondents were 200 students selected from seventh and 10th grade in four schools. Data were collected through in person-to-person communication with the respondents to determine the impact of terror on their academic performance, and a statistical test, i.e., chi-square along-with correlation were used to technically analyzed the data and to verify the mentioned hypotheses of the study for generalization. The result found a statistically significant correlation between terrorism and study participants less attainment in the academic process. The result further showed that terrorism has greatly enlisted hesitancy and anxiety amid students that greatly affect their participation in class and decreases the capacity of learning among students. Furthermore, the result revealed a significant drop in all the students' confidence level, class lecture participation, class attendance and grading in papers. In other words, the result showed a correlation between the students' exposure to terrorism and weaker academic performance, as well students' academic failure. Shany (2017) revealed that fatal terror attack shortly before an exam has a significant adverse effect on students' exam performances.

Shany (2017) explored the effect of terror on cognitive performance in exams of using a large sample of Israeli high-school matriculation examinations, and merged with detailed data on Israeli fatalities from terror incidents in 2001–2005. The data covered two million exam observations of 254,059 Israeli Jewish twelfth-grade students. The

result found a negative correlation between student failure and exposure to terrorism in Israel. Students who recorded lower scores were found to be in the territory where terror attacks with fatalities were carried out by terrorist shortly before the exam. The result also showed that the terror attacks affect student performance on tests mainly through stress that affects the learning process and cognitive acuity during the exam. Hence, the implications of this study are relevant to explain the effect of Boko Haram insurgency on Nigerian children education and cognitive development. The review of selected scholarly studies relevant to psychological reactions to terrorism by children follows.

Psychological Functioning and Coping for Children

Relevant to the children experiences are programs and support services which are available to children learning process to deal with their mental health illnesses following exposure to terrorism. Understanding the coping methods for children affected by terrorism is significant to their recovery. Extant studies provide guidance on understanding how children cope with the stress of fear of going to school or traveling, horror, depression, hostile, miserable, confused, distressed, intense grief, extreme unconsciousness, cognitive impairment, and sleep disturbance (Collins & Collins,2005; Haravuori et al. 2010; Hughes et al., 2011). Studies showed children crying and ruminating about their loss, grief, counseling following exposure to terrorism. The study identified exposure-based therapies as the choice of treatment and coping methods for their PSTD (Nemeroff et al., 2006; Rothbaum & Schwartz, 2002; Servaty-Seib & Taub, 2010). These identified stressor levels of children become part of daily thinking and events that shape their everyday lives (Blair & Raver, 2016; Skimmer & Zimmer-

Gembeck, 2016). Also, strong social support from families, functional parenting, family attachment, individual child personality, preparation and prior exposure, economic status, previous low levels of anxiety and depression as consistent factors for adjustment in children affected by terrorism (Bonanno et al., 2005; Ciccheti, 2010; Garbarino, Governale, Henry & Nesi, 2015; Masten & Osofsky, 2010).

Besides, schools based intervention programs, prior successful academic achievement, gender, and ability to understand the events based on the child age and development level are some of the factors that may moderate the impacts of exposure to terrorism on children (Cummings et al., 2011; 2011 Galea, et al., 2007; Greeson, 2013; Hasija & Gray, 2007;; Henrich & Shahar, 2013; Merrilees, Goeke-Morey, Schermerhorn, Shirlow, & Cummings, 2011; Punamaki et al.,2015). Other estimations showed that religiosity, culture, and tradition may provide a buffer for children to cope with their trauma (Gaffney, 2006).

Hawdon, Räsänen, Oksanen, and Ryan (2012) revealed that community solidarity was a protective factor for coping with trauma among the Nebraska children that experienced school shooting in 2007 in Nebraska is responsible for coping with trauma. Following the Finland's Jokela High School shooting on November 7, 2007, where a lone wolf terrorist fired rifle and killed eight students, and the December 6, 2007 killing of eight people in Nebraska shopping mall, as well as the September 23, 2008 Finland school shooting that killed eight people and injured eleven people, Hawdon et al., (2012) conducted a survey to investigate "if social solidarity, which often emerges after terrorism, serves as a protective factor for community residents recovering from tragic

critical incidents". Study participants were between ages of 31 to 51 many of which were parents of children affected by the shooting. Logistic Regression was used to determine if solidarity promoted coping and increase the wellbeing and decrease depressive symptoms.

In Omaha, Nebraska, the result found that solidarity reduces depression by approximately 19% among people who were experiencing depressive symptoms. Also, in Jokela-Finland, an independent sample was used to investigate if solidarity influences recovery. The binary logistic regression calculation result reveals that mutual support significantly mitigates feelings of despondency and dejection after the shooting by 20.7% among the population.

The result from the study was similar to the findings from Omaha analysis that showed solidarity is responsible for 19% decrease in depression among people that suffers depression in the shootings. In Kauhajoki, a cross-sectional analysis of dependent variable (Kauhajoki) and independent variables (solidarity and recovery) showed a 15% decrease in the chance of suffering PTSD symptoms. The report suggested solidarity is responsible for a positive response that supports influences recovery in the aftermath of exposure to terrorism either in children and adult where there is prevalent of depression.

Masten and Narayan (2012) identified attachment relationship and functional parenting as an important factor for children adaptation following terrorism. Qouta, Punamaki, and El Sarraj (2008) revealed that life threat, violence, and loss were the risk factors that caused PTSD symptoms among Palestinian children exposed to terrorism in Gaza. The study analyzed the effect of exposure to terrorism on mental health, as well as

on the cognitive, emotional and social development of Palestinian children living in Gaza. Second, the study aimed to model familial, and emotional and symbolic process that can harm or protect the mental health of children and third; it determined factors that promote buffer for children exposed to war and violence.

Qouta et al. (2008) reviewed scholarly developmental articles relevant to the work of nongovernmental organizations working on community mental health program for Palestinian living in Gaza following the Intifada of (1987–1993), the Palestinian Authority rule (1994) and the Second Al Aqsa Intifada (2000- 2005). On top of the findings that life threat; violence and loss were the risk factors that caused PTSD, functional parenting, good peer relation, social support, and healthy attachment to other family members on the other hands were identified as the children protective factors following exposure to terrorism and political violence in Palestine. Parental loving, wise parental counseling, parental guiding were identified as characteristics of functional parenting.

Chemtob et al. (2010) implicated lack of functional parenting as the reason for poor recovery among preschool children who were exposed to September 11, 2011, terrorism in the New York. Conversely, it is important to note that Qouta et al. (2008) earlier predicted that strong family relationships predicted resilience among children exposed to political violence in Palestine. Inversely, lack of parental functioning may delay or risk children adaptation and recovery following exposure to violence.

Wickman and Kaspar (2007) revealed that functional parenting adjusted symptoms of PTSD in adolescent exposed to the tsunami. The findings from these

studies are relevant to the focus of this study to determine the cognitive functioning of children following exposure to terrorism and to understand the available resources that are helpful to Nigerian children in coping with cognitive problems following their experience with Boko Haram attacks.

Wickram and Kaspar (2007) reported that religiosity, family attachment, and community solidarity are effective ways of coping with trauma in children exposed to violence. The aim of the study conducted by Wickram and Kaspar was to examine if the exposure to Tsunami influence PTSD and depressive symptoms among the study participants. Equally, the study examined the resilience factors that may help the respondents to recover from PTSD and depression. All the study participants had three children in their families, and 90% of the study mothers had children that were 10 years' age. The result revealed that majority of the mothers identified religious participation, familism, functional parenting, and community support as buffers for recovery of PTSD and depressive symptoms. Also, the outcome of the study identified functional family and high religious involvement as the major significant factors that reduced the impacts of PTSD among the mothers. Betancourt et al. (2010) corroborated Qouta et al. (2008) findings which revealed that family attachment moderated the impacts of PTSD among Palestinian children affected by the Palestinian violence. Similarly, family attachment was found as a psychological adjustment factor among Sierra Leonean's children exposed to eleven years' war and genocide (Betancourt et al., 2010; Ghailian, 2013).

Betancourt et al. (2010) reported on the follow- up phases of a longitudinal study of the former child soldiers in Sierra Leone. The study conducted a study to examine

factors that eliminate risk and promotes coping in the psychological adjustment of Sierra Leonean's children. The sample population were children (n=156) between the ages of 10 to 18 when the study was conducted. These children were either abducted, brutalized, drugged and were given guns to fight; some were made as housewives, cooks, servants, guards, and shield during the war. A face-to-face interview was used to gather data from the children.

Betancourt et al. utilized paired t-test, correlation coefficients, bivariate associations and multiple linear regression analysis to compare psychological adjustment, variable inspections, and adjustment. The result from the study identified family acceptance, community acceptance, staying in school, prosocial attitude mitigates the effects of PTSD in the Sierra Leonean children who were war soldiers. This result is similar to other promotive factors earlier reported by Wickram and Kaspar (2007), and Wickrama et al. (2007).

Although, all these psychological studies on children greatly emphasized the development of functional parenting, schools based intervention programs, prior successful academic achievement, gender, and ability to understand the events based on the child age and development level as some of the factors that may moderate the impacts of exposure to terrorism on children. However, it is also an understandably important endeavor to emphasize that the ultimate success of interventions should equally be determined by other factors, such as the circumstance peculiar to the child–available government policies and programs, cultural practices and norms ethnic and number of children who receive such forms of treatment.

Contrary to the previous studies that identify strong family attachment and functional parenting as protective and resiliency factors for children to cope with trauma, Ager, Stark, Akesson, and Boothby (2010) reported that leveraging on existing community resources, community involvement collaboration and as best practices in care and protection of children in crisis-affected settings. Nevertheless, family support and community-based programs were identified as connecting variables to strengthen children recovery from cognitive impairments (Hughes et al., 2016).

Masten & Narayan (2012) identified functional schools, child nursing related institutions, religion, and community acceptance as protective factor that may help children cope with trauma of terrorism. Interactions between these systems, coupled with strong leadership, effective educational activities, and efficient humanitarian services may serve as a better adjustment for children exposed to terrorism. Similarly, Ager et al. (2010) found community engagement; functional parenting as factors that may help children to cope with mental health disorder.

The aim of this study conducted by Ager et al. was to understand what the study participants considered "best practices" as promotive and protective factors for children who are exposed to extreme violence. Using Internet and Google searches with contacts over telephone and email, 30 participants were enlisted and took part in the study. The sample population was made up of 21 women and nine men who were technical and program design expertise of the different organizations that provide diagnosis, treatment and relevant humanitarian services to children in terrorism or war-afflicted locations

throughout the world. Fifty-five statements were used to elicit information for the "best practice in care and protection of children exposed to terrorism or war.

The research emphasized community engagement as well as parental and children involvement in providing resilience to children with symptoms of mental health disorder. Besides, the study identifies kinship network, schools, religious associations, and social healing rituals as "adaptive systems" for children with symptoms of cognitive problems. The study suggested the involvement of children, youth, parents, and wider community in developing and implementing protective interventions programs for children exposed to terrorism.

The use of school and nurturing institution has created a plethora of intervention programs for protective and resiliency factors in reducing posttraumatic sympathology among children (Berger & Gelkopf, 2015; Slone, Shoshani, & Lobel, 2013). According to a quantitative study conducted by Slone et al. (2013), the school-based intervention program was identified as strengthening factors for children exposed to violence. One Hundred and seventy nine adolescents (82 girls, 97 boys) high school students were chosen from Ashkelon in southern Israel.

The identified students have been diagnosed with behavioral difficulty and PTSD based on their experience of witnessed terrorism and political violence in the south of Israel. The students participated in administered self-report questionnaire assessing their psychiatric disturbance. The surveys also include questions on which social support that were relevant to them in coping with their posttraumatic sympathology. The lists of social support in the survey were family, teachers, friends, community professionals,

religious leaders. The majority of the study participants favored school-based therapeutic support implemented by faculty and behavioral specialists and monitored by education professionals as most active in promoting coping and psychological functioning for an adolescent to overcome behavioral difficulties and psychological traumas.

School counseling and behavioral therapeutic staff support were identified as the major school-based programs that promote coping. Nonetheless, all the study participants identified family and religious leaders to maintain coping and resilience among children exposed to violence. This study corroborates other studies that identified broader community engagement that includes a school that identified School and other child-nurturing institutions as protective and adaptive factors for treatment of PTSD in children.

Hassija and Gray (2007) stated that, "exposure-based interventions have consistently been shown to promote superior posttraumatic adjustment about alternative treatment approaches" (p. 15). Otto, McHugh and Kantak (2010) echoed similar position when they described exposure therapy as an effective therapy in prevention of the progression of acute stress disorder to post-traumatic stress disorder. Myers et al. (2007) described exposure therapy as the type of treatment that is used to treat anxiety disorder (p. 141–2). Dobson and Dobson (2009) identified psycho education as an essential part of the treatment of PTSD (p. 104). Hassija and Gray (2007) categorized exposure-based therapy into both imaginal and in vivo techniques. Imaginal techniques are majorly applied to the treatment of PTSD among children. Study (Foa, Keanne, Friedman & Cohen, 2009) recommended a 10-20 session per week cognitive –behavioral therapy

(CBT) based on an imaginal method for children with PTSD symptoms or behavioral disorder. Other school recommended school-based interventions programs for the treatment of psychological disorder in children include, eye movement desensitization and reprocessing (EMDR), and play therapy (Slone et al., 2013). Consistent with the previous studies conducted by Ehntholt and Yule (2006), Ager et al. (2010) and Stone et al. (2013), identified school based therapy as effective methods of moderating children psychological problems.

The aim of the study conducted by Ehntholt and Yule (2006) was to evaluate the effectiveness of a school-based group intervention designed for children who have experienced trauma. In essence, this study explored the notion expressed by children with the war-related trauma that cognitive behavioral therapy helps them to improve their overall behavioral and emotional symptoms. The study participants were secondary school students who were asylum seekers in London (N= 26), and chosen by the Ethnic Minority Achievement Group (EMAG) teachers. The participants were exposed to war and demonstrated symptoms of PTSD while in school. The participants were divided into two equal groups of treatment and control condition. The treatment group was allocated to CBT program for 6 weeks while the control group was asked to wait until after the treatment group has completed their 1-hour group sessions for 6 weeks.

Ehntholt and Yule reported a high statistically significant difference between the treatment group and oversight group PTSD symptoms after the completion of CBT program for the treatment group (F (1, 23) = 10.955, p = .003). A significant decrease in overall PTSD symptoms within the CBT group (t (14) = 2.934, p = .011) and a non-

significant trend towards an increase in total symptoms in the control group (t (10) = –2.003, p = 0.073) were revealed by Paired t-tests. Also, statistically significant difference between the control group and treatment group after the CBT program for treatment group in terms PTSD symptoms was revealed. CBT group showed a significant improvement in emotional and behavioral challenges (t (14) = 3.826, p = .002). There was no significant change in the control group. There was a significant progression in arousal level of scrutiny group compared to the treatment group (F (1, 23) = 4.741, p = .040) and decrease in the arousal standards of the treatment group. Teachers also reported a significant reduction in PTSD among the children that were in the treatment group. The children in control group did not experience any decrease in the PTSD and behavioral problem. Ehntholt and Yule, (2006) recommended CBT as effective in the treatment of children with an intrusive psychological disorder who have demonstrated PTSD and behavioral problem. Also, they suggested that the program should be made available to wider audience. This treatment should be manually based and does not require the expertise of mental health professionals but trained behavioral specialists.

Additionally, Ehntholt and Yule observed that CBT reduces the stigma attached to mental health in some societies and culture and children felt comfortable with CBT program in the treatment of PTSD. Although there is a consensus among these studies that, a school-based CBT interventions are effective in cognitive restoration or treatment of children exposed to terrorism. However, there is a need to understand the cultural and gender perspectives of exposure –based school-based intervention. Exposure -school-based intervention might serve as understanding the cultural and gender perspectives as

protective factors in children. Previous studies discovered the symbiotic relationship between religion and coping with the psychosocial well-being of children who were exposed to trauma or behavioral problems.

Apart from exposure-school based intervention, Ai, Tice, Huang, and Ishisaka (2005) identify religion as part of the connecting variable which promotes community resiliency for children with psychological problems. The aim of the study conducted by Ai et al. (2005) was to investigate the relationship between trauma and resilience among people who were affected by armed conflict in Kosovo and Bosnia. The participants were war refugee from Kosovo and Bosnia (*N*=138) who resides in the United States. 86 % of the sample population stated that they relied on four types of prayers for coping with their wartime trauma. The study participants showed that their religion was positive to their psychosocial functioning after exposure to armed conflict.

As described in the previous study (Ai et al., 2005), Harris et al. (2008) conducted an insightful study in the understanding of the relationship between religion and resiliency in children. Ai et al. (2005) reveal that religion (community resilience) is the best method for children to achieve desirable emotional and social functioning when exposed to significant adversities.

Harris et al. (2008) explored the relationship between religiosity and behaviors adjustment in a trauma-exposed community in other to understand the effect of religion in the recovery of mental health functions of Christians exposed to terrorism. The study participants comprised of 327 participants from 14 Christian religious denominational affiliations; multiple types of traumas were measured using the Traumatic Life Events

Questionnaire (TLEQ). The Posttraumatic Growth Inventory (PTGI) was used to measure New Possibilities, Personal Strength, Spiritual Change, and Appreciation of Life. The study participants spread among various Christian religious denominations. The result from the study identified seeking spiritual was a positive factor for posttraumatic growth but does not predict lower posttraumatic symptoms. Although religion and tradition might provide coping in children, there is the need for further study in a situation where children relapse into trauma. The implication of this is to find which aspects of religion address differences in stages of short and long term trauma among children based on their genders.

Although the research found significant numbers of the study participants (Christians) relied on prayers to cope with trauma, disaster, and other life adversities. High numbers of the study participants also relied on G-d and their faith as adaptive measures in coping with their trauma. Moreover, the study found that prayers are helpful in relieving symptoms of trauma. Nonetheless, clinical psychologists and studies on children, trauma, and resilience agreed that supportive interventions that include functional parenting, family's attachments, cognitive capability, self-efficacy, acculturation, religion and traditions, school and other relevant child-nurturing institutions are an active adaptive recovery in a child with symptoms of PTSD and behavioral problems (Marcia et al., 2016).

Barriers to Improving the Mental Health of Children

Despite the availability of robust empirical studies reports suggesting important protective factors for children cognitive functioning following exposure to terrorism,

challenges in implementing and progress in mental health service delivery remains a daunting challenge (Saraceno, Van Ommeren, Batniji, Cohen, Gureje, Mahoney & Underhil, 2007). Sustaining interventions is a challenge and may be largely influenced by political interest in priorities to mental health needs, overwhelming families' complex needs, lack of involvement of parent and perceived and unwillingness to participates, poor support for mental health therapists as the impediments to mental health treatment in children (Barker-Ericen, Jenkins & Haine-Schlagel, 2013; Van Cleve, Hawkins-Walsh & Schafer, 2013).

Besides, weak public health agenda, funding, corruption, unqualified, low and few behavioral health workers in mental health care in primary care setting, and poor limited public perspectives, lack of advocacy for people with mental health challenges, lack of inclusiveness in assessment and evaluation of children and parents of children in treatment plans, training of individuals who have mental health disorders and their parents, stigma attached to mental health referrals and only small percentage of children with mental illness are identified in primary care as barriers to the treatment of mental health disorder in developing countries (Gureje et al., 2006, 2007; Kranke, Schmitz, Der-Martirosian, & Dobalian, 2016; WHO, 2006, WHO et al., 2013).

Findings by Saraceno et al. (2007) reported that funding, few numbers of mental health professionals, inadequate advocacy, centralization of mental health resources, and poor skills related to mental health treatment on the part of mental health services providers, poor health infrastructure, and reduced investment in mental health care are challenges to providing efficient mental health services in the countries of the south. The

purpose of the study conducted by Saraceno et al. (2007) was to determine the barriers to mental health care in developing countries.

Study participants consisted of 57 selected international experts and leaders with experience in mental health services in low-income-and middle -income countries. A qualitative survey with open-ended questions was administered to elicit responses from the study participants with 90,848 words. Analysis of the barriers to mental health services discovered that mental health has a weak position on public agenda at central and local levels. Second, advocacy and issues in mental health are not understood by government and citizens. Third, there are no indicators to measure mental health, and fourth, support for mental health is weak, and fear of discrimination has made families silent and invincible. These responses are similar to other studies conducted by Gureje et al. (2007).

Gureje et al. (2007) conducted a panel data study to describe the cost-effectiveness of neuropsychiatry disorder in Nigeria. A World Health Organization (WHO) cost-effective, standardized measure was used to determine the appropriate cost of mental health treatment. The result yielded by the study showed that about 1,000 persons in the community had experienced one depressive situation in their lifetime and 65% of the 1,000 people reported the use of abusive drugs. Less than 1% of the total health budget appropriated to mental health services, and the 1% is not fully utilized due to corruption, 4 psychiatric beds, 4 psychiatric nurses and 0.1% of psychiatrists provided services to 1,000 populations.

One of the challenges to mental health services delivery in Nigeria and some developing countries is corruption and lack of political will on the part of the government (WHO et al., 2013). Van Cleve et al. (2013) showed that the numerous barriers to integrative mental health service include the low level of screening and evaluation for children with mental health symptoms. The survey of literature revealed that only small percentage of children with mental disorders received mental health services, and lack of access to mental health services by children, inadequate training and lack of knowledge on how to receive funding towards mental health programs by mental health agencies are some of the challenges to mental health challenges in the United States.

Gaps in the Literature Review

There are several gaps in the literature reviewed related to terrorism and the designs and implementations of intervention programs to children exposed to terrorism. As noted above, most of the studies reviewed employed quantitative studies with convenience sampling (Ager et al., 2010; Betancourt et al., 2010; Borgeet al., 2016; Chemtob et al., 2010; Lowe & Galea 2015; Masten & Narayan, 2012; Scrimin et al., 2006; Thiabtet et al.,2008; Wickram & Kaspar 2007; and Qouta et al., 2008). Generalization of these data may lead to inconsistencies and conflicts in data. Most of the variables affecting children directly exposed to terrorism were poorly researched. There were attritions in most of the study as study participants dropped out of some studies. Donors funded most of these studies objectives and the results tailored to meet the funders' goals. Due to donors' fund of some studies, autonomy, non-maleficence, beneficence and justice may be compromised (Lenson & Mills, 2016). The study

locations were restricted. Most of the studies were not based on the lived experience of children that were directly exposed to terrorism. Some of the interventions were being wrongly applied. Imposition of scientific data may not accurately present or reveal the risk factors and adaptive coping skills of children exposed to terrorism. In other words, quantitative studies may not lead to greater reliability and accuracy. The majority of the study culturally imposed interventions that may not be applicable in other culture and locations. Most of the researched responses may aggravate or disrupt recovery efforts if not properly applied based on the patient's tradition and beliefs systems.

Summary

The Federal Republic of Nigeria (FGN) recognized that early diagnosis and treatment of mental health can reduce PTSD. Therefore in 1991, FGN enacted MHA to scale up the treatment of mental health illnesses in Nigeria. However, the MHA has not been effectively implemented in 2018 to cater to the mental health of Nigerian children exposed to Boko Haram insurgency. The literature reviewed supported the psychological consequences of terrorism for children. The literature also helped to clarify the impact of terrorism on educational experience of children. Likewise, the literature revealed the types of coping system that may help children cope with the effects of terrorism. An evaluation of all the findings of all the literature reviewed showed that there is a correlation between exposure to terrorism and psychological disorder in children. Findings from studies also showed that terrorism adversely affected the educational performance of children. Also, there is need to investigate further the psychological risk factors and responses to terrorism in children. This study did not only contribute to the

body of knowledge but provide a better understanding of the psychological effects of terrorism on children, their educational experience, and adaptive factors that will benefit children to cope with the trauma of terrorism. Chapter 3 introduces the research design and approach for the study.

Chapter 3: Research Methods

Introduction

The purpose of this qualitative study was to examine the psychological consequences of the Boko Haram insurgency based on the lived experience of Nigerian children exposed to terrorism in northeastern Nigeria. I used face-to-face interviews with key participants, reflexive notes, and a review of literature on the psychological impacts of terrorism on children to develop an enhanced understanding of the subject. From the insight gained in this process, I developed recommendations for practical solutions for the Nigerian government, policymakers, and other interested parties to develop programs and policies that may lead to successful implementation of mental health diagnosis and treatment for children exposed to terrorism in Nigeria.

The first major section of this chapter addresses the research design and rationale of the study, including the study's research questions, which I generated to create (a) an understanding of the psychological impacts of Boko Haram on Nigerian children, (b) the impacts of Boko Haram on children's educational experience, and (c) the potential to minimize the negative influences of Boko Haram on Nigerian children and maximize their resilience and recovery. In this chapter, I also describe my role as the researcher based on the various stages of the design and execution of the research study. Finally, I explain in this chapter how I ensured trustworthiness of the study and ethical treatment of participants, and I provide a summary of why qualitative research design was appropriate for this study.

Research Design and Rationale

I utilized a phenomenological design to understand the participants' subjective experience with Boko Haram terrorism in northeastern Nigeria (Moustakas, 1994). This design allowed for participant-centered data collection and analysis.

The central research question that guided this qualitative phenomenological case study of the psychological consequences of the Boko Haram insurgency on Nigerian children was as follows:

RQ1: What are the adverse psychological effects of the Boko Haram insurgency on Nigerian children residing in northeastern, Nigeria?

The subquestions were the following:

RQ2: How had terrorism impacted the educational experience of children in northeastern, Nigeria?

RQ3: What programs and services were available and perceived by the interviewed children as being helpful in improving their coping with the effects of terrorism?

RQ4: What programs and/or services may help to promote coping and adjustment for Nigerian children affected by terrorism residing in northeastern, Nigeria?

RQ5: What are the barriers to improving the mental health of the children of Nigeria?

This study was aimed at understanding the psychological consequences of the Boko Haram insurgency for children in northeastern Nigeria based on the lived

experience of the study participants with the Boko Haram insurgency. As indicated in Chapter 1, the construct that the study relied on was qualitative phenomenological design. Babbie (2016) described phenomenological qualitative research design as a way to gain an understanding of the underlying opinions, motivations, and perceptions of individuals based on their personal experience.

According to Givropoulou and Tseliou (2018) and Walther et al. (2017), the interpretive phenomenology approach is suitable to uncover the lived experience of people who experienced a phenomenon of interest. Hence, the interpretive phenomenology approach was suitable for this study because the purpose was to uncover the psychological factors that have an effect on the character of Nigerian children's responses to the Boko Haram insurgency. Creswell (2009) and Denzin (2016) argued that effective methods of inquiry in phenomenological research include observing, interviewing, conducting focus group meetings, taking reflexive notes, analyzing audiovisual materials and documents from archival records, and engaging in written reflection. The interpretive phenomenology approach allowed for insights into the study participants' lived experience with the Boko Haram insurgency.

By conducting interviews with people affected by terrorism in northeastern Nigeria, I accurately recorded the lived experiences of Nigerian children. I refrained from forming opinions based on a pre-established framework; instead, I sought to present facts. I maintained a focus on the lived experience of children affected by terrorism to determine the psychological consequences of the Boko Haram insurgency for children in

northeastern Nigeria. The study provided an enhanced understanding of how children were affected by an act of terrorism.

I employed phenomenological design in this study because it was appropriate for understanding the impact of terrorism on the educational experience of the study participants. Phenomenological research involves an attempt to understand people's perceptions of a particular situation, and it is appropriate for addressing, identifying, describing, understanding, and interpreting the experiences that people have in their day-to-day lives precisely as those people have the experiences and understand them (Levitt et al., 2017). I employed phenomenological design in this study to determine what the Boko Haram insurgency meant to the educational experience of the participants, and to provide a comprehensive description of participants' lived experience (Quinn & Clare, 2008). The use of phenomenological research designs enables efficient development of comprehensive data collection (Patterson & Dawson, 2017). From participants' personal stories, general or universal meanings can be derived.

The phenomenon of Nigerian children being affected by terrorism has not been adequately explored based on the children's perceptions. In this research, I sought to explore the impacts of Boko Haram on Nigerian children after 9 years of daily insurgency. Quinn and Clare (2008) suggested that qualitative phenomenology is useful in understanding what happens to children who have been exposed to terrorism.

The qualitative design provided an opportunity to document the lived experience of Nigerian children exposed to the Boko Haram insurgency, how they related to their exposure to terrorism, how they understood their exposure to Boko Haram terrorist

attacks, and the meaning they gave to their experience with terrorism. This method does not involve an effort to impose empirical and statistical data through logical or mathematical proof, nor does it involve an attempt to clarify individual perspectives. Quantitative research employs mathematical knowledge and empirical statements to explain data that are analyzed statistically (Creswell, 2009), so the quantitative method was not appropriate for this study. The qualitative phenomenological paradigm naturally showed the Nigerian children's case through data gathered from their experiences instead of imposing artificial data to present their case.

I conducted individual face-to-face interviews with prospective study participants who had experienced the Boko Haram insurgency in Nigeria. Questions were administered to the participants to determine their experience with and feelings about the Boko Haram insurgency. Blanchard et al. (2001) stated that the general purpose of a phenomenological study is to describe a specific phenomenon in depth based on participants' lived experience. I took notes after conducting interviews with the study participants. This research method was most appropriate for this study, through which I sought to understand the experiences of children and to develop a policy framework for policy intervention and resiliency (Cameron & Schaffer, 2001; Hyeon-Ae, 2001, p. 34).

Role of Researcher

As the researcher, I was the main instrument in this qualitative study. I identified the study area based on my professional interests and determined that the study area was valid for research through an initial literature search. As part of the research process, I developed the study prospectus and conducted a preliminary literature review to expand

on the research topic, research problem, research nature and purpose, theoretical framework, research questions, and methodology. I further narrowed down the study area into the study topic with the support of my research committee and class tutors, with whom I interacted in various courses. Among my qualifications as the researcher for this project was my experience starting in 2007 as the executive director of African Centre for Advocacy and Human Development, a nongovernmental organization that provides psychosocial support to victims of human trafficking in Nigeria. I also had practical past knowledge gained by working with children exposed to violence in Nigeria.

Between 2012 and 2016, I conducted a series of surveys to measure the psychological impacts of human trafficking on victims in Nigeria as part of projects to provide psychosocial supports to victims of human trafficking in Nigeria under the United Nations Office on Drugs and Crime Voluntary Trust Fund for Victims of Human Trafficking. As part of this process, I trained leaders of nongovernmental organizations and government agencies involved in gathering data from victims of human trafficking. I trained these leaders on how to protect the privacy and confidentiality of victims during gender-sensitive reception and interview protocols.

I also had 5 years of qualifying experience in working with people with psychological trauma as a behavior health worker (BHW) in Philadelphia. During that time, I interacted with patients, worked with psychologists and mobile therapists to develop treatments according to the diseases and symptoms diagnosed, prepared medical administration records of individual patients, monitored the behavior of patients before and after treatment, used and modeled behavioral reinforcement, intervened in the event

of crisis, provided psychological and emotional assistance to elderly and adolescent patients, and ensured that patients were not left alone. In this process, I prepared and updated patient records and other reports for administration, provided psychosocial therapy programs and activities to people with psychological disorders, and implemented programs designed to meet the social and emotional needs of clients. In sum, I had qualifying experience working with people with psychological traumas. This experience corresponded with Campbell et al.'s (2009) suggestion that researchers must have relevant knowledge of the study to be conducted.

Eisner (2017) identified the functions of researcher in phenomenology to "include, gather, organize, and analyze perceptions from people who have experienced a phenomenon" (p. 276). Following Patton's (2002) recommendation, for this study, I (a) identified study participants by contacting organizations and individuals providing services to children (e.g., IOM, parents, psychologists, and social workers); (b) organized face-to-face interviews and focus group discussion (to give feedback to study participants); and (c) audio recorded study participants to gather their perceptions. I avoided leading the study participants with gestures, facial expressions, and questions. In addition, I provided the participants with information on the study's objectives and limitations, as well as their rights. I issued this information to adults who were no longer children when this study was conducted. Participation in this study was limited to individuals between the ages of 22 and 25 years. I conducted the study without the assistance of anyone else.

To avert bias, I did not extend participation to persons who met the demographic requirements of this study but did not agree to be audio recorded. I reviewed the study participants' responses concerning their lived experiences and provided feedback to them to ensure that the conclusions that I reached reflected the research participants' perceptions. In addition, I ensured the protection of the study participants' confidentiality by avoiding leading questions, unwanted observations, intrusions, and unwanted solicitations. Further, I obtained all study participants' consent before proceeding with interviews and kept recordings and documents in a secure file cabinet.

I identified emotional and cultural attachments as potentially thorny issues to grapple with in this study. I grew up in Nigeria and shared a cultural background with some of the study participants. Brinkman and Gradle (2005) stated that power relation is at the center of qualitative study. Additionally, Finlay (2002) identified reflexivity–introspection, intersubjective reflection, mutual collaboration, and discursive deconstruction as methods to balance power relations between the researcher and study participants. To make my experiences, opinions, thoughts, and feelings visible as an acknowledged part of the research process, I kept reflexive journals and used them to write up the research. I coded reflexive notes and used them as potential data, balancing them with interviews with the study participants. I combined reflexive journals, bracketing, debriefing, member checking, and thick description and used them to create transparency in the research process (Creswell, 2009).

Methodology

Participant Selection Logic

The goal of this study was to examine the psychological consequences of the Boko Haram insurgency based on the lived experience of Nigerian children exposed to terrorism in northeastern Nigeria. Therefore, participants in this study included individuals who were children when exposed to the Boko Haram insurgency (now adult) in northeastern Nigeria. I chose purposive sampling, a nonprobability method, to identify eight primary participants for this study. The selection of eight participants for this qualitative phenomenological study aligned with the requirements for previous studies and literature on phenomenological study (Creswell, 2009; Groenewald, 2004; Welman & Kruger, 1999). This sampling method was selected based on my sense of judgment and the purpose of this study (Babbie, 2016). As noted previously, to qualify for this study, all participants needed to satisfy the following criteria:

1. enrolled in secondary school for at least 6 months during the Boko Haram insurgency from 2009 to 2010;
2. resided in northeastern Nigeria for at least 5 years after the insurgency began, and exposed to Boko Haram insurgency between 2009 and 2010;
3. between the ages of 15 and 18 during the Boko Haram insurgency (this study was conducted in 2017, when study participants were between 22 and 25 years old);
4. able to remember the events that occurred during the Boko Haram insurgency;

5. willing to provide details about, and express and explain, their lived experience during the Boko Haram insurgency.

All potential study participants satisfied all of the criteria above. Bentley and O'Conner (2014) reported that people who have experienced trauma can handle interview participation beginning 5 months after their trauma.

Participants who did not meet all of the above criteria were not allowed to participate in this study. I employed a snowballing method to identify additional participants because the initial recruitment efforts resulted in few participants. Groenewald (2004) defined "snowballing as a method of expanding the sample by asking one participant or relevant organization to recommend others for interviews" (p. 8). Specifically, I identified the study participants for the pilot study and for the regular case study through the coordinator of the refugee camp in Nigeria. Out of the eight individuals who participated in both the pilot study and the regular case study, I received contact information from seven of them from the coordinator of the refugee camp, and three were identified through the recommendation of the participants in the pilot study.

Following the recommendation of the study participants, I contacted study participants by phone and sent letters explaining the study, along with consent forms and consent-to-audio-recording forms to them. I issued written consent forms to the study participants through hand delivery. I arranged interviews for the eight selected study participants. I used the transcripts of the interviews conducted with the study participants in combination with the informed consent as the primary unit of analysis for this study

(Bless & Higson-Smith, 2000; Street, 1988). The table below provides demographic information and brief descriptions of individuals who participated in this study.

Table 1

Demography of Study Participants

Demography	Description
Age restriction	Experienced Boko Haram insurgency between the age of 15 and 18 between 2009 and 2010. Although the study participants experienced terrorism between the age of 15 and 18 years of age at the time they experienced Boko Haram insurgency, however since this study will be conducted in 2017, the average age of the study participants as at the time this study will be conducted will be between the age of 22 and 25.
Residency requirement	Resided in northeastern Nigeria for at least 5 years after the insurgency began, and exposed to Boko Haram insurgency from 2009 to 2010.
Education	Enrolled in secondary school for at least 6 months during the Boko Haram insurgency from 2009 to 2010.
Other conditions	Participants must be able to remember the events that occurred during the Boko Haram insurgency, and Participants must be willing to provide details about, and express and explain, their lived experience during the Boko Haram insurgency. All potential study participants must meet the above criteria to qualify for this study.

Instrumentation

I utilized interviews, field notes, (Locke, Maxwell, 2016; Silverman & Spirduso, 2010), a review of peer-reviewed articles (Creswell, 2003), and reports relevant to the psychological theories (Marshall & Rossman, 1999) to gather data for this study. I

developed data collection template for capturing data on psychological consequences of Boko Haram insurgency on the study participants, because I could not locate any existing tools that could be used for the study (Table 2 & Appendix C). I used the same open ended questions template to interview all study participants to gain an understanding of the individual lived experiences. This approach helped me to facilitate effective interviews that could be more easily analyzed and compared. I employed qualitative research interviews and reflexive notes described the meanings of the psychological consequences of the Boko Haram insurgency in the perception of study participants. The interviews and reflexive notes captured what the study participants said, and gained an understanding of the study participants lived experiences with Boko Haram insurgency in Nigeria (Maxwell, 2012; Ritchie, Lewis & Ormston, 2013).

I applied to Walden University Institutional Review Board (IRB) for approval to conduct the pilot study. Upon approval by IRB, I pilot-tested the interviews questions before the regular case study with selected five participants. I conducted face-to-face interviews using the same template of semi-structured interview questions to pilot-tested the interviews questions before the regular case study with selected five participants. I intentionally made use of pilot study from the beginning of this study before the actual interview. The key reasons for pilot study in this research were to ensure that methods and ideas of this study would work in the substantive interviews (Jariath et al., 2000). Second, pilot study provided an opportunity to make adjustments and revision in the main study. Third, I used pilot study to determine the feasibility of the research process within Nigeria cultural and political context (Teijlingen & Hundley, 2002). Finally, because the

study participants had experienced trauma due to the Boko Haram insurgency, I employed pilot study to identify likely adverse effects (pain, suffering, distress or lasting harm) that the interview protocols may cause, and to establish the effectiveness of actions to reduce them (e.g. counseling and schedule) (Ruxton & Colegrave 2006).

I used study codes on data documents and kept the identities of the study participants confidential to promote the confidentiality of individual participant. In other words, I ensured neither the names of the participants nor their any other identifying information were associated with the audio recording or the transcript. I was the only one who listened to the recording. I transcribed the interviews and erased the interviews on the record tape once the transcriptions were checked for accuracy. The data documents collected from the pilot study participants were securely stored in a file cabinet in my office. I assigned security codes and locked the file cabinet. I am the only one who has access to the locked security codes. The data will be preserved for 5 years, after which I will shred the data documents.

I used an audio recording device Tascam Audio digital recorder to conduct the interview with the study participants and took note (reflexive journals) during and after the interviews respectively as potential data for this study. The use of audio-recording was advantageous because it preserved the entire verbal part of the interviews for analysis. Study participants who objected to being audio recorded were not allowed to participate in this study. I kept notes that I took during the interviews and used it to write up the research findings. I obtained the written consent of the study participants for audio

recording and transcription. The informed consent includes provision for the study participant's confidentiality.

As part of the data collection process, I reviewed relevant documents and reports from NGOs such as IOM, International Rescue Committee (IRC), UNICEF, WHO, NNGOs, UNODC and Transparency International (TI) to support lietrature review for this study. The relevant documents provided continuous and regular surveys such as the psychological needs of children experiencing terrorism,. It also provide empirical data that covers other countries on the similar areas relevant to this study . The use of these manifold documents and reports, provided opportunities for new discoveries that helped me with vast amount of information, relevant to this study research questions and objective (Silverman, & Spirduso, 2010).

As the researcher in this study, I recognized that the study participants might not share their true feelings through interview because they may see me as a stranger. To overcome this challenge, I established rapport with the study participants, and explained the goals and objectives of the study to them. I provided individual participant with confidential information that their participation in the study was voluntary and anonymous. Thomas and Silverman (2015) identified building rapport with study participants, providing informed consent and informing the study participants that participation in research study will be voluntary and anonymous as the best methods to overcome the challenges of problem posed by interview as source of collection method in qualitative study.

A challenge for the use of audio recording for this study was that audio tape may malfunction. To avert this problem, I kept fresh batteries and extra voice recording tapes, and made sure the voice recording tape worked properly. Also, I occasionally stop and play back some of the interviews to ensure that the voices of the interviewees were clear and the data was recorded. When the audio recording tape malfunctioned, I stopped the interview and took reflexive notes before inserting new batteries into the audio recorder.

Following the IRB approval from Walden University (IRB approval number: 09-14-17-0431883) and, compliance with the requirements of National Health Research Ethics Committee of Nigeria (NHREC) guidelines relevant to conducting research in Nigeria, I contacted IOM, relevant nongovernmental organization, social workers, coordinator of the IDP camp in Nigeria and/or psychologists working with the study participants to facilitate the researcher's meeting with the study participants. During the meeting, I explained the nature and purpose of the study to them. Nigerian educational curriculum is fashioned after the British educational system and lessons are delivered in English language. Hence language was not a barrier to the study participants in understanding the contents of application for the meeting as well as informed consent. After securing the study participants' informed and voluntary consent to participate in the study, I conducted a pilot study with the research participants.

Pilot Study

Following the process above, I conducted a pilot study with the study participants. During the process, I administered survey questions to five participants through face- to-face interviews at the selected location in Nigeria. Prescott and Soeken (1989) defined a

pilot study as "small-scale versions of the planned study, trial runs of planned methods, or miniature versions of the anticipated research"…in order to "answer a methodological question(s) and to guide the development of the research plan" (p. 60).

The purpose of piloting the interview for this study on five respondents before data collection was to establish if the schedule is clear, and to understand the capability of the respondents of answering the research questions, and to determine if any changes to the interview schedule are required (Gil et al., 2008). The pilot study also allowed the study participants to have prior knowledge about the research topic. Campbell et al. (2009) suggested that research participants should have prior knowledge about the topic of research in trauma related studies. Participants' reactions to questions were individualized. For Goodrum and Keys (2007), pilot interviews will enable the researcher to determine terms that should be avoided during regular case study interviews.

As noted earlier, I intended to identify study participants through contact with IOM, parents, social workers, psychologists, and/or local non- governmental organizations working with the prospective study exposed to terrorism in Nigeria. However, when I arrived in Nigeria, I discovered that IOM is not providing direct support to the study participants; rather it funded nonprofit organizations that provided support to people affected by Boko Haram insurgency in Nigeria. The IOM funded organizations have lost contact with the prospective study participants. There are many IDP camps in Nigeria; I identified the study participants through the coordinator of one of the refugee camp in Nigeria. After the study participants' informed consent to participate in the

study were secured, I used pilot study and administered an initial survey questionnaire for five participants selected through purposive sampling. I utilized face- to- face interview with open-ended questions for interviews and questionnaires to elicit information from the five study participants. For the purpose of this study, the purpose of face- to -face discussions with the participants were to gather the feelings, expectations, and concerns of the target samples (Wilkson & Birmingham, 2003).

Following these procedures, regular case study interviews were conducted to capture the experiences and feelings of eight participants. The eight participants included the five that participated in the pilot study. Samples size follows existing literature recommendations. For example, Creswell (2009) recommended a sample size between five and twenty-five participants for phenomenological studies. Similarly, Morse (1994) suggested at least six participants when collecting data for phenomenological studies.

During the pilot study as well as regular case study interview, I recorded notes, listened and asked questions to capture individual experiences of the study's participants, and their thoughts. I interviewed and analyzed the study participants' point of view based on the interviews and reflexive notes. I stored all collected information in Word document files and the documents will keep it for 5 years. I am maintaining a password on protected flash data memory storage.

To avoid the danger of exposing the interviewees' self-perceived mental disorder challenges, as well as reducing the psychological pressure of what other people might think about individual study participants, I conducted interviews with individual participants in a place that was visible to other household members or other study

participants but out of earshot (Chikwanha, 2005). I was the only one that involved in the administration of the interviews (Khan & Ara, 1983). Furthermore, I periodically reminded the study participants that their privacy will be protected. The interview took place in Nigeria because that is where the victims of Boko Haram insurgency that fits this study presently lives. The lengths of interviews for this study were 30 minutes. This aligns with literature (May, 1991) on recommended time and duration for conducting interviews in phenomenological study. I also conducted one follow discussion with the same study participants lasting 20 minutes to confirm their feelings on the information elicited from them through interviews and note taking. This ensured transparency and accountability of the data collection as the respondents had opportunity to find out if the researcher's analysis reflects the feelings of the study participants.

I employed Colaizzi's (1978) method of phenomenological enquiry to extract data from the study participants through individual interview, organize the data, and used it analyze data. The cassettes were occasionally replayed during the interviews to ensure that the voice of the study participants was clear, and after the interview, I listened to the recording and make notes. When the interview was completed, I put a debriefing protocol in place. The purpose of debriefing was to allow me to deal with the issue of deception, issues of withholding information, and harmful effects of participating in the research (Cozby, 2009; Fanning & Graba, 2007; Kaplan, Lancu & Bodner, 2003; and Sawyer et al., 2016). During debriefing, I informed the study participants the purpose, and implications of participating in this study. Following debriefing, I "transcribed keywords, phrases and statements in order to allow the voices of each participant to

speak" (Groenewald, 2004; p. 14). Finally, I presented the findings of the interviews to the study participants.

Data Collection and Analysis

The data for this qualitative phenomenology was collected from the combination of individual face-to-face interviews, reflexive notes, peer-reviewed journals, and pieces of literature that related to the psychological impacts of terrorism on the children (Groenewald, 2004). Activities for the interview included signing of consent form, building rapport and gathered information about the individual study participants lived experience with the Boko Haram insurgency in northeastern, Nigeria.

Through pilot study, I administered 28 primary survey questions to five participants through face to face meetings in Nigeria. Before administering the survey questions, I obtained a written informed and voluntary consent of each study participants. The data gathered through the pilot study provided related information about the challenges and factors that influenced the experiences of the affected study participants (Axinn & Pearce, 2006; McCormick, 2011; Sallman, 2010; Wilkson & Birmingham, 2003).

After the pilot study, I conducted one-on-one discussions to capture the experiences and feelings of the eight study participants. All of the participants received an identical set of open-ended questions. The participants were asked to provide responses to the interview questions. The interview collected background information from the participants. It also focused on asking the participants about this study research questions. I relied on the interview protocol to ask each of the participant on how their

experience with the Boko Haram insurgency had affected them psychologically and educationally. I also asked the participants about the nature of services they received to cope with their trauma. In addition, I asked them to identify which of the services promote coping and adjustment, as well as the barriers they encountered to receiving mental health services.

The table below provides description of a mini version of the interview questions and the corresponding research questions. The full list of interview questions and the corresponding research questions is in Appendix C.

Table 2

Survey Questions and Corresponding Research Questions

Survey question no.	Question	Corresponding RQ(s)
1	Can you tell me your experience related to Boko Haram insurgency?	1
2	What kinds of things raise your stress level (e.g., school, family, neighbors)?	1, 2
3	Can you tell me your schooling experience before Boko Haram insurgency?	1, 2
4	What was your schooling experience after experiencing Boko Haram terrorism?	2
5	What kind of psychological-related concerns do you have for your education? Can you communicate discomfort?	3
6	Can you share with me what programs and services available to you following your exposure to terrorism?	3
7	What coping strategies do you practice to manage your trauma?	3, 4

Consequently, the consistency of these prompts depended on the participants' openness to honestly respond to the interview questions. Also, I designed the interview

to align with the Piaget Cognitive Development Theory (Schemas –building blocks of knowledge, adaptation processes- equilibrium, assimilation, and accommodation) and Punctuated Equilibrium Theory. I bracketed my feelings to get a real shared experience of the study participants' experiences with Boko Haram insurgency.

Following data gathering, the review of literature and peer journals**,** I put a debriefing structure in place. The purpose of debriefing was for me to deal with issues of withholding information, deception, and potentially harmful effects of participation in the study (Cozby, 2009). I informed the participants about the reasonable purpose of the research study. Following this step, I categorized the participants' information to identify any patterns representing the participants during the data collection phase. I employed Colaizzi's (1978) strategy of descriptive phenomenological data analysis to organize data into thought, idea, arguments, reason, and principles. The summaries brought meaning to the manuscript of notes. Edward and Welch (2011) stated that Colaizzi's (1978) descriptive phenomenological data analysis is suitable for extracting, organizing, and analyzing such narrative dataset. They write,

> Colaizzi (1978) is suitable in transcribing, extracting, creating formulated meanings, aggregating formulated meanings into theme clusters, developing an exhaustive description [that is, a comprehensive description of the experience as articulated by participants], interprete analysis of symbolic representation, identifying the fundamental structure of the phenomenon, and returning to participants for validation in narrating dataset in qualitative phenomenological study (p. 165).

The detailed information about the research questions, interview questions, and themes is attached as Appendix C.

Data Analysis Plans

The formulation of interview questions was driven by the research questions. There was a clear connection between methodology, research questions, and interview questions (Maxwell, 2012). I ascribed fictitious name to each of the participant to protect their privacy. I transcribed verbatim all interviews and reflexive into Microsoft word document. I manually transcribed the data using Colaizzi's (1978) strategy of descriptive phenomenological data analysis.

The fieldwork was expensive, tedious and rigorous. I flew for 10 hours from United States and spent two months in Nigeria to gather the data. The gatherings of data on the topics of psychological impacts of Boko Haram on the lived experience of the study participants were emotional, stressful and difficult. A meticulous organizational skill was applied in coordinating, scheduling interviews, transcription, and data analysis. I maintained accurate records of all communications, actions, procedural steps, and decisions. Table 4, presents the relationship between the research questions, the interview questions, and the review of records.

Trustworthiness

Credibility

I developed this study in order to understand the psychological consequences of the Boko Haram insurgency on Nigerian children. The goal of qualitative research was to achieve truth (Dillaway, Lysack & Luborsky, 2017). Phenomenological design

contributes to truth because it obtains stories of people affected by phenomenon and present it based on the perspective of the people. I equated the issues of trustworthiness in this research to credibility and validity of a qualitative study (Polit, & Beck, 2012). Guba and Lincoln (2004) identified credibility, transferability, dependability, confirmability, intra-and intercoder reliability as the methods for measuring trustworthiness in qualitative research. To enhance credibility, I gathered data from individual study participant through personal interviews; I took notes, and gathered information from literature review to develop data collection. I employed member checking to enhance the study credibility. Miles et al. (2013) and Patton (2014) argued that member checking allows participants to review transcripts of their interview sessions to ensure that it accurately presented their views. I provided transcripts of the interviews were provided to the study participants to confirm its accuracy.

Transferability

Patton (2014) argued that the transferability of a qualitative study depends on the ability of the researcher to provide a rich and thick description so that readers can compare the study to other situations. I developed a comprehensive data collection by interviewing participants who experienced the Boko Haram insurgency in northeastern, Nigeria. The theoretical framework relevant to understanding children cognitive development was employed for this study. Miles et al., (2013) stated that compliance with theoretical frameworks ensure transferability. The literature review, official documents taken from peer-reviewed journals to analyze this study were accurate and valid, as they are related to psychological consequences of terrorism that were sourced

from peer review articles and official documents (Creswell, 2003). The findings of this study are relevant to similar situations facing the same problem as addressed in the study (Patton, 2014).

Dependability

I provided accurate descriptions of the sample, setting, procedural steps, and analysis in other to achieve dependability. Through thick description of the study processes, dependability occurred (Guba &Lincoln, 1994).

Confirmability

In other to relate the study's interpretations and findings to its data collection, I ensured that the questions drove the formulation of interview questions. Hence, the data collection formed the foundation of the study's analysis. Direct quotes from the study participants were incorporate into the study where necessary to support analysis and study outcomes.

Ethical Procedures and Assurances

Access to study participants. Approval of IRB to gain access to participants, their treatment, protections, and maintaining confidential data were the issues of ethical considerations for this study. I secured the IRB approval from Walden University before gaining access to the study participants. I conducted the study under Walden University's Institutional Review Board approval number 09-14-17-0431883.

Consent. I recognized the sensitive nature of the discussion topics as well as the disposition of Nigerians in sharing personal information related to mental health illnesses. This study recognizes and acknowledges the potential risks of recalling and reflecting on

the life experience of people related to psychological impact of the Boko Haram terrorism. Discussions on terrorism with the study participants may evoke distressed feelings of anger, grief, frustration, despair and anxiety. Emotional reactions may interfere with the participant's ability to articulate feelings about their experiences with Boko Haram. To address these challenges, I conducted pilot study with five study participants to identify adverse effects that the study procedure may cause, and put in place actions to reduce them. I also obtained the informed consent of the study participants prior to pilot study and substantive interviews. As part of the process, I offered the participants the option to decline a question and withdraw from this study if they feel unease or unable to continue. Consent to participate in the study was voluntary, and consent was established by signing the consent form. Participants were also encouraged to contact me in the event that they experience distress following the interview.

I also debriefed the participants at the end of the interview and provided them the space to share their reflections if they wanted. The study participants are between the ages of 22 to 25 years and were able to comprehend this disclosure. Nigeria educational system is taught in English, hence there was no challenge with understanding the content of the letter of consent. Specifically, I obtained the "Informed Consent to Participate Letter" from each of the study participants. I informed the participants that I will conduct the study, the goal and objectives this study, as well as how the study data will be used. In addition, I explained to the study participants that participation in the study was voluntary and they can withdraw from the study at any time.

Confidentiality. In other to ensure safety and support, and maintain confidentiality of the study participants, I informed participants how the information they will provide will be used, how data will be stored, and how the result will be presented. As such, participants were informed of their rights as a participant of the study and the potential, though improbable, risks in being a part of the study. Participants were required to sign an informed consent before they may take part in the study. For their reference, each of the participants was given a copy of the informed consent form after the interview. I labelled the data collected from the study participants anonymous to ensure that each of the study participant's privacy is protected. This will avert any adverse public and government reactions for revealing the mental health challenges as well as support available to the participants. I informed the study participants that findings from the study will be shared with them after approval by Walden University. This will enable me to debrief the participants before public dissemination.

Data storage. The data was kept in flash drive and password and assigned to the documents. Hard copies of the data were saved securely in a file cabinet for the duration of five years in the researcher's office. I will shred the data with shredding machines after 5 years.

Summary

This chapter presented the research design for conducting a phenomenological study of the psychological consequences of terrorism on Nigerian children. The research findings were presented in Chapter 4. The interpretation of the results and suggestions on

the psychological impacts of terrorism on children's cognitive development and resilience will be presented in Chapter 5.

Chapter 4: Results

Introduction

Nigerian children whose mental health has been affected by the Boko Haram insurgency are being overlooked because there has been no comprehensive mental health plan or social program to cater to their needs (Schininá et al., 2016). The ongoing acts of terrorism perpetrated by Boko Haram in Nigeria have created a need for research to understand the psychological effects of terrorism on Nigerian children and then to determine what programs and other forms of support are available to help them cope with the trauma of terrorism. Along with malnutrition, studies have identified strange behaviors, cognitive impairment, numbing, fear, avoidance, and recurring flashbacks as common effects of exposure to terrorism in children (see, for example, Halevi, Djalovski, Vengrober, & Feldman, 2016; McLeod, 2015; Rosshandler et al., 2016). To help them cope, what is needed is strong social support from families, functional parenting, community attachment, religion, and school-based cognitive-behavioral therapy (Ager et al., 2010; Dobson & Dobson, 2009; Friedman & Cohen, 2009; Harris et al., 2008).

The data analyzed in this study were collected through face-to-face interviews with eight people who met demographic requirements, of which five participated in the pilot study, as described in Chapter 3. Participants provided detailed descriptions of their psychological experience with being exposed to the Boko Haram insurgency in Nigeria. The following five research questions were used to drive data collection:

RQ1: What are the adverse psychological effects of the Boko Haram insurgency on Nigerian children residing in northeastern, Nigeria?

RQ2: How has terrorism impacted the educational experience of children in northeastern, Nigeria?

RQ3: What programs and services were available and perceived by the interviewed children as being helpful in improving their coping with the effects of terrorism?

RQ4: What programs and/or services may help to promote coping and adjustment for Nigerian children affected by terrorism residing in northeastern, Nigeria?

RQ5: What are the barriers to improving the mental health of the children of Nigeria?

The participants' narratives were interpreted, and the following four themes emerged: (a) emotional sadness, grief, and sorrow; (b) struggling with education; (c) coping and support structure: prayer as robust support system; and (d) social implications of therapy. This chapter documents the process of recruitment, the pilot study, the substantive study, the profile of the participants, methods of data gathering, data storage, data analysis, and identification of themes and trustworthiness.

Before the substantive study, five participants were selected to take part in the pilot study. The five participants were also among the eight individuals who participated in the regular case study. I included the pilot-study participants in the main study to secure the required number of study participants in the main study, because doing otherwise would have resulted in too small a sample in the main study. The purposive sampling was used to select eight participants for the substantive study, in which each

participant was interviewed according to a template of questions. The selected eight participants provided comprehensive information about their lived experiences with the Boko Haram insurgency. The following sections explain the conduct of the pilot study, the participants' profiles, the data gathering method, the methods of data preservation, and the identification and documentation of the themes.

Description of the Conduct of the Pilot Study

The purpose of the pilot study was to understand whether the respondents could answer the research questions and to determine whether any changes to the interview schedule were required (Gil et al., 2008). The pilot study also alerted the participants that the topic of the research was related to trauma (Campbell et al., 2009). Initial interviews were conducted with five participants, all of whom met the study's demographic criteria. Participants in the pilot study and the substantive study were located in Nigeria. The coordinator explained that the best method to initiate contact with the participants was through phone calls and that the best way to deliver documents was through hand delivery to them on Wednesday at the IDP camp in Nigeria. All recommendations were followed. I (a) obtained telephone contact information for the participants from the coordinator, (b) contacted participants by telephone, (c) invited them to participate in this study, (d) determined if they wished to participate, and (e) determined whether they were qualified to participate. Five participants took part in the pilot study, and eight recruits were selected for the general case study. The five participants for the pilot study were part of the final eight participants selected for the substantive study. Morse (1994) suggested at least six participants for data collection in a phenomenological study.

I hand delivered letters explaining the study, along with consent forms and consent-to-audio-recording forms, to each of the participants in Nigeria. If they were willing to participate in the study, recruits were asked to hand deliver all completed consent forms to me (see Appendices A and B). Data collection involved the demographic questionnaire as set out in Table 1. The structured research questions administered to all study participants for interviews corresponded to the survey and research questions as described in Table 2.

Face-to-face interviews were conducted in Nigeria at locations convenient to the participants. I digitally recorded the interviews, transcribed them, and stored the results in a locked filing cabinet in my office. Before completing verification procedures, I removed all identifying information.

The pilot interviews affected the substantive interviews. I became familiar with the nature of conducting interviews with the participants. The pilot interviews also provided ample opportunity to build rapport with the participants. In addition, the pilot study enabled me to determine the potential risks of discussing the psychological impacts of Boko Haram on the participants. At the end of the interview, the participants were provided the opportunity to reflect on the questions. This allowed them to be at ease and objectively express their experiences with Boko Haram during the substantive interviews.

Setting

The intended recruitment venue for participants for the pilot study and substantive study was the IOM's office in Nigeria. Initially, my reason for choosing the IOM office for the recruitment of participants for this study was that IOM was providing

psychological and social support to victims of the Boko Haram insurgency in Nigeria. However, upon getting to Nigeria, I found out that the IOM office did not provide direct support to the victims of the Boko Haram insurgency in Nigeria. Instead, IOM was funding organizations to provide services to the study participants. These organizations are no longer providing services to the study participants. Due to these challenges, another alternative was pursued to identify and recruit the study participants.

As an alternative means of participant recruitment for the study, I contacted the coordinator of the IDP camp in Nigeria, where most of the refugees who relocated from northeastern Nigeria first resided before dispersing to their various locations in Nigeria. Most internally displaced persons (IDP) in Nigeria registered with the IDP coordinators at various IDP camps in Nigeria and remained in constant and consistent touch with them. The coordinator recommended to me on how to locate the study participants. First, the coordinator advised me to either contact the prospective participants with by phone or to visit the IDP camp on Wednesday if I decided to meet them face to face because they reported to the camp every Wednesday for verification exercises. Second, the Coordinator recommended that documents be hand delivered to the study participants rather than using a courier. I followed the IDP coordinator's recommendations and visited the camp to recruit study participants. I also visited the study participants in one of the IDP camps in Nigeria on a Wednesday and delivered consent forms and audio-recording forms to them at agreed-upon locations in Nigeria. This in no way affected the demographic requirements.

The eight participants in the substantive study met the demographic requirements for this study. All participants resided in Nigeria at the time the interviews were conducted. The interviews were conducted through face-to-face interactions with the study participants. This allowed me to observe their body language and establish rapport with them. The data analysis provided further information regarding each participant's attendance and participation in the study.

Demographics

Participants selected for the pilot study were two females and three males who were Nigerian, had experienced the Boko Haram insurgency between 2009 and 2010, and were between the ages of 15 and 18 between 2009 and 2010, with current ages ranging between 22 and 25 years. All participants had resided in northeastern Nigeria for at least 5 years after the insurgency began, had been exposed to the Boko Haram insurgency between 2009 and 2010, and had been enrolled in secondary school for at least 6 months during the Boko Haram insurgency from 2009 to 2010. Additionally, all of the participants were able to remember the events that occurred during the Boko Haram insurgency and willingly provided details about their lived experience during the Boko Haram insurgency.

Demographic Profile of the Study Participants

The description below provides a brief description of each study participants. Due to the study participants' confidentiality, the participants' names were changed, and rough approximations of their age was provided.

Aisha. Participant 1, Aisha, was a 24-year-old Nigerian woman who was born in northeastern part of Nigeria and resided there continually until 2016. She worked as a volunteer at the IDP camp in Nigeria. Aisha experienced the Boko Haram insurgency from 2009 to 2016. Aisha also experienced a Boko Haram attack on her secondary school in 2015. During the Boko Haram attack, her class teacher was abducted. She lived in Nigeria and chose to participate in the pilot study and the substantive study through face-to-face interview with me at the IDP camp in Nigeria.

Amina. Participant 2, Amina, was a 25-year-old Nigerian woman. She was born in northeastern, Nigeria and resided there until 2016. Amina schooled in Nigeria and resided in Nigeria at the time of the study. Amina was recommended for this study by Moses (Participant 5), who knew Amina from northeastern Nigeria. Amina's parents were killed by Boko Haram. Amina participated in the pilot and substantive study.

Aremu. Participant 3, Aremu, was a 24-year-old Nigerian man who was born in Nigeria and attended primary and high school in northeastern, Nigeria. Aremu lived in Nigeria at the time of the study and worked as a volunteer at the IDP camp. Aremu experienced Boko Haram attacks at school and at home. He witnessed a Boko Haram attack in Nigeria, during which his sister was killed and his grandmother was abducted. He was recommended to me by the national coordinator of the IDP camp in Nigeria. Aremu resided in Nigeria and chose to complete a face-to-face interview with me at the IDP camp due to convenience. He participated in the pilot and substantive study.

Yakubu. Participant 4, Yakubu, was a 25-year-old Nigerian man who was born and schooled in northeastern Nigeria. Yakubu lived with his uncle in Nigeria at the time

of the study and was working as a fruit and vegetable seller. He heard about this study from Amina (Participant 2) and contacted the IDP camp coordinator to indicate his interest and participate in this study. He chose to be interviewed face to face. He participated in the pilot study and substantive study.

Moses. Participant 5, Moses, was a 24-year-old Nigerian man who lived with his elder brother in Nigeria at the time of the study. Moses was schooled in northeastern Nigeria and witnessed Boko Haram attacks on his school and village. Moses did not know the present location of his parents because they had been displaced due to Boko Haram violence. He believed that his parents were currently displaced to Cameroon. Moses was recruited into this program through phone calls. I obtained his contact phone number through the IDP camp coordinator in Nigeria. He chose to participate in the substantive study through face-to-face interview with me in Nigeria.

Participants 1 to 5 were included in the pilot study and the substantive study, and Participants 6 to 8 took part in the substantive study.

Shehu. Participant 6, Shehu, was a 23-year-old Nigerian man who was born and schooled in northeastern Nigeria. Shehu experienced the Boko Haram insurgency in Nigeria. Shehu lived in Nigeria at the time of the study and worked as a security guard. He also registered for Joint Examination Matriculation Board Exams (JAMB) for university admission. Shehu was recommended for this study by the IDP camp coordinator. He participated in the substantive study through a face-to-face interview conducted in Nigeria.

Garba. Participant 7, Garba, was a 25-year-old Nigerian man who resided in northeastern Nigeria at the time of the study. Garba was schooled in Nigeria and experienced the Boko Haram insurgency. Garba participated in the substantive study. Moses (Participant 5) recommended Garba for the study. He chose to be interviewed face to face in Nigeria.

Hussianah. Participant 8, Hussianah, was a 24-year-old woman who received her high school education in northeastern Nigeria. Hussianah experienced the Boko Haram insurgency in Nigeria. She lived in Nigeria at the time of the study. I received her contact information through the IDP camp coordinator in Nigeria. She chose to be interviewed face to face in Nigeria. Table 3 provides a summary of the study participants' demographics.

Table 3

Demographics of the Study Participants

Reference	Religion	Gender	Age	Level of education
Participant 1	Christian	F	24	High school
Participant 2	Christian	F	25	High school
Participant 3	Muslim	M	24	High school
Participant 4	Muslim	M	25	High school
Participant 5	Muslim	M	24	High school
Participant 6	Christian	M	23	High school
Participant 7	Muslim	M	25	High school
Participant 8	Christian	F	24	High school

Data Collection

I interviewed eight participants (of which five participated in the pilot study) using the same semistructured interview template. Interviews were digitally recorded. Consent forms for the interview and audio recording were reviewed with the study participants at the beginning of each interview, when I handed the consent forms directly to each participant. The mood was calm, and the majority of the participants greeted me enthusiastically. However, there was uneasiness and frustration reflected in their body language as they began to speak about their experience related to Boko Haram attacks. Many of the participants experienced difficulty finding accurate words to describe their feelings and shifted thought processes midsentence. Three of the participants wept when they narrated their experiences, and two participants smiled when they described how they ran to the mountain when Boko Haram invaded their communities or when there were early signs of impending attack. Each of the participants was interviewed in English with structured interview questions and was recorded with a Tascam digital audio recorder.

Data from the interviews were transcribed, filed and saved in my private computer and later transferred to the researcher's and locked in file cabinet in my office in Nigeria. The location for the data collection was Nigeria. Although I envisaged that each interview would last 30 minutes in chapter 3; however, each interview lasted between 25 and 35 minutes with frequent short pauses. All identifying information was removed from the transcripts before verification procedures. I was calm and remained empathetic throughout the interview process.

I felt a sense of relief from the study participants after they shared their stories. They thanked me for allowing them to share their stories. To capture the true essence of the experience, maintain objectivity, and set aside my own emotions, I utilized bracketing and followed the procedures discussed in chapter 3. I kept reflexive journal and described my feelings before and after each interview.

The initial data collection process was to mail a letter explaining the study purpose of the study, consent forms, and consent to audio-recording forms to the participants. However, during the main study, I hand delivered all the forms to the study participants at IDP camp in Nigeria. I requested participants to return the completed consent forms by mail if they are willing to participate in the study to me. During data collection, there was no unusual circumstance recorded. All participants responded to the interview questions within the allotted time.

Data Analysis

The findings from this study emanated from the qualitative phenomenological study of the lived experience of the participants exposed to the Boko Haram insurgency in northeastern Nigeria. These documents became the working transcripts for analysis and coding purposes. Colaizzi's (1978) methodological approach was employed to elicit an exhaustive description about the phenomenon regarding the study participants' experience with the Boko Haram insurgency. Sanders (2003), Speziale and Carpenter (2007) listed the following steps as Colaizzi process for phenomenological data analysis:

1. Each transcript should be read and re-read in order to obtain a general sense about the whole content.

2. For each transcript, significant statements that pertain to the phenomenon under study should be extracted. These statements must be recorded on a separate sheet noting their pages and lines numbers.
3. Meanings should be formulated from these significant statements.
4. The formulated meanings should be sorted into categories, clusters of themes, and themes.
5. The findings of the study should be integrated into an exhaustive description of the phenomenon under study.
6. The fundamental structure of the phenomenon should be described.
7. Finally, validation of the findings should be sought from the research participants to compare the researcher's descriptive results with their experiences (as cited in Sanders, 2003; Speziale & Carpenter, 2007).

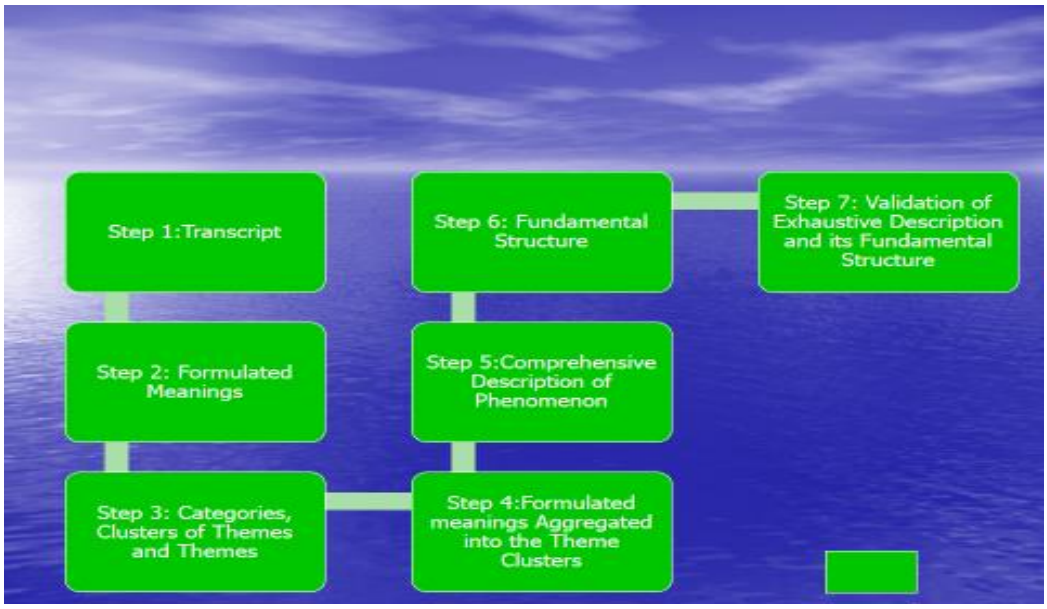

Figure 1. Summary of Colaizzi's strategy for phenomenological data analysis.

The first step in Colaizzi's (1978) methodological approach after the researcher has immersed himself with the data is to transcribe all the subject descriptions (Edwin & Welch, 2001). I conducted an initial review, read and reread each of the reproduced data seven times to gain a deeper understanding of what the data were providing (Collaizzi, 1978, p.59; Giorgi & Giorgi, 2003).

The second step in Colaizzi's method is to extract significant statements that are directly related to the phenomenon under investigation. I reviewed substantial sentences and key phrases relevant to the psychological consequences of terrorism and educational experience as well as programs and support available to the study participants to cope with their trauma and barriers that exist to receiving mental health diagnosis and treatment as presented in the data by the study participants. To achieve this, I employed multiple qualitative data analysis techniques to identify key phrases.

These observational techniques include the identification of repetitive words, identifying similarities and differences, recognized transition in narratives, and utilized cut and sort to categorized statements (Bernard & Ryan, 2010). I extracted repetitive statements and removed them from the transcript; this aligns with Colaizzi's suggestions that repeated statements may be eliminated when compiling the significant statement. I coded key phrases and statements manually to represent preliminary theme clusters.

Colaizzi recommended creating formulated meaning in step three. Colazzi, (1978) described formulated meaning as the process where meaning of each significant statement are spelt out. In other words, I moved from what the participants said to what the participant means while maintaining the substance connected to the description.

In step four, step three was repeated to validate formulated meanings. Formulated meanings were aggregated into the theme clusters. I grouped the expressed meanings into the theme clusters. An initial review of data 22 cluster themes was identified, upon further review and analysis, 12 themes were determined. I further review the essential statements, formulated meanings, and cluster themes; and then reduced the cluster themes to 8. A further review led to the emergence of four emergent independent themes.

In step five and six, I developed a comprehensive description of the lived experience of the study participant psychological and educational experience related to exposure to Boko Haram insurgency as articulated by each of the study participant and was presented in the dissertation. In step seven, I conducted a rigorous analysis of the lived experience of the study participants and identified the fundamental structure of the phenomenon (Edward, & Welch, 2001; Polit & Beck, 2012, p.591).

Colaizzi (1978) recommended the development of an exhaustive description of the phenomenon through integration of the significant statements, theme clusters, and emergent theme to present a robust description of the lived experiences of the study participants in step seven. Polit & Beck (2012) also recommended that second interview be conducted with each participant to confirm the findings. In step seven, I recycled the findings of the study back to the study participants for validation or member checking. To achieve this, follow-up appointments to each of the study participants to validate the essence of the phenomenon with the participants were made. During the meeting, each of the study participants was provided with a list of themes and descriptions of their

accounts for review. There were no alterations or additional information that emerged from the follow-up

Discrepant Cases

When the transcription of the participants' interview was completed, along with the review of the reflexive notes, there were no cases or evidence of disclosed discrepant cases in the research data.

Evidence of Trustworthiness

Credibility

The credibility of this study was ensured by recycling the project outcomes to the participants for accuracy and validation before moving the verbatim transcript to the next level of organizations and analysis. Data for this study were collected from multiple sources. Maxwell (2012) and Miles et al. (2013) argued that researcher should ensure that information gathered reflects an accurate representation of historical events relevant to the objective of the study. I interviewed participants who experienced Boko Haram insurgency in northeastern Nigeria. I also reviewed literature relevant to the psychological consequences of terrorism to children.

Validity

I ensured validity through member checking. Member checking allows study participants to review the transcripts of their interviews and verify, edit, or expand on the interview material if they desired (Carlson, 2010). I made a follow-up appointment to each of the study participants to verify and clarify portions of the interview. During the meeting, each of the participants was provided with the list of the themes and description

of their accounts to review. Participants were asked to add any comments they felt were essential to the interviews content that were not mentioned during the interviews. All the eight participants participated separately in the member check. Member checking aligns with Moustakas (2008) position that, sharing data with study participants through member further validates the degree of trust in the descriptions of their experiences along with the use of journaling. I also bracket my personal preconceptions and biases based on personal and experiential experience. I assigned time for each interview to reflect on my personal feelings, ponder specific issues that were anticipated, and inventory of my beliefs. Documentation of this period of pre-reflection occurred in my journal before each interview.

The participants for this study were selected because they had experienced the phenomenon. Each participant had an experience with Boko Haram insurgency in northeastern Nigeria. I confirmed their participation by reviewing demographic requirements for participating in this study with them. I also confirmed that participants were refugee who experienced Boko Haram insurgency from northeastern Nigeria from the refugee register log through the coordinator of IDP camp in Nigeria. All of the transcripts for the interviews will be retained for five years. All eight interview transcripts were shared accordingly, and the validated scripts were imported into Microsoft Word document for further organization.

Transferability

I placed guided value in the description of the demographic requirements of the study participants. The views of the participants were clarified, and thick description was

provided on how the study participants were selected. The setting of each interview also ensures that this research data will provide transferability to other parts of Nigeria where terrorism is being experienced. As indicated in Chapter 2, Boko Haram activities occurred throughout the entire northeast and in Abuja and Nasarawa (northcentral) of Nigeria, and since there was lack of varied study participants' experiences across the entire northeast for this study: not all study participants comes from the entire northeast and northcentral Nigeria and as such the experiences of the study participants expressed in this study may not reflect the views and experiences of other children in Nigeria. Therefore, I made it known that the study was based on the lived experiences and perception of the study participants that had experienced Boko Haram violent attacks.

In Chapter 3, I indicated that members check, thick description and audit trails will be used to address the issue of transferability in this study. Members check, thick description and audit trail were used as quality measures for this study. The participants selected for this study were victims of Boko Haram insurgency in northeastern Nigeria that met the demographic requirements in Table 1, as such I mentioned to them the benefits of their participation. I also mentioned to the study participants that there were no compensation for their participation in this study and as such participation was voluntary. During the second contacts with the study participants, I informed them that they will have access to the transcribed interviews. This ensured the accuracy of their statements as well as provided them with level of comfort to give through objective of their lived experiences with Boko Haram insurgency. This member check also helped me to establish rapport and trust with the participants.

I utilized field note to organize data for this study. Demographic categories, thick description were used to categorize themes and create tables. Tables were created to identify the study participants' names (vague names), age, religion and level of education. Field note, transcribed interviews, and audio recording device, are maintained and locked in a secure cabinet.

Dependability

I ensured that there was a synergy between the purpose of the study, research questions, methodology, and theoretical frameworks to generate dependable findings. The purpose of this study was to examine the psychological consequences Boko Haram insurgency based on the lived experience of Nigerian children exposed to terrorism in northeastern Nigeria. The interview questions were designed to understand the psychological effect of Boko Haram insurgency based on the lived experience of the study participants. The PTCD theory was employed because it measures the psychological effects of violence on children in terms of identify formation, personality structure, and adaptive and coping measures. PET was also utilized to understand how government policy impacted the psychological experience of children exposed to terrorism.

Literature review, official documents taken from peer-reviewed journals used to analyze this study are accurate and valid, as they are related to psychological consequences of terrorism on children (Creswell, 2003). In order to ensure dependability, study (e.g., Guba & Lincoln, 1994) suggested active engagement with data gathering and data analyzing are essential. Over the course of approximately 3 months, I

actively engaged in data gathering and analyzing processes. The process for recruitment of the study participants was intense, sufficient time was set aside for the interviews, as well as considerable amount of time was used to organize and analyzed the data, through which robust and accurate information was obtained.

Reliability

Qualitative research must ensure consistency. The interview protocol form used for this study noted the day, time, and setting of each interview session. I arranged the interview questions by the five research questions. Equally, data collected from interviews were already organized to provide information addressing the study's purpose. The review of literature was also organized based on the research questions. Each participant was interviewed through face-face-to-face and all interviews were recorded. I manually used Colaizzi to transcribe and analyze the data. The accurate description of the participants, setting, procedural steps, and analysis in accordance with Colaizzi's methodology, as described in Chapter 4 enhancing reliability of the research findings in Chapter 5. Digital audio interviews, interview records and reflexive notes are well handled and kept in a secured and locked in a cabinet. The data will be stored for 5 years to ensure that records are void for errors and omission.

Confirmability

To reduce the breach of study participants confidentiality and privacy as well as the possibility of intra and inter-coder reliability, I was exclusively responsible for data collection, and data analysis. To maintain consistency, I used open-ended questions that focused on the topic relevant to the psychological effect of Boko Haram insurgency on

the study participants. Following data gathering, the reviewed of literature and peer journals**,** I debrief the study participants to deal with the issue of withholding information.

Results

The purpose of this qualitative phenomenological design was to determine the psychological and educational experience of Nigerian children exposed to the Boko Haram insurgency in northeastern Nigeria. The analysis of the data of this study is based on the interviews and narratives of eight Nigerians who were between the ages of 15 and 18 when exposed to Boko Haram terrorism. The research questions guiding this study were as follows:

RQ1: What are the adverse psychological effects of Boko Haram insurgency on Nigerian children residing in northeastern, Nigeria?

RQ2: How has terrorism impacted the educational experience of children in northeastern, Nigeria?

RQ3: What programs and services are available and perceived by the interviewed children as being helpful in improving their coping with effects of terrorism?

RQ4: What programs and/or services may help promote coping and adjustment for Nigerian children affected by terrorism residing in northeastern, Nigeria?

RQ5: What are the barriers to improving the mental health of the children of Nigeria?

Relying on the actual interviews, I developed the themes and sub-themes. Also, I used some direct quotes from the study participants to document the result of this study. The section below provides the depth of the discussion of the phenomenon related to the study participants experience associated with Boko Haram insurgency.

Based on the considerable immersion in the data and careful examination of the transcribed interviews, my memo and syncopation with research questions and literature, as well as the analysis of the interviews, the following four themes emerged:

1. Emotional sadness, grief, and sorrow
2. Struggling with education
3. Coping and support structure: Prayer as robust support system
4. Social implications of therapy.

Each of the themes identified and discussed above aligned with the research questions and illustrated in Appendix C.

Detailed discussion of each of the theme identified above as related to the interviews questions will be discussed in the following paragraphs.

Theme 1: Emotional Grief, Sadness, and Sorrow

All of the participants expressed emotional distress over their direct exposure to Boko Haram insurgency in northeastern Nigeria. Participants expressed sadness, grief, shock, frustration, disbelief, anger, sleeping phobia, fear, lack of appetite, depression, emotional numbing, mourning, pain, insomnia, and anxiety, feeling of upset, worry, fear, death, injury, and avoidance, and sense of insecurity over the killings or kidnapping of either their parents, grandmother, grandfather, friends, classmates, teachers and

destruction of their farmlands and schools by Boko Haram insurgency as well as their families displacement.

When asked the question, "Tell me your experience related to Boko Haram insurgency," participants whose parents were killed by Boko Haram expressed a deep emotion of sadness, anger, helplessness, insecurity, shock, and disbelief. Aisha reported, "It was a sad day that I will never forget, I cried, and I am still crying over the killing of my mother by Boko Haram when they invaded our village at midnight." Similarly, Amina reported that "I do not have enough words to express my shock, anger, and sadness over the kidnapping of my friends and teacher in the hostel… I cried for three days, could not eat and frustrated, my eyes turned red, and my throat got dried." Yakubu expressed his emotional distress and sorrow and stated,

> I had never seen someone killed with sword in my life before my grandmother was beheaded with sword by Boko Haram … I fell into coma and was later revived, I cried, sobered and refused to eat and talk to people for two days … I was scared and confused to see my grandmother in such an abusive and degrading manner.

More so, some of the participant's emotional disturbance was aggravated by family displacement and lack of insensitivity on the part of the government to protect their lives and property, from the government. Aremu stated,

> Not only that our people were killed due to lack of government insensitivity for not providing us with security, Boko Haram also burnt down our homes,

> destroyed our farmlands, today my sister was kidnapped and her where about unknown, I learned my father is in Cameroon.

Moreover, Shehu lamented,

> One thing about my experience with Boko Haram is that today my life is shattered, my mother is dead, my father is believed to be in Cameroon border or even dead, my sister was kidnapped and either killed or forcefully married to Jihadist either in Niger or in the forest … yet all we hear from government is that Boko Haram has been degraded, I am grieved, sad and life for me is hopeless, brutish and nasty.

Similarly, participants were asked, "How did you feel about your experience with terrorism?" Yakubu narrated his feelings,

> Boko Haram invaded our town at midnight, they started shooting into the airs, I and my family ran out through the backdoor and we ran towards the mountain, only for me not to see my mother and younger sister on the mountain, when soldiers arrived and started evacuation, Allah! My mother and sister were among the dead with another 38 people massacred in cold blood. I cried uncontrollably and felt sad, grieved, insecure, hyperactive and hopeless.

Hashanah expressed similar raw emotion and stated,

> When Boko Haram attacked our village, I called my friend, but she did not pick her phone, and I called her brother only to tell me that she was kidnapped and another friend of ours killed, I was speechless, incoherent, and fainted …. I felt sad, angry, frustrated and grieved.

As the participants reminisced about their experience with Boko Haram insurgency, all the participants used the phrases “I felt sad, frustrated and grieved." Also, an emotional and devastated statement about anger, shock, flashback, fear, severe anxiety, or mistrust, nightmares and unwanted thoughts emerged as all participants continued to share their experience related to Boko Haram insurgency in Nigeria. Garba declared,

> It is a nightmare that Boko Haram invaded our town, killed our families and friends, displaced us, destroyed our schools and farmland, forcefully kidnapped our women and girls and married them into slavery, created fear in the mind of people in our town, makes us filled unsecured and mourning.

Shehu stated,

> Since our school was attacked, and my teacher and some girls were kidnapped, my desire to further my education has been disrupted, and my interest in furthering my education to become a lawyer has vanished, nevertheless, if I have the opportunity, I will still go back to school.

Shehu continued, “I have fear for the future, and cannot trust government with my security, often I am angry with what nature has presented to me.” Moscardino et al. (2007) reported similar findings that students exhibited aggression, defiant behaviors, problems following and accepting adults' directions, developed a sleeping phobia, and lack of appetite after experiencing the traumatic events . Also, Comer et al. (2010) reported similar findings among a sample population of 8,236 New York public school students that experienced September 11, 2001, terrorist attacks. Analysis of the result showed that family displacement and loss of their parental job following the 9/11 terrorist

attack in New York were found to be the reasons why the children developed ASD and PTSD symptoms. Also, these findings were consistent with severe depression, anxiety, and symptoms related to PTSD among Rwandan genocide survivors (children). On the contrary, this study did not find permanent PTSD, depression, deviant behaviors, and lack of appetite, as described by (Moscardino et al., 2007).

Family displacement, emotional grief, avoidance of discussion related to the event, headaches, emotional numbing, mourning, and families were identified as effects of terrorism on people exposed to terrorism (Pereda, 2013). The early reactions of all the study participants to the killings of friends and families, displacement and kidnapping of loved ones as experienced by the study participants did not lead to permanent mental illnesses. All these experiences lasted for few months; however, following application of coping methods, the study participants were able to overcome their challenges. This was confirmed when Hussainah stated, "Indeed, three weeks after the killing of my friends in the village, I was shocked, cried, and mourned, but as time progresses, with prayers and my family support, I was able to overcome this experience." Amina, Aisha, and Yakubu were surprised they could be narrating their experiences without crying, cursing, and developing headaches. This position is in tandem with Perada (2013) findings which reported that the psychological impacts of terrorism may not be transitory from short term to long term if proper coping methods are applied.

Theme 2: Struggling With Education

Following the attack on the schools by Boko Haram as well as the kidnapping of students and teachers that occurred frequently, children and parents were worried that

Boko Haram could carried out such devastated attacks on their lives and communities. Inspite of the government provision of military security around schools, parents withdrew their children from school and teachers refused to go back to classes. This led to the abruption of normative academics activities in schools. Theme two captures the impacts of terrorism on the educational experience of the study participants. When asked the questions, "Tell me your schooling experience before Boko Haram insurgency." "What was your schooling experience after experiencing Boko Haram terrorism?" "In what ways do you think terrorism has affected your schooling experience?" Aremu stated, "Before Boko Haram invasion, to me school was a second home, where I learned, made friends, and follow instruction." Aremu continued, "When Boko Haram came, our school and community became theatre of violence that led to the destruction of many valuable properties of government and individual such as: schools, police station, farm land and farm produce, houses, etc., and the displacement of almost all people in the village and killing of some of us". Similarly, Amina revealed,

> Normal day-to-day activities was going on before Boko Haram invaded my village, I went to school, I went to church, I went to farm to help my parents, and also I learn vocational work, but when Boko Haram came all these activities stopped due to destruction, fear, insecurity, displacement, and killing … For a very long time, I could not assimilate anything that I read, and when I eventually returned to school, my grade was poor and I cannot remember what I have read.

Amina, Aisha, Yakubu, Moses, Shehu, and Hussainah, were also withdrawn from school by their parents. The reality of the effect of Boko Haram attack on the study

participants was evident as virtually all the parents of study participants removed their children from school. As Amina stated, "all that happened in my school was that at the first stage of the attack my parent withdrew me from school, and I stayed away from school." Yakubu echoed similar position and stated,

> When the Boko Haram attack started, my parents removed me from school, but following few months of relative peace, my parents returned me to school, however, due to the fact that a friend of mine and my class teacher was kidnapped in the initial attack, I was confused and could not determine whether am safe being in school, hence I could not concentrate on my studies.

According to Gonzalez, et al. (2016), when children are exposed to terrorism, they become confused and unstable at their developmental stages. Also, exposure to severe violence causes poor concentration problems and low cognitive capacity among children (Qouta, Punamäki, & El Sarraj, 2007).

Further to confusion and instability experienced by the participants in their studies, Hashanah, Aisha, Shehu, Moses, Yakubu, and Aremu also reported that they suffered the loss of concentration in their studies as well as having difficulty remembering and processing what they have learned in school. Hashanah stated,

> Since my experience with the havoc that Boko Haram wrecked on our school, at the initial stage, if I read, I cannot assimilate anything that my teacher taught me, what ran through my mind was the devastation that our community has suffered, but as time progresses, I became good.

Shehu said, “First, my concentration is not even in my study, talk less of remembering what I have taught, every day when I go to school, I am worried that Boko Haram may invade our school and kidnapped me."

Aisha and Moses reported that they were the best student in their various school and classes before their experiences with Boko Haram attack on their school; however, following Boko Haram attacks on their various schools, they developed low concentration and low attitude to school. Aisha stated,

> Personally inside me, I resolved that I will not go to school again, and even when I went to school my morale to learn was down, however, out of respect for my parent, I only went to school without any desire to learn.

Moses reported, “Despite the fact that I was the best student in my class before the Boko Haram attack on our school, however, after Boko Haram insurgency, my school report sheet showed that I recorded poor grade with an average result." Virtually all the participants reported poor academic concentration, low morale, cognitive impairment and confusion as the effect of Boko Haram insurgency. The participant's experience confirmed Piaget cognitive development theory that when children are exposed to trauma at the operational stage, they become cognitively impaired. In addition, the study participant’s educational experience following direct exposure to Boko Haram insurgency is in parallel with Pedro (2015) argument that if a child is out of school due to exposure to violence, children may become doubtful, exhibit negative behaviors, unconstructive, lack self-reliance and becomes pessimistic about life and his or her environment, including negative attitude to schooling and positive attitudes to violence .

Further to this, the reported educational experience of the study participants with Boko Haram insurgency confirms Gonzalez et al. (2016) report that showed, poor concentration in school, and low cognitive capacity among children as the adverse effects of being exposed to violence. Besides, children who lost their parents to terrorism either by death or displacement and experiencing continuing terrorism has poor information processing and lack creativity (Olff et al., 2006). All participants acknowledged that their poor academic performance and noticeable family displacement were partly responsible for their poor assimilation and information processing. The educational experience of the participants related to Boko Haram insurgency confirmed the findings from the study conducted by Bonanno et al. (2010) identified life disruption, missed school, weak academic functioning as some of the adverse cognitive effects on children exposed to terrorism in the short term and the long term. As reported by the all the participants, they missed schools due to the closure of their schools by the government to avert further attacks on their schools and pupils, as well as their removal from school by their parents for fear of being kidnapped contributed to their poor grade and academic functioning . However, study participants did not report long-term or permanent stress.

Theme 3: Resilience Program and Support Services: Prayer as Strong Support Coping System

Functioning parental support, community support, individual children personal quality, counseling, peer support, school-based therapeutic support for treatment of trauma, administration of medication, ritual and traditions, children preparation and prior exposure, economic status, previous low levels of anxiety and depression as buffer

for adjustment in children affected by terrorism (Bonanno et al., 2005; Ciccheti, 2010; Cummings et al., 2011; Garbarino et al.,2015; Greeson, 2013; Hasija & Gray, 2007; Henrich & Shahar, 2013; Merrilees et al., 2011; Moscardino et al.,2007; Schermerhorn, Shirlow, & Cummings, 2011; Thiabtet et al., 2008; Punamaki et al., 2015). Religiosity, culture, and tradition may also provide a buffer for children to cope with their trauma (Gaffney, 2006).

Participants reported programs and support services that helped them to cope with the trauma of being exposed to terrorism. When asked these questions, "Can you share with me what programs and services available to you following your exposure to terrorism"? There are some beliefs and views of mental health, and treatment that can stand as barriers for seeking psychological support, in your opinion what do you think constitutes mental "? " Can you share with me a little bit about the type of programs and support you have received"? "What kind of psychological issues was addressed in the therapy"?

All the study participants received support from families, non-governmental organizations, religious institutions (Churches and Mosque) and temporary shelter support from the government in the IDP camp. This support is partly instrumental to coping with their trauma. Majority of the participants identified prayers and religious support as the primary way to deal with their psychological trauma. Moses reported,

> I did receive counseling support from church and as a Christian; I read my Bible, prayed and fasted. I also received clothes, foods, and finance occasionally support from Government, friends and non-governmental organizations … my

> brother has also been helpful in sheltering me presently in Abuja. The government provided me first shelter at IDP camp and feeding; they also provided blankets and security around the camp.

Amina expressed similar feelings when she said,

> I observed my prayers daily and fasted, at the initial stage of the attack, government provided security in around our village but when the attack became consistent, government relocated me to the IDP camp and also provided daily feeding and blanket in the camp, I have also received vocational job training in the IDP camp with support from some foundations and NGOs that came to the camp, as well as one time fifty thousand naira (equivalent of $150) from an NGO.

Equally, Aisha reported, "All I did to cope with my worries was that I drew closer to my religion, which I think gave me to comfort and courage to overcome my challenges." The findings from this study again further emphasize the importance of religiosity and strong family support as a protective and effective intervention program for children exposed to terrorism (Ager et al., 2010; Hughes, Joslyn, Wojton, O'Reilly, & Dworkin, 2016).

When asked the questions, "Which formal and informal respite services and support do you receive?" Aisha stated, "The Muslim Cleric came to pray with me, and Nelson Mandela Foundation also gave me stipends and free vocational job training". Moses also echoed similar remarks and said, "My Pastor visited me and encouraged me in the Bible, gave me some money and clothes, while Nelson Mandela Foundation also offered me free vocational training in bead-making". All the study participants

acknowledged that they received support from families, non-governmental organizations, religious institutions (Churches and Mosque) and temporary shelter support from the government in the IDP camp.

All the participants identified prayers and religious support as the primary way to deal with their psychological trauma. When asked the questions, "Do you have any rituals that you find helpful…? Your parent, community, discussing achievements, integrating siblings, shares dreams, and prayers"? Yakubu was very vocal about the help he received from the Mosque after experiencing Boko Haram attacks, he stated,

> When I was in the IDP camp, I observed my fasting and daily prayers for 60 days and I saw the hand of God in my prayers and subsequent help that I received … if not for fasting and prayers, I would probably have been dead.

Hussainah said, "I read my Bible daily, observed my morning prayers, and God answered my prayers and sent help to me." Shehu stated, "Prayer and fasting were most helpful, because whenever I remembered my experience with Boko Haram, I encouraged myself in the word of God." Aremu said, "Prayers is the key to my coping with Boko Haram trauma."

When asked, "Which of these programs and support services did you perceived eliminate the risk and promoted coping in the psychological adjustment - Parent, Extended family, Friends, Religion/Faith, Community resource centers"? Moses reported

> I did receive counseling support from church and as a Christian; I read my Bible, prayed and fasted. I also received clothes, foods, and finance occasionally from Government, friends and non-governmental organizations … my brother has also

> been helpful in providing shelter for me in Nigeria, the government provided me first shelter at IDP camp and temporary feeding; they also provided blankets and security around the camp.

Amina echoed similar feelings when she said,

> I observed my prayers daily and fasted, at the initial stage of the attack, government provided security in around our village but when the attack became consistent, government relocated me to the IDP camp and also provided daily feeding and blanket in the camp, I have also received vocational job training in the IDP camp with support from some foundations and NGOs that came to the camp, as well as one time fifty thousand naira (equivalent of $150) from an NGO.

Equally, Aisha reported, "All I did to cope with my worries was that I drew closer to my religion, which I think gave me the comfort and courage to overcome my challenges." The findings from this study again further emphasize the importance of religiosity and strong family support as a protective and effective intervention program for children exposed to terrorism *(*Ager et al., 2010; Hughes, Joslyn, Wojton, O'Reilly, & Dworkin, 2016).

When asked the questions, "Which of these services and programs will you recommend for other children experiencing terrorism … and why?" All the study participants suggested fasting and prayers. Hussianah stated "Prayer is the best…Government failed me, and nongovernmental organizations are inefficient, but God did not fail me." Garba said, "I relied on fasting and prayers to cope with my trauma, and I also advised people in similar situation to rely on God in the times of

trouble." Moses said, "If not God by my side, I would have been consumed… tell others in similar situations to trust in God through fasting and prayers…human beings can disappoint, but God never fails." Aisha stated, "God is my strength in the time of trouble and was my strength during my experience with Boko Haram." "Do you believe that other services could have helped you to cope more efficiently with your issues."? Amina said, "I think so, if government decides to help, it would have been helpful." The response that I received from Aisha was generic and basic "Government intervention will encourage me to deal with my immediate challenges and needs, and would have encouraged me to achieve a lot of things." Aremu stated, "I am optimistic that if government has showed concern the same way that my Imam and nongovernmental organizations did, life would have been more meaningful to me."

To further understand if there were government supported school-based intervention programs and services available to them as students, Yakubu stated," For where! No known government school program was available to help me cope with my trauma." Aremu also recounted his experience and said, "All that was available in school as support was the police and soldiers patrolling our school." This position is consistent with Ola, and Atilola, (2017) argument that school-based mental health services are non - existent in Nigeria as well as the punctuated equilibrium theory (Baumgartner, Jones and Mortensen, 2014) which argued that changes and implementation of government policies and programs have a role to play in diagnosis and treatment for people exposed to mental illnesses. The non-implementation of Nigeria MHA invariably led to non-availability of school-based mental health support services and programs for people exposed to

terrorism in Nigeria. This position was also supported by similar study Eseadi et al., 2016) which argued that Nigerian government did not provide effective mental health treatment for children affected by terrorism in Nigeria. Myers et al. (2007) identified exposure-based therapy as school-based therapy that is essential for the treatment of anxiety disorder among students exposed to trauma. Dobson and Dobson (2009) identified psychoeducation as an essential part of the treatment of PTSD (p. 104), while Foa, Keanne, Friedman, and Cohen, (2009) recommended a 10-20 session per week Cognitive Behavioral Therapy (CBT) based on an imaginal method for children with PTSD symptoms or behavioral disorder.

Furthermore, when asked if they received any medication or school-based therapeutic support, all the participants acknowledged that there was no school-based or IDP camp therapeutic support received, neither do they take any medication. Hashanah stated,

> I only took treatment for malaria which I had in the IDP camp due to malaria, since then, there is no need for me to take medication … you know my parents and religion had prepared me for challenges of life before now, both taught me steadfastness and courage in the faces of challenges, so what has happened do not require me to take medication, rather it requires me to be prayerful and courageous, anybody can experience what I experienced.

Also, two of the participants reported that they avoided discussing their challenges at the initial stage, those with parent recognized parental support and peered

support as a buffer for coping with their trauma. Shehu narrated his experience when he was in the IDP camp and said,

> During my sojourn in the camp, I played soccer with my friends and other games to divert my attention from my challenges … my friends were beneficial because we all assembled on the field to play soccer in the morning and evening, and helped the IDP camp management during the day to keep the camp clean.

Hussainah acknowledged, "My brother advised me that the experience we had was to prepare us for greater height and ensured that we observe our prayers daily." All the participants acknowledged the availability of government counseling services available, but they refused to participate in the counseling services due to corruption and financial constraint as well as stigma attached to receiving mental diagnosis and treatment.

Functioning parental support, community support, individual children personal quality, peer support, religiosity are all support systems that the participants identified in decreasing their psychological effect of being exposed to terrorism as observed above (Bonanno et al., 2005; Ciccheti, 2010; Cummings et al.,2011; Garbarino et al.,2015; Greeson, 2013; Hasija & Gray, 2007; Henrich; Moscardino et al.,2007). When the participants were asked about the programs and support that helped most to cope with their trauma and which of these programs and support services did they perceived eliminate the risk and promoted coping in the psychological adjustment. All the participants identified fasting and prayers as well as counseling from the Pastors and Imams as the major factors that aided in coping with the psychological challenges they experienced from Boko Haram insurgency.

Ultimately the number one coping strategies agreed by all the participants that helped them to cope with their psychological support was fasting and prayers. Moses stated, "The daily reading of my Bible coupled with prayers and occasional fasting brought the healing that I needed." Furthermore, Hussainah explained,

> I am grateful to "God" for knowing Him at the early stage of my life and I am also grateful to my parents for introducing me to prayers and words of spirituality from the Bible … so far so good, I got my healings through prayers, fasting and word of God.

Shehu exclaimed,

> Islam thought me to pray five times a day, and the Ramadan fasting session that fell within the period of the incident of my experience with Boko Haram helped me to overcome my stress level, I thank Allah for helping me to overcome my sorrow, grief, and frustration.

Follow up question to the each of the participants asked, "Tell me why do you think fasting and prayers as well and your spirituality is the best support services that helped you to cope with your trauma"? Aisha replied,

> Trust! Trust in Allah!! For instance I already lost my mother, while the NGOs many at times failed to fulfill their promises and the little help that government provided is not consistent … there was no assurance when government would provide services, but for prayers and fasting, they are personal to me and can be controlled by me, I have also tested prayers and fasting to address some

challenges in my life before the event of Boko Haram, and Allah answered my prayer, my strong faith in prayer and fasting to Allah was the best option for me.

Moses quoted some verses from the Bible and stated,

> Call upon me in the days of trouble, and I will deliver you and though shall glorify me, Psalm 50 verse 15 and Psalm 46 verse 1, God is our refuge and strength and ever-present help in trouble, also Psalm 91 verse 15 says that "when you call upon me, I will answer, I will be with you in trouble and will rescue thee."

Theme 4: Social Implications of Receiving Therapy

Misconceptions about mental health and therapeutic support processes were identified as one of the reasons six of the study participants identified as an obstacle in going to therapy. When asked, *"*Can you tell me about your understanding of mental illnesses before receiving treatment (Cognitive barrier)"? "Can you say the primary barriers to the treatment of your mental health barriers"? "Can you tell me about other obstacles that may have restrained you from going to therapy or receive support"? "Do you feel any shame, disappointment, discrimination, and embarrassment for receiving psychological support"? For Aisha, Hussainah, Shehu, Garba, Yakubu and Moses only "mad" or "crazy" people that go to the psychiatric center to receive mental health support. Aremu stated, "The moment you go to a psychiatric center in our community, people tag you as a crazy person, become careful with you, and every behavior you demonstrated in the community, people read meanings into it." Garba reported,

> It is a shame to be identified as "crazy" person to individual and family, If you don't want to bring your family and your next generation into disrepute, don't go near hospital for mental health illnesses related problem, hardly will you and your next generation will be able to get husband or wife in our community, people will say, "craziness" is hereditary and flows in the blood from generation to generation.

Such beliefs and misunderstanding coupled with the Nigerian culture of stigmatizing people that received therapy for mental health treatment were the misconceptions why the participants refused to enter into therapy for mental health treatment.

Amina demonstrated different view of positive effect of receiving therapy for mental health illnesses, she identified corruption on the part of health workers for asking for kickbacks before receiving treatment, long hours of waiting for services due to limited social worker staff, lack of financial strength to cover medication and transportation as some of the barriers for entering into therapy. Amina explained,

> First, there is nothing bad in going to hospital to receive mental health treatment, if I am sick, however my frustration of entering into psychological therapy include lack of financial strength, transportation, long hour of waiting due to limited number of staff.

When asked, "Do you feel any shame, disappointment, discrimination, and embarrassment for receiving psychological support"? Amina said, *"*My life is more precious to me than community perception." Aremu identified long hour of staying in the hospital and the hygienic conditions of the hospital as the reasons why he stayed

away from going to hospital to receive diagnosis and treatment for his trauma. Aremu stated,

> Going to hospital in one of the States in the northeast is like going to hell, there is only one psychiatric hospital serving almost 3 states in the northeast, serving millions of people, even the stench coming from the hospital can even cause sickness, when you succeeded to secure appointment … to receive diagnosis, you will have to pay a lot of money, and the hospital beds are like rags, you have to buy food on your own and give kickbacks to nurses for supply of drugs and treatment, I am not ready to go through all that.

Moses echoed similar view when he stated,

> I do not have the money to pay for my bill in the hospital and even if they decided to give me medication, there is no provision for feeding. Admitted in psychiatric ward is also perceived by members of the community that I am "crazy", after leaving the hospital, friends and family will become careful and think that I am mentally unstable.

Hussainah was more concerned about the stigma attached to people with mental health illness, when she stated,

> I have to think twice before I step into any hospital to receive mental health therapy as long as my family and community continue to frown at mental health therapy. I will continue to stay away from receiving mental treatment, and even if I will ever receive it, I will have to go to where people will not recognize me. What I need now is to be loved, not to be hated.

The participants in this study expressed their level of disappointment related to barriers that exist to receiving diagnosis and treatment for mental health illnesses. Finding from this study aligns with studies and literature that identified inadequate mental health services, lack of knowledge, lack of inclusiveness in assessment and evaluation of children and parents of children in treatment plans, training of individuals who have mental health disorders and their parents, stigma attached to mental health referrals and corruption on the part of health workers have been identified as the obstacles to the treatment of mental health disorder in developing countries(Barker-Ericksen et al., 2013; Gureje et al. 2007; Van Cleve et al., 2013). The table below provides each theme and phrases that were used as codes to indicate the corresponding themes.

Table 4

Emergent Themes and Emergent Coded Phrases

Emergent themes	Emergent coded phrases
Emotional sadness, grief, and sorrow	Sadness/Grief/Shock/Frustration/Disbelief/Anger/ Sleeping phobia/Fear/Pain/Depression/Emotional numbing/Mourning/Insomnia/Anxiety/Feeling of upset/Worry/Fear/Death/Angry/Injury/Avoidance/ insecurity/Scared/Confused/Sobered/Helplessness
Struggling with education	Devastation/Difficulty remembering/Worried/Poor assimilation/Cognitive impairment/Weaker school performance/Poor academic/Poor concentration/ Poor school grade/Pessimistic/Suffered/Doubtful/ Struggling/Low morale

Resilience program and support services: Prayer as strong support coping system	Peer/Parent/Religious support/God/Prayers/Fasting/ Spirituality/Reluctance/Church/Mosque/ Nongovernmental organizations
Social implications of receiving therapy	Fear/Corruption/Discrimination/Poor financial strength/Stigmatization

Summary

This chapter described the psychological consequences of Boko Haram insurgency for eight Nigerian exposed to terrorism in northeastern Nigeria. The research questions aimed at determining whether Boko Haram insurgency has psychological impact on the study participants. Four themes emerged based on the participants' response. Their psychological experience provided new insight into a credible foundation to develop appropriate interventions and policies. Participants' narrative provided the foundation for exploration of future study on psychological consequences of Boko Haram terrorism on children. Chapter 5 concluded this research study and provides an interpretation of the findings, identified limitations of the study implications for social change, recommendations, implications for social change and conclusions.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this study was to examine the psychological consequences of the Boko Haram insurgency based on the lived experience of Nigerian children exposed to terrorism in northeastern Nigeria. I employed phenomenological qualitative methodology to determine the lived experience of the study participants exposed to Boko Haram terrorism in northeastern Nigeria. Prior research on impacts of the Boko Haram insurgency in Nigeria primarily focused on economic impacts on the adult population. To fill the gap, the literature review for this study focused mainly on psychological effects of the Boko Haram insurgency on Nigerian children. Prior research has not examined how Boko Haram has impacted the educational experience of children in Nigeria, programs and services that are perceived as available and helpful in improving individuals' ability to cope with the trauma of terrorism, or barriers to improving the mental health of the children in Nigeria. Examining these factors through the lived experience of children exposed to the Boko Haram insurgency is important in decreasing the psychological impact of the Boko Haram insurgency as well as developing reform efforts and policies to reduce the psychological effects of terrorism on Nigerian children.

In this study, all participants identified the psychological impacts of the Boko Haram insurgency and the effects of terrorism on their education. The study participants also identified programs and services that were available to help them cope with their trauma, as well as programs and services that promoted their coping and adjustment after exposure to the Boko Haram insurgency. In addition, they identified barriers that existed

to improving their mental health. All participants shared their grief and mourning following Boko Haram attacks on their communities and schools, which resulted in the death of their parents, friends, and/or other family members. Their initial reactions to Boko Haram attacks reflected a human "normative" response to terrorism. These responses aligned with Peredo's (2013) argument that children's reactions to trauma may be short term and may not lead to permanent mental illnesses. As shown in Chapter 4, four themes emerged in this research study and provided a framework to determine the psychological consequences of Boko Haram for Nigerian children. Those themes were as follows:

1. Emotional grief, sadness, and sorrow
2. Struggling with education
3. Resilience program and support services: Prayer as robust support coping system
4. Social implications of receiving therapy

Themes were derived from the interview answers, which stemmed from questions linked directly to the research questions. This chapter provides interpretations of the research findings, with specific emphasis on how literature supports the results and phenomenon of the study participants' psychological experiences with the Boko Haram insurgency. This chapter addresses some of the limitations of the study. It also provides recommendations for further research on this topic and discussion of the study's implications for social change. The chapter concludes with a complete summary of this research study.

Interpretation of the Findings

The study confirms that children exposed to terrorism experience psychological trauma (Pine et al., 2005). For example, all of the study participants confirmed their grief, sorrow, frustration and exhibited psychological symptoms such as sadness, pain, shock, disappointment, disbelief, anger, sleeping phobia, fear, lack of appetite, depression, emotional numbing, mourning, grief, insomnia, anxiety, feeling of upset, worry, avoidance, and sense of insecurity over the killings or kidnappings of their parents, grandparents, friends, classmates, and/or teachers, and/or the destruction of their farm produce, farmland, and/or school by the Boko Haram insurgency.

Findings from the study also confirmed that the study participants exhibited avoidance, headaches, emotional numbing, and mourning more specifically within the first 3 months of experiencing the death or kidnapping of parents, other family members, or friends. However, the study participants' responses to interview questions showed that these pathological reactions to terrorism were "normative responses" to unnatural acts that did not lead to permanent mental health illnesses. This confirms the findings of North and Pfefferbaum (2002), who stated that the distress that children suffer during exposure to terrorism is considered a "normative response" that may not necessarily be regarded as pathological.

All of the participants praised churches and mosques for their caring presence and prayers; they also identified encouraging themselves in the word of God. Participants acknowledged the effort of the government to provide security to their schools and communities. They also urged religious, governmental, and nongovernmental

organizations to provide support to other children who might seek similar help in the same situation.

Piaget's cognitive development theory (CDT) and punctuated equilibrium theory (PET) were the theoretical frameworks that I used to interpret the findings from this research. Piaget developed cognitive development theory to focus on the mechanisms by which children develop and adjust to their environments (McLeod, 2015). CDT has been useful to researchers investigating the assimilation and accommodation of children in terms of educational performance (Balk, 2011). However, CDT was employed in this study to understand the assimilation and accommodation of the study participants after exposure to terrorism.

Data collated and analyzed in this study showed that the accounts of individual participants (who were between the ages of 11 and 18 years when they experienced the Boko Haram insurgency) indicated that these individuals attributed their memory loss, negative attitude toward schooling, weaker school performance, pessimism about life and the environment, poor concentration, low cognitive capacity, poor information processing, and lack of creativity to their exposure to the Boko Haram insurgency. However, the study participants did not exhibit permanent cognitive impairment. The specific behavior identified by the study participants at the formal phase aligns with Piaget's CDT, which indicates that children who are exposed to violence and instability, who are taken out of school, and who experience displacement due to violence or disaster may suffer memory loss, weaker academic performance, and impaired assimilation and accommodation (Miller et al., 2000a). The study also confirmed the findings of Olff et

al. (2006) that children who lost their parents to terrorism through either death or displacement experience poor information processing and lack of creativity, as posited by Piaget's CDT.

The study participants' accounts were often very detailed when they recounted their experiences with resiliency program and support services and identified prayer as a strong support coping method. The findings from this study showed that Nigerians are likely to consider any form of treatment once they have experienced psychological trauma. All of the study participants agreed that prayers and religiosity were the most reliable methods that helped them to overcome trauma; nevertheless, virtually all of the participants acknowledged that they had received clothing and temporary shelter from the government. The participants also recognized parental support, peer support, community support, counseling from churches and mosques, their individual religious background, and in-depth knowledge of the Bible and Koran (Bonanno et al., 2005; Ciccheti, 2010; Cummings et al., 2011; Garbarino et al., 2015; Greeson, 2013; Hasija & Gray, 2007; Moscardino et al., 2007).

All of the study participants were raised to follow Nigerian traditions and had specific mechanisms through institutions such as churches and mosques that allowed for the preservation of their values. Traditional Nigerian parents taught their children to rely on these institutions to cope with challenges, as demonstrated by the study participants when they recounted their experiences concerning what constitutes a mental health problem and how they relied on their religion and faith to cope with the trauma of being exposed to the Boko Haram attacks. The study participants conceptualized people with

psychological health illnesses as “crazy people” who walk on the street aimlessly without shelter and care. To them, avoidance, mourning, fear, numbing, and anxiety did not constitute mental health illnesses and were merely “normative responses” that did not indicate a pathological problem.

Many of the study participants identified shame and stigma attached to mental health illnesses in their communities, as well as financial challenges, transportation difficulties, lack of medicine, long hours of waiting to receive services at the hospital with no adequate experts for diagnosis, and corruption as some of the reasons why they did not receive treatment for mental health illnesses. Misinformation about what constitutes mental illness was a significant factor in study participants’ refusal to seek mental health intervention. Additionally, fear of being stigmatized for receiving mental health diagnosis and treatment was a concern that prevented participants from receiving therapy for mental health illnesses. Study participants considered the implications that receiving mental health diagnosis and treatment would have in relation to their family background, traditions, and cultural beliefs. All of the study participants relied on the healing power of God as alternative to receiving treatment for mental health illnesses.

This study confirmed the findings of studies that showed families’ complex needs, inadequate support for mental health, and corruption as impediments to mental health treatment for children (Barker-Ericken et al., 2013; Van Cleve et al., 2013). It also confirmed that lack of awareness about misconceptions concerning mental health illnesses, inadequate awareness of what constitutes mental health illnesses, centralization of mental health resources, and poor skills related to mental health treatment on the part

of mental health service providers are challenges to providing efficient mental health services in Nigeria (Saraceno et al., 2007). The participants also identified lack of free medical care for children with mental health disorders as one of the reasons for staying away from therapy. One of the study participants noted lack of transportation and the high cost of hospital treatment as reasons for not entering treatment following exposure to trauma. All of the participants confirmed that lack of free health care services and lack of mental health support from the government were barriers to entering mental health therapy (Van Cleve et al., 2013; WHO et al., 2013).

Limitations of the Study

The purpose of this study was to examine the psychological consequences of the Boko Haram insurgency based on the lived experience of Nigerian children exposed to terrorism in northeastern Nigeria. Additionally, the goal was to examine factors that promote or hinder the development of resiliency among Nigerian children. In Chapter 1, I addressed limitations on generalizing the findings of the study, which derive from the fact that the participants were from northeastern Nigeria. Because Boko Haram activities occur across all six states in northeastern Nigeria, Nassarawa and Abuja (northcentral), and affected 3.7 million Nigerian children, it is not clear whether the experiences of these study participants in northeastern Nigeria reflect the lived experiences of other children affected by terrorism in Nigeria, and as such it may not be possible to generalize the lived experience of the study participants. Studies (e.g., Gasson, 2004; Goulding, 2002; Kroening, Moore, Welch, Halterman, & Hyman, 2016; Morrow, 2005) have suggested member checking and thick description as methods of addressing the issue of

generalizibility in qualitative studies. This study applied member checking and thick description to improve accuracy and transferability.

The second limitation of this study had to do with the fact that the survey questions were many and very broad, which resulted in the study participants responding to the questions based on their interpretations of them. To address this challenge, I conducted a pilot study to understand the capability of the respondents to answer the research questions and to determine if any changes to the interview schedule were required (Gil et al., 2008). Moreover, the questions did not point to specific government programs. The study participants identified a series of short resiliency programs designed to help them cope with their trauma. Because most of the programs available to the participants were scattered without any form of cohesion between the government and nongovernmental organizations, the study participants could not distinguish support programs provided by the government from those provided by nongovernmental organizations. The pilot study was also used to determine which government programs and services were available to the study participants to help them cope with their trauma.

Another limitation had to do with issues of ethnicity and religion. All of the study participants were Hausa from the northern part of Nigeria, and participants were evenly divided between Muslim and Christian religious backgrounds. There were no other nationalities (e.g., Yoruba, Igbos, or Fulani people born in Maiduguri) among the participants selected to recount their experiences and thoughts regarding Boko Haram terrorist attacks. Further, there was no atheist or traditionally religious participants in this study.

Recommendations for Further Research

This doctoral dissertation relied on the lived experiences of study participants who had been exposed to Boko Haram. This study addressed a gap in the literature concerning the psychological effects of the Boko Haram insurgency on Nigerian children residing in Nigeria. This study addressed issues regarding how terrorism impacted participants' educational experience, as well as available programs and services that were perceived by the study participants as being helpful in improving their ability to cope with the effects of terrorism. It also touched on programs and/or services that may help to promote coping and adjustment for this population, as well as barriers that exist to improving the mental health of children of Nigeria, through qualitative phenomenological study. Five recommendations for addressing the psychological consequences of terrorism for Nigerian children are described below.

First, findings from this study suggest the need for additional quantitative and mixed methods research on the psychological consequences of terrorism for this population. There is a need to quantify the data used in this study to find the correlation between the study participants' subjective experiences and terrorism. To ascertain whether the study participants' psychological response to the Boko Haram terrorist attacks was a "normative response" to unexpected acts, it is suggested that the longitudinal effect of psychological responses to the Boko Haram insurgency on the study participants be studied. It is also important that the longitudinal impact of terrorism on the educational experiences of the study participants be explored.

Second, there is a need to study Nigerian government policy responses to the mental health needs of people exposed to terrorism. Additional studies need to be conducted on mental health policies and programs of the Nigerian government that cater to the mental health needs of children who have experienced Boko Haram violence. All of the participants in the study reported that there were no government policies or programs that catered to their mental health needs following the Boko Haram insurgency.

Third, activities of donors in northeastern Nigeria who are providing psychological support to children exposed to the Boko Haram insurgency need to be studied, given that the study participants reported that the activities of these donor agencies made no appreciable impact on their psychological and economic needs.

Fourth, one of the outcomes of this study was that the study participants did not use available government resources to address their psychological trauma because of how they would be perceived for doing so. Hence, there is need for a study to assess perceptions of mental health care and how these perceptions impacted the study participants.

Fifth, the study participants were restricted to people who had been exposed to the Boko Haram insurgency in Nigeria, and the data used for the results of this study were exclusively based on their lived experiences. However, Boko Haram activities are occurring throughout northeastern Nigeria and have spread to northcentral Nigeria. There is a need to study the lived experiences of other participants from other geopolitical zones where Boko activities are being experienced. Such individuals might have

different views and opinions than the study participants in this study, which might yield mixed results.

Implications for Positive Social Change

Findings from this study mark a foundational step in describing the psychological consequences of Boko Haram insurgency on the lived experience of Nigerian children. The research findings also suggested positive social change through the development and implementation of social programs which will decrease the psychological effects of terrorism for Nigerian children. The psychological consequences of terrorism on Nigerian children exposed to terrorism have been in existence for a very long time (UNICEF, 2016). Studies showed that an estimated 3.7 million children exposed to Boko Haram insurgency mental health needs are unmet (Hawke, 2015; IOM, 2015). Policies and programs to address the mental health problem of Nigerian children have received minimal progress.

The failure to update the MHA to cater to the mental health need of children exposed to terrorism is a gap that continues to put Nigerian children into high risk of permanent psychological health illnesses. Failure to fix this problem is unjust, and inimical to the health of Nigerian children. The findings from this study revealed that the study participants needed support and care to address the psychological challenges that they experienced immediately following exposure to terrorism. There is need for consistent and constant support system for Nigerian children to support their coping with the trauma of violence. Although some researcher may argue that the grief and shock that accompanied the symptoms of the psychological problem is “normative" and

reasonable in the circumstances of children's exposure to violence. However, failure to provide early diagnosis and treatment for children exposed to violence may lead to permanent mental health illness at long-term (Qouta et al., 2008). Poor information processing, lack of creativity, weak academic functioning, are cognitive effects for children exposed to terrorism in the short term and the long-term (Bonanno et al., 2010). The Nigerian government MHA, policies and programs are failing to meet the mental health needs of children exposed to Boko Haram insurgency. Successful update of the MHA, as well as the development of policies and programs to support the psychological health of children exposed to terrorism, will have direct positive social change on the children and their families. The provision of immediate, straightforward, mental health diagnosis and treatment, as well as school-based mental health therapy, will play an essential role in extending care to the children with the greatest need.

Development organizations and mental health professionals have affirmative and professional obligations to aid disadvantaged children with mental health challenges. Misconceptions about mental health and therapeutic support processes, corruption, and inadequate treatment facilities have widened the diagnosis and treatment gap in mental health for children in Nigeria. Nongovernmental organizations can help provide treatment, rehabilitation, community care, research, training, and capacity building for local mental health providers which may aid effective service delivery to children with mental health. Fredrickson (2005) suggested that professionals should actively promote policies that reduce social inequities rather than serve as neutral arbiters of policy. Psychologists and professional mental health providers can use their knowledge and

expertise to counsel lawmakers and policymakers on the need to update the MHA as well as development and implementation of programs that support psychological health of children exposed to terrorism in Nigeria.

Over the years, government of Nigeria has made some progress in developing MHA to provide for the mental health of Nigerians. However, in the view of the emergence of terrorism in Nigeria, there is need for government to reconsider policies and programs in light of more recent perceptions. To improve and strengthen implementation of MHA to provide for the mental health needs of Nigerian children, the government must set up management structures to facilitate the smooth operation of mental health support for children. These includes policymaking and planning, appropriate administration structures, provision of resources, decentralization, training personnel, onward referral systems and monitoring and evaluation. Mental health policies that strive to promote diagnosis and treatment of mental health illnesses in children will be more sustainable if they reflect the results of a deliberative process that includes diverse points of view.

It is also imperative that government mental health policy and programs should provide free medical care to children with mental health. International standards such as free medical health care, provided to victims of terror in the US and Israel are instructional in this perspectives. Bureaucracy and corruption that impede the provision of support for children with mental health illnesses should be addressed. Participants identified corruption, lack of free medical care as some of the reasons they did not receive treatment for their psychological trauma.

This project supports immediate diagnosis and treatment for children exposed to terrorism. To help children cope with the trauma of terrorism, Nigerian government and professionals should create a safe environment and keep children to people they are familiar with, and ensure children keep their routine regular. Second, children should be reassured and provided extra emotional support, third, health services providers and government should be honest with the children about what happened, inform them about the effort which the state, local and federal government are making to protect them - reassuring them on the efforts which police, soldiers, hospitals and countries around the world are doing to help.

An additional policy to consider is whether school-based psychological intervention plan exists within the Nigerian health sector to cater to the need of children with psychological challenges, and if it exists does it address the needs of children with the psychological disorder? Studies (e.g., Hassija & Gray, 2007; Otto, McHugh & Kantak, 2010) suggested school-based therapeutic support for the treatment of cognitive disorders in children exposed to terrorism. Myers et al. (2007) described school-based exposure therapy for the treatment of anxiety disorder in children (p. 141–2). Dobson and Dobson (2009) identified psychoeducation for the treatment of PTSD (p. 104), and assault during the classroom activities or school hours in children with cognitive and behavior disorders.

Adults and experts should be aware that children are conscious of the anxiety and reactions of the adults around them to terrorism. School and home-based mental health intervention services should be introduced to help children cope with their emotional and

behavioral needs. Therapeutic staff support (TSS) should be added to the school system to provide immediate therapies for children that are exhibiting strange behaviors at schools and home. Also, teachers should be offered school-based intervention trauma training on therapeutic behavioral support to gain practical knowledge on how to provide one-to-one attention in compliance to severely emotionally disturbed children or adolescents who may attempt to bite, kick, scratch, punch or otherwise.

Finally, adults, parents, and experts must reassure children who are victims of terror, put the situation in perspectives by informing the children that terrorist attack is often a rare incident and let them know they are safe (Dewolfe, 2001). The government, policymakers, civil society organizations and line responders should be challenged to begin the dialogue and discuss either the implementation of existing policies and law such as MHA and openly come up with practical and appropriate plans to address the need of children exposed to terrorism.

As long as the culturally based social stigmas towards mental health and the costly social ramifications of entering therapy persist within Nigerian communities, rates of mental health utilization are expected to remain low. The implications are that lacks of programs and policies which provide comprehensive diagnosis and treatment for children whose cognitive development were impaired at a formal stage might permanently derail educational experience for the children to adulthood. Notable higher numbers of participants in this study although regained their memory loss within a short period, but were unable to overcome their weaker educational performances. Seven of the study participants reported a loss of interest in pursuing academic goals that they had

earlier set for themselves due to experience with Boko Haram violence. The findings showed that the study participants need urgent interventions for reorganization towards remedying the cognitive challenges of assimilation and accommodation that are needed to overcome weaker educational performances and to develop an interest in education. A policy framework that will integrate diagnosis, treatment and school-based programs as suggested by Myers et al. (2007) would be an ideal measure to begin to address the cognitive development barrier that emanated from children experience with Boko Haram.

The result from this study identified misinformation, poor knowledge and cultural barriers (stigma and discrimination, traditional beliefs on mental health, diagnosis and treatment) that Nigerians encountered in their processes towards psychological treatment. The implication, therefore, is that there is underutilization of poor or limited mental health services which has led to the increase in the number of people with mental health in Nigeria. This was also partly due to lack of knowledge about symptoms of mental health illnesses in Nigeria. Hence, there is a need for creating awareness of the symptoms of mental health illnesses and attitudinal change in public perception towards receiving treatment for mental health in Nigeria.

Conclusion

In this research study, I examined the psychological consequences Boko Haram insurgency for Nigerian children exposed to terrorism in Nigeria. The study participants reflected on the psychological effects of Boko Haram insurgency on their mental health, effects of terrorism on their education, programs and support services available to them to cope with the trauma of being exposed to Boko Haram as well as programs perceived to

be most effective in dealing with trauma of being exposed to terrorism, and barriers that exist to receiving mental health supports. Research on the psychological effect of terrorism reported negative symptoms of mental health disorder for those who participated in the study. The report also showed weak academic performance and cognitive disorder that included problems with assimilation and information processing among the study participants due to their exposure to Boko Haram insurgency. However, the study participants were able to overcome their psychological disorder within few months. In other words, study participants reaction to Boko Haram insurgency was "normative response" to an unexpected event. The report showed that government response to psychological needs of the study participants was poor and lack cohesion. Prayer and religiosity were identified as the most reliable coping system.

The findings from this study confirmed the historical result that the participants' psychological response to terrorism was "normative," which might lead to permanent mental illnesses if not properly treated or managed. Despite poor resilience programs, study participants were able to overcome their mental health challenges occasioned by exposure to terrorism. Also, the study confirms the impacts of violence or terrorism based on the study participants at the operational state based on PCDT; this problem did not lead to permanent mental health illnesses for the study participants.

This study did not disregard the traditional methods of coping with trauma by children but instead confirmed functional parenting support, strong family support, prayers and religiosity, customs and tradition, community resilience programs as methods of coping with trauma in children. Notwithstanding, the study participants identified

strong religious beliefs-prayers and faith in God as the most helpful means of coping with their trauma.

Misconceptions about mental health illnesses fueled by corruption of medical staff, financial constraints, poor diagnosis and treatment, poor hospital environment and bureaucracy government were identified as barriers to receiving treatment mental health by the study participants confirmed previous studies.

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Appendix A: Letter to Program Officer

Date:

Name of PO
Address

Dear (Name),

Name of PO
Address

Dear (Name),

My name is Paul Adepelumi and I am a doctoral candidate at Walden University. I am contacting you to request for your support towards gathering data for my study. I am conducting dissertation research on the psychological consequences of Boko Haram insurgency for Nigerian children. There are a vast number of studies on effects of terrorism on Nigerian population. What is not known however, are the adverse psychological effects of Boko Haram terrorism on Nigerian children. This research will provide insight into what children experience for being exposed to Boko Haram insurgency in northeastern Nigeria.

The participants of this study need to experience Boko Haram insurgency between the age of 15 and 18 between 2009 and 2010. Although the study participants experienced terrorism between the age of 15 and 18 years of age at the time they experienced Boko Haram insurgency, however since this study will be conducted in 2017, the average age of the study participants as at the time this study will be conducted will be between the age of 22 and 25. Also, the prospective study participants must have resided in northeastern part of Nigeria for at least 5 years after the insurgency began, and exposed to Boko Haram insurgency between 2009 and 2010, enrolled in secondary school for at least 6 months during the Boko Haram insurgency from 2009 to 2010. In addition, participants must be able to remember the events that occurred during the Boko Haram insurgency, and participants must be willing to provide details about, and express and explain, their lived experience during the Boko Haram insurgence. All potential study participants must meet the above criteria to qualify for this study.

Your assistance in conducting this much needed research is important. If willing, I need for you to distribute the letters of invitations to participate in this study and consent forms to the study participants.

The participants are free to choose whether or not to participate and can discontinue participation at any time. Information provided by the participants will be kept strictly confidential.

I would welcome e -mail response or a telephone call from you to discuss any questions you may have concerning this study and your role in distributing the consent forms and letter of invitation. I can be reached at (267) 881-8163 or emailed at paul.adepelumi@waldenu.edu

Sincerely,

Paul Adepelumi
Doctoral Candidate
Walden University

Appendix B: Letter to Participants

Date:

Name of Participant
Address

Dear (Name),

My name is Paul Adepelumi and I am a doctoral candidate at Walden University. I am conducting dissertation research on the psychological consequences of Boko Haram insurgency for Nigerian Children. There is a breadth of studies on effects of terrorism on Nigerian population. What is not known however, are the adverse psychological effects of Boko Haram insurgency on Nigerian children residing in northeastern Nigeria. This research will provide insight into what children (as at when exposed to terrorism, now adult between the ages of 22 to 25 years) experience for being exposed to Boko Haram insurgency in northeastern Nigeria

I realize that your time is important to you and I appreciate your consideration to participate in this study. In order to fully understand your experience, we need to meet on two separate occasions for approximately thirty minutes and twenty minutes each meeting. Meetings can be held at your location in Nigeria that you choose and will not require you to do anything you don't feel comfortable doing. The meetings are designed to simply get to know you and learn about your psychological experience of being exposed to terrorism in northeastern Nigeria. All information gathered during our meetings will be kept strictly confidential.

Please contact me at your earliest convenience to schedule a date and time that we can meet. You can also email me at paul.adepelumi@waldenu.edu.

I look forward to hearing from you.

Paul Adepelumi
Doctoral Candidate
Walden University

Appendix C: Survey Questions and Corresponding Research Questions

Survey Question No.	Question	Corresponding RQ(s)
1	Can you tell me your experience related to Boko Haram insurgency?	1
2	How did you feel about your experience with terrorism?	1,3
3	What kinds of things raise your stress level (e.g., school, family, neighbors)?	1,2
4	Can you tell me your schooling experience before Boko Haram insurgency?	1,2
5	What was your schooling experience after experiencing Boko Haram terrorism?	2
6	In what ways do you think terrorism has affected your schooling experience?	3
7	Can you describe how you adapted to school after experiencing terrorism?	2,3
8	What kind of psychological-related concerns do you have for your education? Can you communicate discomfort?	3
9	Can you share with me what programs and services available to you following your exposure to terrorism?	3
10	Can you tell me a little bit about the type of programs and support you have received?	3
11	What kind of psychological issues was addressed in the therapy?	3
12	There are some beliefs and views of mental health, and treatment that can stand as barriers for seeking psychological support, in your opinion what do you think constitutes mental	3
13	What do you find to be the most important source of programs and support?	3,4
14	Which formal or informal respite services and support do you receive? Is it helpful? How? Who is providing/provided these programs and support services mean to you?	3
15	What coping strategies do you practice to manage your trauma?	3,4
16	Do you have any rituals that you find helpful? Your parent, community, discussing achievements, integrating siblings, shares dreams, and prayers? Are these rituals available to you when you need them?	3,4
17	Can you share with me your experience when you started receiving mental health support and why? How have these coping mechanisms been helpful in adjusting to normal lives?	3,4

Survey Question No.	Question	Corresponding RQ(s)
18	Can you tell me your experience related to Boko Haram insurgency?	1
19	Which of these programs and support services did you perceived eliminate the risk and promoted coping in the psychological adjustment? School based therapy ,Parent, Extended family, Friends, Religion/Faith, Community resource centers, Professional Counseling, Support Services/respite and other (please explain)? Why?	1,3
20	Which of these services and programs will you recommend for other children experiencing terrorism, and why?	3,4
21	Do you believe that other services could have helped you to cope more efficiently with your issues? Which of the services??	4
22	Is there any way in which you think the services that you received or are receiving could be improved?	4
23	Can you tell me about your understanding of mental illnesses before receiving treatment (*Cognitive barrier)?*	3,4,5
24	Do you have any concerns about any treatment or support services you are receiving?	3,4,5
25	Can you say the primary barriers to the treatment of your mental health barriers?	5
26	Can you tell me about other obstacles that may have restrained you from going to therapy or receive support? For example, financial restraint, resourcefulness, health insurance, lack of available resources, time commitment, means of traveling, etc.?	5
27	Tell me about the process of entering into receiving psychological support services? Was there a breaking point for you?	1,2,3,4,5
28	Do you feel any shame, disappointment, discrimination, and embarrassment for receiving psychological support?	1,2,3,4,5

Appendix D: Emergent Themes and Corresponding Research Questions

Survey Question No.	Question	Corresponding RQ(s)	Theme
1	Can you tell me your experience related to Boko Haram insurgency?	1	1
2	How did you feel about your experience with terrorism?	1,3	1
3	What kinds of things raise your stress level (e.g., school, family, neighbors)?	1,2	1
4	Can you tell me your schooling experience before Boko Haram insurgency?	1,2	2
5	What was your schooling experience after experiencing Boko Haram terrorism?	2	2
6	In what ways do you think terrorism has affected your schooling experience?	3	2
7	Can you describe how you adapted to school after experiencing terrorism?	2,3	3,
8	What kind of psychological-related concerns do you have for your education? Can you communicate discomfort?	3	3
9	Can you share with me what programs and services available to you following your exposure to terrorism?		3
10	Can you tell me a little bit about the type of programs and support you have received?		3
11	What kind of psychological issues was addressed in the therapy?		3,4
12	There are some beliefs and views of mental health, and treatment that can stand as barriers for seeking psychological support, in your opinion what do you think constitutes mental		3, 4
13	What do you find to be the most important source of programs and support?		3, 4
14	Which formal or informal respite services and support do you receive? Is it helpful? How? Who is providing/provided these programs and support services mean to you?		3
15	What coping strategies do you practice to manage your trauma?		3,4
19	Which of these programs and support services did you perceived eliminate the risk and promoted coping in the	1, 3	3

16	Do you have any rituals that you find helpful? Your parent, community, discussing achievements, integrating siblings, shares dreams, and prayers? Are these rituals available to you when you need them?	3,4	3
17	Can you share with me your experience when you started receiving mental health support and why? How have these coping mechanisms been helpful in adjusting to normal lives?	3,4	3
18	Can you tell me your experience related to Boko Haram insurgency?	1	1,2
	psychological adjustment? School based therapy, Parent, Extended family, Friends, Religion/Faith, Community resource centers, Professional Counseling, Support Services /respite and other (please explain)? Why?		
20	Which of these services and programs will you recommend for other children experiencing terrorism, and why?	3, 4	3
21	Do you believe that other services could have helped you to cope more efficiently with your issues? Which of the services?	4	3
22	Is there any way in which you think the services that you received or are receiving could be improved?	4	3
23	Can you tell me about your understanding of mental illnesses before receiving treatment (Cognitive barrier)?	3, 4, 5	4
24	Do you have any concerns about any treatment or support services you are receiving?	3, 4, 5	4
25	Can you say the primary barriers to the treatment of your mental health barriers?	5	4
26	Can you tell me about other obstacles that may have restrained you from going to therapy or receive support? For example, financial restraint, resourcefulness, health insurance, lack of available resources, time commitment, means of traveling, etc.?	5	4
27	Tell me about the process of entering into receiving	1, 2, 3, 4, 5	5

	psychological support services? Was there a breaking point for you?		
28	Do you feel any shame, disappointment, discrimination, and embarrassment for receiving psychological support?	1, 2, 3, 4, 5	5