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Adverse childhood experiences and self-reported emotional well-being for well-functioning young adults: The case of Burundian college students

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Adverse Childhood Experiences and Self-Reported Emotional Well-Being for Well-Functioning Young Adults: The Case of Burundian College Students

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Abstract

As the body of research on adverse childhood experiences (ACEs) has grown over the last few decades, a gap between how individuals and families experience and cope with such adversities in Western societies versus in non-Western communities has also widened. Moreover, many studies conducted in low/middle-income countries on ACEs have looked at marginalized populations, such as children-soldiers, homeless children, refugee camps, etc. The present study, on the other hand, sought to explore childhood adversities, as well as current emotional well-being and coping strategies for Burundian well-educated, high-functioning young adults. A survey of 100 Burundian college students documented many adverse childhood experiences, including 95% reporting that they had witnessed community violence. Most respondents also suffered emotional abuse, physical abuse, and neglect. Significantly, all interviewees expressed mistrust of others, reflecting a pervasive insecurity in social attachments. They evidenced a tendency to retreat, process, and resolve adversities alone. Furthermore, their coping style was characterized as solution-orientation, minimization, or normalization of the issue. Absent from their processing was emotional attunement and self-compassion. Those who reported higher levels of adverse experiences were also more likely to use drugs to cope and to have strained relationships. Those with relatively fewer adverse experiences were more likely to express a sense of hope for the future. This study comes as a unique contribution in that it offers a greater understanding of the experiences that Burundians have endured, the psychological impact of these experiences, and the need for mental health services, even among high-functioning Burundians in college.

Chapter I

Introduction

Overview

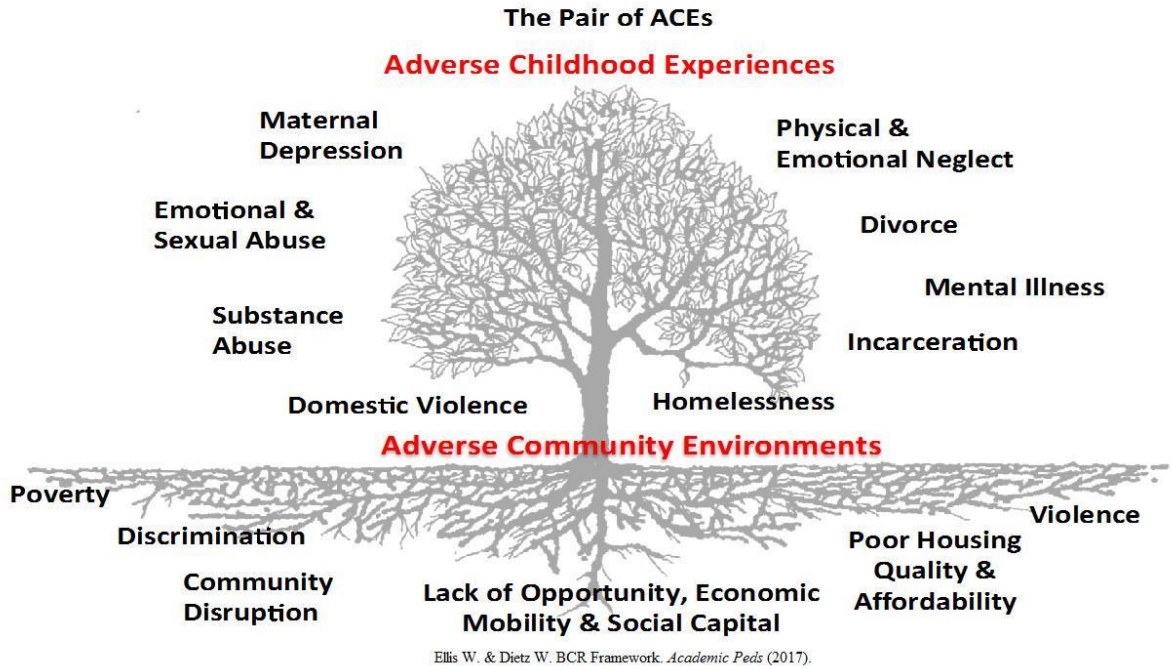
By 2050, at least two billion individuals throughout the world will be directly affected by the ever-increasing hardships of violence, devastation, wars, social conflicts, and natural disasters (Ronan & Johnston, 2005). Research findings are consistent that these adverse events can cause significant psychological impact (Gulliver et al., 2014). Such adversities threaten to interfere with children's emotional well-being and disrupt their developmental trajectories. Childhood traumas undermine regular social interactions, sabotaging families and community support networks (Catani et al., 2008). Furthermore, researchers have gathered disturbing evidence of the corrosive effects of ongoing biologically and psychologically toxic conditions on children's well-being (Yoshikawa et al., 2012).

Trauma comes from the Greek word for wound and refers to a serious psychological injury that results from a fear-inducing experience (Echterling et al., 2018). Metaphorically, a psychological trauma can "bleed" like a physical wound, but in this case, it may spread throughout a person's entire being (Solnit, 2013), profoundly impacting his or her cognitive abilities, emotional reactivity, behavior, and even neural functioning (Gaskill et al., 2012). Consequently, a significant number of trauma survivors can develop PTSD and other trauma-related disorders, which highlights the importance of trauma-informed treatment as the treatment of choice (Steele et al., 2012) when working with childhood trauma survivors.

The adverse experiences suffered during childhood may consist of child maltreatment (emotional abuse/neglect, physical abuse/neglect, and sexual abuse) and household/family dysfunction (domestic violence, substance abuse, mental illness, incarceration, parents' separation/divorce, etc.) (CDC, 2015). In addition to these family-related childhood adversities, children can also be exposed to community adversities. These experiences may consist of systemic discrimination, community violence, bullying, etc., which can create a negative cycle of ever worsening outcomes (Ellis et al., 2017). Ellis and his colleagues illustrate the combination of childhood adversity occurring both within the family and within the community in the model below, referred to as the Pair of ACEs Tree (see Figure 1).

Figure 1

The Pair of ACEs



Adverse childhood experiences can have a significant impact on a person's well-being. Some of the disorders or dysfunctions that may develop as a result of earlier adverse experiences include depression and anxiety, self-destructive behaviors (e.g., substance abuse, sexual misconduct), behavioral issues (antisocial behavior, misconduct, etc.), personality disorders (e.g., narcissism), eating disorders and other health problems, (e.g., such as diabetes, heart problems, and even death). Research has shown that most of these disorders are partly developed as people try to cope with the pain and trauma associated with childhood adversity experiences (Boppre et al., 2019). Other relevant factors include environmental adversities as discussed above, as well as brain-based changes resulting from childhood trauma (Perry, 2000).

The early years of development are critical because this is when children start to develop their understanding of self, of others, and of the world around them (Corcoran et al., 2018). This is a relational process whereby children develop and internalize models of relating and of attachment through interactions with their attachment figures. For instance, research on the theory of attachment (Corcoran et al., 2018), indicates that an emotionally unstable caretaker may interact with a child in an emotionally abusive manner, therefore increasing the likelihood of the child developing insecure or disordered attachment patterns.

Moreover, individuals with experiences of childhood abuse may struggle with an unclear or negative sense of self-concept/self-identity that stems mainly from deep-seated, distorted beliefs that looks at self as inherently defective (Peckels, 2017). Others may develop a sense that the world is an unsafe place altogether, therefore causing them

to shut down and retreat on themselves, which might hinder their ability to develop healthy relationships (Sheffler et al., 2019).

ACEs in Non-Western Societies

Childhood adversities in non-Western societies are prevalent. In Africa, research findings indicate high rates of child abuse and neglect, including 53% for physical abuse and 56% for sexual abuse (Charak et al., 2017). Research conducted in developing countries has shown that risk factors for child maltreatment are higher than in developed countries (Charak et al., 2017). These higher risk factors include extensive poverty, higher rates of illiteracy, lack of legislation and child welfare services, poor access to healthcare and limited access to education, as well as an environment plagued with armed conflict (Charak et al., 2017). For instance, Kara et al. (2019) found that the rates of mental health disorders are higher among children who experience adversities, such as an armed conflict than those who do not.

Another risk factor that has been discussed is poverty. Poverty is not necessarily part of child maltreatment but is a risk factor in that it affects parents/caretakers' ability to invest in their children's development by means of economic pressure, financial instability, unemployment, and parental high levels of stress (Kara et al., 2019). Poverty then hinders children's well-being by interfering with parental investment, well-being, and healthy child rearing practices (Kara et al., 2019). Further, the authors also noted that poverty-related aspects, such as "housing quality, crowding, exposure to toxins, and chronic noise are associated with cognitive deficits and higher levels of emotional and behavioral problems in children as well as less parental responsiveness and monitoring, higher child maltreatment, and psychological distress in adults" (Kara et al., 2019, p. 3).

Most early research on adverse childhood experiences (ACEs) has been conducted in the United States with a predominantly white, middle class, college educated, non-clinical sample (CDC, 2016). In developing countries, however, ACEs-related research has focused on marginalized child populations, such as children soldiers, refugees, homeless children, children with HIV, etc. Although this is a good start, the problem of childhood adversity/trauma in many developing countries is more widespread and affects a much wider range of populations and families than in developed countries (CDC, 2016), necessitating the need for research on the adverse childhood experiences of well-educated populations in developing countries.

Childhood Adversities with Burundian

The Burundian society has endured decades of major adversities, including extreme economic hardships, armed conflict and war-related violence, massive losses, etc. (International Growth Center, 2018). Other family-related hardships that have plagued Burundians have involved situations, such as child abuse, mental illness and substance abuse in the household, and poverty (Familiar et al., 2013). It is understandable that such persistent adverse experiences would potentially deeply undermine Burundians' psychological well-being.

Childhood traumatic experiences in Burundi are believed to be rampant and yet research on such experiences is still quite scarce. Most child-related research conducted in Burundi has focused on homelessness and armed conflicts (Charak et al., 2017). In addition, several factors that are known to increase the probability of trauma exposure for children are prevalent in Burundi. Some of these factors include parents' personal experiences with childhood abuse and neglect, caregivers' mental illness/distress, cultural

values, socioeconomic status and financial stress, as well as political unrest (Charak et al., 2017). Moreover, the repercussions of childhood adversity may take on a form of an intergenerational abusive cycle. In their study, Crombach and Bambonyé (2015) found that childhood maltreatment is a strong predictor of intergenerational violence in Burundi, i.e., participants with some form of childhood abuse were found to be more violent toward their children and their intimate partner.

A study of 231 participants was conducted in Burundi to assess rates of child abuse and neglect (namely, emotional, physical, sexual abuse, and emotional and physical neglect) among Burundian adolescents from all provinces in comparison to high-income countries rates (Charak et al., 2017). All participants stated that they have experienced at least one type of abuse and/or neglect and 15.2% reported dealing with all five types of abuse. Thirty-two percent (32%) of the adolescents reported experiencing emotional abuse, 20.8% for physical abuse, 14.7% for sexual abuse, 89.2% for physical neglect, and 93.5% for emotional neglect (Charak et al., 2017).

Such findings show that childhood adversity in Burundi is prevalent with little preventive/protective measures in place. Additionally, certain cultural beliefs, such as parental harsh discipline or lack of warmth may increase the risk of child abuse and neglect (Flouri et al., 2017). With such prevalence, it is likely that childhood adversity in Burundi is rather a common experience within the Burundian community. While outlying cases, such as homeless children, etc., are more alarming, it is important to note that children's exposure to childhood adversity in Burundi and the impact it has on their overall development is far from being trivial (Charak et al., 2017). In fact, these children will later be confronted with having to navigate interactions with families of their own,

manage decision-making positions, and overall have an influence on younger generations.

Moreover, despite the well-known traumatic history in this country, Burundian families and communities have received little to no professional mental health assistance. In fact, in 2013, the World Health Organization (WHO) spoke to this matter and reported concerning rates of the widespread shortage of mental health assistance in low/middle-income countries, stating that up to 85% of people with severe mental illness in these nations receive no treatment (WHO, 2013). It is, in fact, disheartening to think that the majority of the Burundian people who suffer from mild to severe mental illness will go through their lifetime without receiving proper mental health care. One can also imagine the alarming repercussions of the constant large-scale exposure to the many types of trauma on the mental health of the Burundian community.

The present study focuses particularly on Burundian college students to examine childhood trauma repercussions on a well-educated population of young adults in Burundi who seem to have more of a promising future than the marginalized groups. The following section expands on this rationale.

Rationale for a Study on Childhood Adversity with Burundian College Students

Studies on childhood adversities in non-Western communities are still relatively few. Moreover, the current study represents a pioneering research endeavor on this topic with college students in Burundi. A college student population represents a valuable human resource for a nation's future. These are high functioning people who will be tending to the social, economic, and political needs of their communities and families (Taylor et al., 2019). In taking a closer look into Burundian college students' experiences

with childhood adversity and into their current emotional well-being, the main gap that the current study seeks to fill is to identify and better understand the emotional repercussions of such experiences on a population that is considered to be highly-functioning and draw attention on their needs and the importance of meeting them. Here, the underlying assumption is that childhood trauma and its repercussions deserve mental health attention in Burundi, even for people with higher intellectual abilities, a promising future, and seemingly successful lives.

Purpose of the Study

The present study seeks to identify whether high-functioning, seemingly successful young adults in Burundi, a developing country, can also carry concerning rates of childhood trauma. Although most studies conducted in Burundi adverse childhood experiences have focused on marginalized groups, such as homeless minors and refugees, this study is targeting a high-functioning population, that is college students. The researcher's speculation is that, like the US sample, individuals across all levels of SES, including higher SES in Burundi may have endured a traumatic past that is significantly affecting them. These are people who make it to college and represent the future families, community, and leadership of the country on many levels.

The study is a mixed method research project where the quantitative portion aims to collect adverse childhood experiences rates among college populations in Burundi while the qualitative portion gathers information about how such experiences affect this population's current emotional well-being. The qualitative part of the study also seeks to gain insight into the coping strategies of the Burundian college students. This study seeks to answer two questions, namely: (a) Do college students in Burundi experience high

rates of childhood adversity/trauma according to their ACEs scores? (b) How do college students in Burundi with a childhood adversity/trauma background, experience their current emotional well-being and coping processes?

The present study utilizes two assessment instruments including the WHO Adverse Childhood Experiences-International Questionnaire (ACE-IQ) and an emotional well-being instrument for the quantitative and the qualitative portions of the research, respectively. In 2018, the WHO put together a newer version of the ACE-IQ that assesses three domains, namely childhood maltreatment, household/family dysfunction, and violence outside of the home (WHO, 2018). The ACE-IQ represents a more global version of ACEs that includes and recognizes the "violence outside the home" as the additional, third category of childhood adversities (DeLisi et al., 2019). This category includes bullying, peer violence, and/or violence/killings in the community.

The emotional well-being instrument is a semi-structured survey tool that was based on the Emotional Well-Being Scale (EWBS) (Şimşek, 2011). Emotional well-being was defined by the Mental Health Foundation as "a positive sense of well-being which enables an individual to be able to function in society and meet the demands of everyday life" (Ojha et al., 2018, p. 112). The interview instrument addresses three main questions, namely interviewees' recent happy experiences, their recent unhappy experiences, and their coping strategy.

The rationale for conducting this mixed-method study is to attempt to show that just because high functioning people/young adults in Burundi make it to college and go on to lead seemingly successful lives, does not imply that they are not carrying the heavy weight of past trauma and the high cost that comes with it. It is also to help create more

opportunities for Burundian young adults to share their experiences and feel heard. Findings may support the fact that mental health care is not only needed among refugee camps, former soldiers, or people with more alarming psychological disorders, such as schizophrenia, etc., but among the college-educated Burundian population as well.

In the following chapter, an extensive exploration of the general impact of childhood trauma is provided. Other main points discussed below include the state of mental health in Burundi as well as an overview of the ACE-IQ instrument as informed by previous research findings.

Chapter II

Literature Review

Impact of Trauma

Childhood trauma consists of a series of events that convey a message of threat to the child, whether that is physically, psychologically, or socially (American Psychiatric Association, 2013). A single threatening event, such as a car accident or a hurricane can take a psychological toll on children as well (Capretto, 2020). Although many children are exposed to traumatic events at one point in their developing lives and may experience distress following a traumatic event, most of them will usually return to a normal state of functioning in a relatively short period of time (Saunders et al., 2014).

However, when traumatic experiences are frequent, the child experiences ongoing psychological stress reactions to situations, such as poverty, lack of physical safety, or constant verbal abuse. This psychological stress can be traumatic as well, even when the person somehow adapts to the chronic stress and it is interpreted as normal, daily life. Below is a discussion of some of the main effects of childhood trauma.

Physical Development and Long-Term Health Consequences

Childhood trauma may compromise a child's physical development. These experiences create chronic fear and constant high levels of stress for the child, undermining optimal development of both the immune system and the brain's ability to develop healthy emotional responses capacities. (Cloitre et al., 2009). In the event of perceived stress, an individual may experience significant physiological reactivity, such as rapid heart rate or rapid breathing.

A child's immune system may also be compromised due to chronic stress caused by trauma (De Bellis et al., 2014). For instance, children with complex trauma histories

may develop chronic or recurrent physical complaints, such as headaches or stomachaches. Moreover, adults with histories of trauma in childhood are more likely to engage in poor health choices and even risky behaviors, such as smoking, unprotected sex, and unhealthy diet.

Similarly, body-dysregulation has also been found to be one of the byproducts of childhood trauma in later years. Body-dysregulation refers to a physiological over-response or under-response to sensory stimuli (Cloitre et al., 2009). For example, childhood trauma survivors may be hypersensitive to sounds, smells, touch, etc., or may become unaware of physical pain. As a result, they may injure themselves without feeling pain or, on the other hand, they may complain of chronic pain in various areas of their bodies without any substantial physical cause (Cloitre et al., 2009).

In addition to a compromised physical development, early traumatic events are also associated with lifelong health consequences. In other words, the more the experience of childhood trauma, the more severe health and wellness problems of a person later in life can be (Overstreet et al., 2017). Some of the health problems that may be more likely to occur due to childhood trauma include: Asthma, coronary heart disease, depression, diabetes, and stroke. Likewise, suicide attempts are also more prevalent with adults who experienced childhood trauma, such as physical abuse, sexual abuse, and parental domestic violence (Wagner, 2016). Such findings highlight the importance of child maltreatment prevention to mitigate adult morbidity and mortality.

Below, attachment is discussed as it relates to the impact of childhood trauma.

Attachment

Attachment Theory. Bowlby (1988), the founder of attachment theory, developed the notion that behaviors, such as crying, sucking, smiling, following, and clinging demonstrated a baby's connection with the primary caregiver, generally the mother. He regarded these attachment behaviors as holding the same level of importance as eating and sex and holding protection as its biological function in that it increases proximity with the primary attachment figure (Cassidy et al., 2001), which then leads to a substantial sense of safety.

In her study on the attachment dynamics between infants and their mothers in Uganda, Ainsworth's findings yielded evidence that infants rely on their mothers as a safety haven and a secure base from which they can explore the world. Some of the behaviors indicative of attachment were shown as the baby displayed distress and following behavior when separated from the mother and by greeting and proximity seeking when reunited with the mother (Bowlby et al., 1991).

Secure infants typically showed expectation of the mother's availability and responsiveness regarding their needs, as well as comfort and easiness with both proximity seeking and exploratory behaviors. Ainsworth referred to this dynamic as an "attachment-exploration balance" (Ainsworth et al., 1971). Additionally, although the caregiver's sensitivity and responsiveness are central to the creation and the maintenance of secure attachment, the child's attachment organization also entails co-regulation, which refers to the dynamic of emotional/verbal exchanges that take place between a child and the caregiver (Evans et al., 2009).

This aspect is important because it suggests that attachment organization is a co-created process where infants are recognized to have an active role as well in the

connections taking place with their caregiver (Waters et al., 2000). Overall, through such positive experiences, infants integrate the message that they are truly seen and cherished, which establishes a deep foundation that will allow for a future of emotional and psychological well-being (Ainsworth et al., 1978).

Bowlby argued that attachment systems are active through a person's lifespan as well (Bowlby et al., 1991) by means of acquired mental representations of the self, others, and the world. He pointed out that these repeated experiences with caregivers in the early years were integral to the attachment behavioral system and influenced the way a child interprets an experience and impacts his subsequent response/behavior. These mental representations, also known as Internal Working Models (IWM) can be restructured through different experiences and within specific relationships. While they tend to operate without conscious awareness of the individual, attachment processes are amenable to change (Bowlby, 1980).

Thus, although IWM can be fairly resilient patterns, it is important to understand that they refer to a way the mind organizes information about self and others, either through obtaining information, interpreting information, or limiting access to information (Main et al., 1985). Understanding this concept is an important step in the assessment and intervention process with individuals who have experienced insecure patterns of attachment (Waters et al., 2000).

Attachment and Relationships. Bowlby's attachment theory states that when the emotional needs of a child are not met by a caregiver, an insecure attachment may result (Joeng et al., 2017). The relationship between children and their caregiver is therefore, essential to their emotional health in that it helps them learn to trust others, manage

emotions, interact with the world around them, and realize their own value as individuals. In fact, the premise of the concept of attachment is that human beings are relational beings wired to carry on mental representations developed during childhood into adulthood (Corcoran et al., 2018).

If the child's caregiver was available, caring, and consistent, the child internalizes this model and develops secure attachment patterns in future relationships and in the way one approaches life as well. On the other hand, if the caregiver was unavailable, uncaring, and inconsistent, the child will develop insecure/disordered attachment patterns, mainly involving avoidant and/or anxious attachment styles (Corcoran et al., 2018). Avoidant attachment in adulthood refers to a tendency to withdraw oneself from closeness because the person fears rejection, while an individual with anxious attachment will pursue closeness harder because of fear of rejection or disconnect (Corcoran et al., 2018).

This phenomenon is known as the child's conflict between approach and avoidance (Cassidy et al., 2001), which can result in disorganized attachment patterns. Adults with disorganized attachment patterns may also become controlling in an effort to bring a sense of organization in their relationships (Cassidy et al., 2001). In the context of romantic relationships, research has shown that adults who are survivors of childhood trauma report a higher rate of failed marriages (Draper et al., 2008).

When trauma occurs, the child learns that others cannot be trusted or relied on and they develop instead the idea that the world is not a safe place and that all adults are dangerous, which then generates significant relationship difficulties as the emotionally wounded children struggles to form and maintain healthy relationships throughout their childhood and into the adult years (Cassidy et al., 2001). Moreover, childhood trauma

has also shown to undermine a person's ability to emotionally self-regulate, as discussed in the following section.

Emotion Regulation

Children who have experienced complex trauma often have difficulty with emotion management, including identifying and expressing the different emotional states they are experiencing (Kuo et al., 2011). The experienced stress serves as a trigger that causes them to internalize and/or externalize stress-related reactions and as a result, they may experience significant depression, anxiety, or anger episodes, as well as be subject to unpredictable or explosive emotional responses (Kuo et al., 2011).

Another aspect of the emotional management difficulty is the child's hypersensitivity and overreaction to a reminder of a traumatic event, which can involve trembling, anger, sadness, or avoidance (Kuo et al., 2011), as well as difficulty calming down when upset. Such responses are usually out of proportion and often perceived by others as "overreacting" or as unresponsive/detached.

In the context of interpersonal trauma experiences, trauma reminders may include even mildly stressful interactions with others and will still trigger intense emotional responses. The perception of the world being a dangerous place and the difficulty trusting even loved ones create patterns of vigilance and guardedness in interactions with others for children and adults with a trauma history (Kuo et al., 2011). While this defensive posture is protective when an individual is under attack, it becomes problematic in situations that do not warrant such intense reactions. Alternately, many children also learn to "tune out" (emotional numbing) to threats in their environment, making them vulnerable to revictimization, which perpetuates abuse and traumatic experiences

throughout their childhood and into adulthood.

Difficulty regulating emotions is pervasive even beyond the context of relationships (Rudenstine et al., 2019). For instance, having never learned to emotionally self-soothe, many of the children with traumatic experiences can feel overwhelmed with tasks that only present a mild challenge, making them vulnerable to chronic discouragement and to self-sabotaging tendencies (Kuo et al., 2011).

Emotion Regulation for Adult Survivors of Childhood Trauma. Emotion regulation has been defined as "the ability to effectively monitor, evaluate, and modulate emotional responses regarding intensity, duration, and valence across contexts" (Rudenstine et al., 2019, p. 125). Emotion regulation may also be mediated by attachment quality in that individuals who are able to accept and integrate both positive and negative emotions are thought to be generally securely attached whereas those who display limited or heightened negative affect are more likely to be insecurely attached (Cassidy, 1994).

The lack of ability to emotion regulate may play out in different ways, including "attentional or behavioral avoidance, over engagement or rejection of negative emotions, anxiety, self-destructive behaviors, maladaptive cognitions, behavioral difficulties, emotional suppression, and/or erratic emotional responses" (Rudenstine et al., 2019, p. 125). Therefore, emotion regulation has been determined to be crucial to human adaptive functioning as well as distress tolerance.

One study found that childhood adversity has shown to have a negative effect on adult ability to respond to stress or conflict in a healthy manner (Winer et al., 2018). On the other hand, childhood family background can shape adult cortisol responses to conflict. Moreover, adult emotion dysregulation, whether it manifests in terms of

emotional reactivity or shutting down, is better understood in the context of childhood adversity. A child's brain development in a traumatic environment will produce high levels of cortisol, which is a hormone that serves as an alarm-system in situations of danger (Rudenstine et al., 2019).

In adulthood, a brain highly wired for survival tends to misinterpret danger and mismanage stress, therefore reverting to the maladaptive coping discussed above (Rudenstine et al., 2019). For instance, a person who grew up with an angry father might struggle being able to handle anger and turn to alcohol abuse to cope, hence developing a psychological disorder. In fact, research has shown that mental health disorders are, in a way, disorders of emotion regulation (Rudenstine et al., 2019). The next section discusses the impaired cognition that can develop as a result of childhood traumatic experiences.

Impaired Cognition

Childhood trauma may lead to impairments in thinking clearly, reasoning, or problem solving for these psychologically wounded children (Stien et al., 2014). The constant exposure to threat and chronic stress causes these children to focus all their internal resources on survival, making it difficult to think through a problem calmly and consider multiple alternatives. Moreover, they may find it hard to engage in cognitive operations, such as acquiring new skills, sustaining attention, or language development. Children experiencing such challenges may require support in the academic environment to help with these learning difficulties (Stien et al., 2014).

Problematic Behavior

Behaviorally, because children with a trauma history struggle significantly in managing their emotions, they may be easily triggered and more likely to react intensely

(Ford et al., 2010). The resulting behavior may show as unpredictable, oppositional, volatile, and extreme. For instance, a child who was exposed to chronic fear and developed feelings of powerlessness may react defensively and aggressively in response to perceived blame or attack. Alternately, the child may at times display an overcontrolled, rigid, and unusually compliant behavior with adults (Ford et al., 2010).

Additionally, children who are victims of trauma may engage in high-risk behaviors, such as self-harm, unsafe sexual practices, and excessive risk-taking decisions, such as wandering around at night in a dangerous neighborhood (Ford et al., 2010). In some extreme cases, these children may also engage in illegal activities, such as alcohol and substance use, assaulting others and stealing, etc., thereby making it them more susceptible to enter the juvenile justice system.

Self-Concept and Future Orientation

Self-concept refers to the extent to which a person's sense of identity is certain, stable, and coherent (Wong et al., 2019). Children's self-worth is formed as they observe others' reactions, particularly their caregivers and loved ones (Ainsworth et al., 1978). In the presence of abuse and neglect, the child is made to feel worthless, powerless, and "damaged." For these children, it is also easier and safer to feel guilty than to blame the parents and recognize them as unreliable and dangerous. The traumatic events create distorted beliefs, thoughts, and feelings about self, others, and the world. The maltreated child is more likely to develop an intrinsic sense of defect in one's view of self, therefore struggling to strive to achieve one's full range of competencies (Peckels, 2017).

To plan for the future with hope and purpose proves to be particularly difficult for the abused children who have a hard time recognizing that their lives have value and

meaning (Ainsworth et al., 1978). The distorted beliefs about themselves and the world around them, as well as the feelings of powerlessness diminish their sense of competency and undermine the ability to dare and make a difference in their own lives. They live in survival mode, from moment-to-moment, unable to reflect or dream of a desired future (Forster et al., 2019).

In addition, childhood trauma survivors may experience a more difficult/turbulent transition into adulthood. The theory on emerging adulthood suggests that there are various dimensions of transition processes, including identity exploration, focus on self or others, experimentation, and instability (Forster et al., 2019). In this regard, some research has found that young adults with past experiences of childhood adversity scored higher on instability and lower on experimentation and self-focus than those without such background, which also correlates with high levels of substance use, low tolerance of stress, poor behavioral self-regulation, and maladaptive coping (Forster et al., 2019).

The previous few sections have addressed the ways in which childhood adversity may contribute to creating psychological deficits, i.e., issues around attachment, emotion regulation, and self-concept, hence leading to a heightened vulnerability with regards to psychological distress in adulthood. Fortunately, a history of adversity is not the only factor that plays into a person's psychological wellness in adulthood. People with childhood trauma can, in fact, recover and even thrive in life depending on their ability to engage in healthy coping mechanisms (Echterling et al., 2018). The following section focuses on the topic of coping strategies and resilience-building processes.

Coping Strategies

Dissociation

Dissociation is often seen in children and individuals with histories of complex trauma during childhood (Gomez, 2013). Dissociating involves mentally separating self from the overwhelming and distressing experiences that are happening. During such moments, children may perceive themselves as detached from their bodies and merely watching what is happening. They may feel as if they are in a dream or some altered state that is not quite real. Alternately, they may lose memories or sense of the experiences having happened to them, which may result in a shattered sense of time and continuity in their personal history. Much like the emotional numbing to threats discussed above, dissociation may give way to increasing revictimization over time (Gomez, 2013).

Dissociation may have adverse effects on learning, classroom behavior, and social interactions, which may appear to others as if the child is simply "spacing out," daydreaming, or not paying attention (Gomez, 2013). In the event that the process of emotional and mental recovery is taking place, adult-survivors of childhood trauma may express feeling as if those childhood years were robbed from them.

Problem-Focused and Avoidant Emotion-Focused Coping

Sheffler and his colleagues identified strategies that individuals, survivors of childhood trauma, may utilize to cope (2019). These strategies include the problem-focused (PF) and the avoidant emotion-focused (AEF) coping mechanisms. The PF approach appears to be healthier in that it leads to problem resolution and enhances resilience. An example that illustrates this approach would refer to a person who as a child, was told that he would amount to nothing. This person may develop a desire to counteract these words and may consequently become a hard worker and a big achiever.

Alternately, the AEF seeks to alleviate immediate stress by avoiding the experience of negative affect, hence promoting risky behaviors to avoid these distressing emotions (Sheffler et al., 2019). To illustrate this, a person with the same background as above may struggle to "overcome" the pain related to the emotional abuse and engage in substance abuse as a distraction from the emotional distress that is associated with it.

Hope

Due to the resulting trauma and rumination patterns, childhood trauma has been linked with lower rates of hope in adulthood (Munoz et al., 2019). Hope has also been associated with well-being for people facing adversity in that it fosters positivity, empowerment, and overall life satisfaction. It is a psychological state that fosters positive coping when under stress and has shown to be an even more significant predictor of childhood trauma survivors' ability to thrive than resilience. In fact, some research has suggested that hope facilitates the capacity for resilience and enhances one's physical and mental health (Munoz et al., 2019).

Resilience

Resilience is not the most common outcome of childhood trauma. In a longitudinal study of individuals who had experienced abuse and neglect during childhood, only 22% of those who had been abused or neglected achieved resiliency based on a comprehensive assessment of healthy adult functioning (De Bellis et al., 2014). Additionally, age of the child on the onset of trauma seems to play a determining role in a person's ability to develop resilience. A study conducted on this matter found that participants first exposed to child maltreatment during early childhood had depression and PTSD symptoms that were about twice as high as those exposed during later developmental stages (Dunn et al., 2017).

Nonetheless, resilience-promoting factors have been identified. These factors include social purpose, motivation, reflection, personality traits, social support, turning points, etc., all of which are, in a way, facilitated by the trauma history and determine survivors' ability to cope with its impact (Mc Gee et al., 2018).

Spirituality and Religious Engagement

Religious engagement and spirituality has been identified as another protective factor for people who experienced childhood trauma (Brewer-Smyth et al., 2014). In fact, spirituality/religious engagement has shown to promote resilience in that it facilitates forgiveness, a sense of purpose and meaning in regard to the traumatic experiences, a connection with a Divine through prayer, and social support. In this way, typical responses to childhood adversity, such as depression or anxiety are alleviated and individuals' ability to adapt and even thrive is enhanced (Echterling et al., 2018).

That being said, this resource can also play an adverse role in the lives of people who have experienced childhood trauma in that there can be exercise of control in some faith-based groups, spiritual/religious values that can dissipate as a result of the experienced trauma, and individuals may experience an insecure connection with God/Higher Power despite an experienced greater desire to connect with a Divine (Santoro et al., 2016).

College Students and Childhood Trauma Coping Experience

College student populations with a history of trauma can tap into the different coping strategies and manage to navigate the challenges of college life. However, several studies have discussed findings around unique difficulties that such populations face. For

instance, early traumatic experiences have contributed to college students increased repetitive negative thinking, therefore causing heightened anxiety (Taylor et al., 2019).

They also predicted more family and health difficulties (e.g., depressive symptoms), which negatively affected academic success (Hinojosa et al., 2019); they explain an adopted stress mindset, which causes hypersensitivity to perceived stress and leads to poor coping overall (Long, 2019); and finally, they predicted, alongside attachment anxiety patterns, detachment coping or avoidance among college students (Saunders, 2019).

Mental Health in Burundi

In 2010 (as cited by Familiar et al., 2013), the World Health Organization [WHO] called attention to "the urgency to address the specific needs of people with mental and psychosocial disabilities as part of the social reconstruction of post-conflict settings" (para 2). In fact, research has supported that mental health morbidity is more prevalent in conflict-affected countries than it is in more stable societies (Baingana et al., 2004). For instance, a study conducted by De Jong et al. (as cited by Baingana et al., 2004) on refugees from four different countries found that there was a 44% rate of psychopathology among people who experienced violence, compared to a 17% rate among people who did not.

Burundi is one of the more conflict-affected countries. Its population has had a tremendous amount of conflict-related and economic hardships. Decades of political unrest and on-going violence have affected the overall state of mental health of the Burundian society (Familiar et al., 2013). This can be a challenging environment to raise children. In fact, research has shown that low Social Economic Status (SES) can foster

parenting stress as well as infliction of traumatic treatment unto children (Steele et al., 2016). Moreover, experiences of childhood trauma in combination with community violence exposure has shown to elevate rates of post-traumatic stress disorder (PTSD) (Walling et al., 2011).

On the other hand, support from caregivers and other close relationships may be an important factor in helping poor children develop resilience and experience positive developmental processes (Hostinar, 2019). Community violence, low SES, etc., are factors that can heighten children's exposure to trauma. Based on such findings, it is possible that the Burundian youth have had to deal with such trauma at a significant level.

Childrearing Practices

Childrearing practices are embedded within a community's culture. Often, caretakers will tend to engage in the kind of discipline that they received themselves growing up (Fontes, 2017). Harsh parental discipline, which consists of severe verbal discipline, such as yelling, 'telling off' a child etc., and physical punishment, such as beating (Flouri et al., 2017) are associated with wanting to raise strong children than hating one's own children (Fontes, 2017). A caretaker in Somalia expressed the following about harsh discipline:

> We do practice spanking, for instance, we spank children, in school, at home… It is not because you don't like your children, on the contrary, but one has the intention to raise them strictly. You want that person to stand strong as stone. (Fontes, 2017, para 5).

Harsh parental discipline in association with other factors, such as parental lack of warmth, child's sensitive temperament, environmental/family stressors (violence,

poverty, etc.), has shown to be a contributing factor in child's emotional and behavioral problems (Flouri et al., 2017). Traumas and adversity, either developmentally or socially, can contribute to caretakers' perceived loss of control and therefore, they attempt to regain control by disciplining the child to ensure a better future than theirs (Fontes, 2017).

Caretakers may also downplay the consequences of harsh discipline, thinking their offspring need to toughen up to be better able to face life challenges. Further, research has shown that parental harsh discipline plays a role regarding emotion regulation (Baron et al., 2019). For instance, a study on parental harsh discipline and child' self-regulation ability found that the more harshly parents administered discipline, the less children were able to emotionally self-regulate, which then increased the harshness in parental discipline (Baron et al., 2019).

In 2019, the United Nations' Children's Fund (UNICEF) classified Burundi at the 11th highest level of violent discipline among 97 countries overall (UNICEF, 2019). UNICEF defines violent discipline as including psychological aggression, such as shouting, yelling/screaming, calling the child offensive names, e.g., dumb, etc., and physical punishment, namely shaking, hitting, or beating the child (UNICEF, 2019). Although Fontes (2017) noted that mental health professionals should be able to differentiate between harsh parental discipline and merely unfamiliar child discipline practices, it appears that there is a fine line between childrearing practices and child abuse in some cultures and societies, and namely in Burundi. Further, statistics on violent parental discipline in Burundi also suggest the rate of child abuse is likely significantly elevated within households, therefore indicating high levels of adverse childhood

experiences within the Burundian society. The following section discusses the Adverse Childhood Experiences (ACEs) assessment as well as important relevant findings.

Overview and Background of ACEs

In the 1980's, Felitti and his colleagues mailed out a questionnaire about adverse childhood experiences to 13,494 adults who had completed a standardized medical evaluation and 9,508 (70.5%) responded (Felitti et al., 1998). The research team sought to study seven categories of adverse childhood experiences (ACEs), namely: psychological, physical, or sexual abuse; violence against mother; or living with household members who were substance abusers, mentally ill or suicidal, or ever imprisoned; and compare results to measures of adult risk behavior, health status, and disease. Findings showed a strong relationship between the scope of exposure to abuse or household dysfunction during childhood and multiple risk factors for several of the leading causes of death in adults (Felitti et al., 1998).

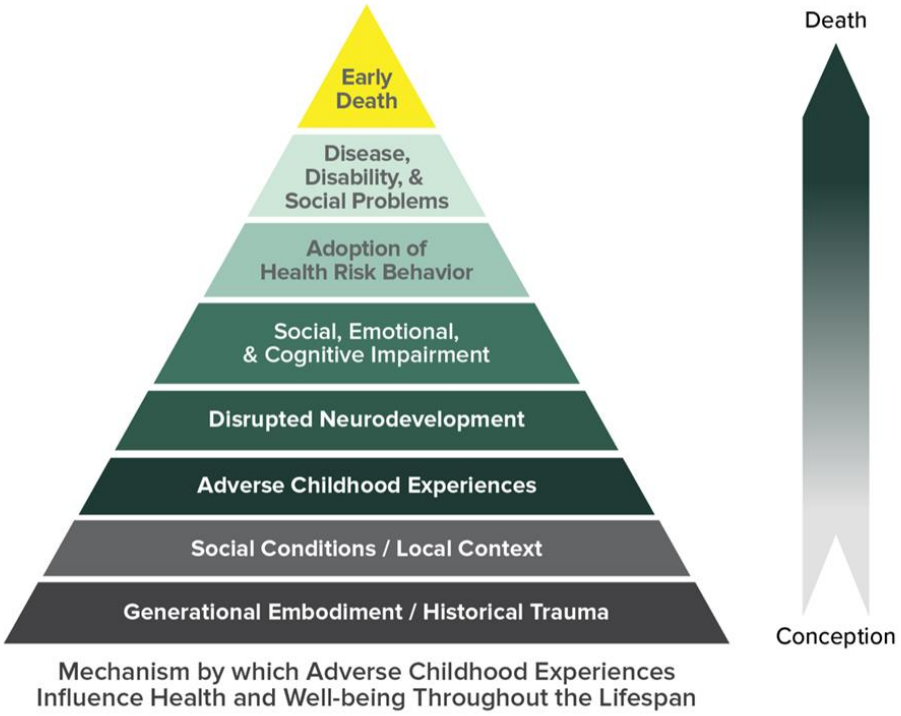
The ACEs categories discussed above were later refined into eight, more specific types, namely physical abuse/neglect, emotional abuse/neglect, sexual abuse, exposure to domestic violence, household substance abuse, household mental illness, parents' separation or divorce, and incarceration of a household member (Felitti et al., 2003). The Felitti and Anda's study on ACEs conducted under the Center for Disease Control and Prevention (CDC) found that childhood adversities were related to health and social problems later in life (CDC, 2015). As a consequence of these influential studies, the potential association that is between ACEs and health outcomes has been the focus of a growing body of research.

Findings on ACEs

The Center for Disease Control and Prevention (2016) has found that ACEs were associated with a person's social, emotional, and cognitive problems, which potentially lead to a tendency to engage in risk-behaviors and thereby, exposing oneself to diseases such as diabetes, disability, and even premature death, as the Kaiser pyramid (CDC, 2020) illustrates below:

Figure 2

Kaiser pyramid



According to the CDC (2016), child maltreatment and family dysfunction play a significant role in a person's mental and physical illness later in life. For instance, the United States' Substance Abuse and Mental Health Services Administration (SAMHSA) conducted a study on ACEs and found that 49% of all participants had been either physically or sexually abused (SAMHSA, 2016). Additionally, the study found that

ACEs tend to occur together, i.e., participants from the substance abuse program reported two or more ACEs (SAMHSA, 2016).

More recently, findings have indicated associations between ACEs and Antisocial Personality Disorder, including severe implications such as crime and violence (DeLisi et al., 2019); associations between ACEs and substance abuse both to cope/self-medicate and to escape a dysfunctional environment (Boppre et al., 2019); associations with difficulty transitioning into adulthood e.g., struggling with identity, with experimentation, etc. (Forster et al., 2019); and a strong inclination toward perfectionism (Chen et al., 2019). Childhood adversity has also been linked with severe depression and anxiety (Sheffler et al., 2019). In fact, the authors reported that prior research concluded that a reduction of 10 to 25 % in maltreatment could prevent millions (31.4-80.3) of depression and anxiety cases globally.

Conclusion

Although there is intriguing research pertaining to the impact of ACEs in Western societies, similar wide-spread studies in Burundi are limited. In particular, such studies have focused on marginalized and high-risk populations. The conceptual framework of attachment theory and emotion regulation hold promise in providing insight into the impact of ACEs on the level of adult well-being.

This study provides a preliminary look at the adverse childhood experiences and current levels of well-being among high functioning college students in Burundi. The ultimate purpose of this research is to assess the potential mental health needs of this population and to recommend potential prevention and intervention strategies that are culturally sensitive and effective.

The following chapter describes the methodology to be employed in answering these research questions and providing information regarding the incidence of various childhood adversities and their impact on the level of well-being among Burundi college students.

Chapter III

Methodology

Participants

The present study focused on the lived childhood experiences of Burundian college students (n=100) as well as their current emotional well-being (n=8). Sampling for the quantitative portion of the study was based on convenience selection of participating students for easier access purposes. A university from Bujumbura the capital of Burundi (International Leadership University, ILU) was selected, and announcement of the research project was made via notice boards and in classes by instructors. The totality of the ILU students, i.e., approximately 500 students, were informed of this research project.

Surveys were sent to 102 students who volunteered to provide their email addresses and all completed surveys were considered for analysis. After a review of the surveys, two forms were found to be incorrectly completed. After unsuccessfully attempting to contact the two students, the researcher included two additional volunteering participants. All 102 participants, however, received the incentive. Participants were able to complete the ACE-IQ online survey via QuestionPro. Upon analysis of the survey results, four students on the lower end of the distribution and four students on the higher end of the ACE-IQ scores were interviewed regarding their current emotional well-being and coping strategies.

The sampling procedure for interviewees followed a purposeful selection strategy to ensure saturation, i.e., to strive for a comprehensive understanding of interviewees' experiences by continuing to sample until no new substantive information was acquired.

To provide more balance in gender for interview participation, purposeful sampling also entailed that an equal number of females and males that met the score criteria was selected. Participants were expected to be anywhere between 20 and 25 years of age, which is a common college age range in Burundi.

Participants with childhoods (at least 14 years) spent in Burundi, regardless of the province, were included, to ensure that these experiences would be embedded in the overall cultural context. Further, prior to the interview, I sent out the interview consent form to the interviewee in order to make certain that I receive a signed form in a timely fashion. During the interview, I invited participants to share their experiences in completing the ACE-IQ survey.

Survey/Interview Protocol

As mentioned earlier, the ACE-IQ is a survey that was developed by the World Health Organization in 2018 (WHO, 2018). This survey assesses three domains, namely childhood maltreatment, household/family dysfunction, and violence outside of the home. The ACE-IQ is a 29-item questionnaire. The ACE-IQ content validity and face validity were both supported, with the scale-level validity for relevance and appropriateness ranging from 0.86 to 0.99 (Ho, et al., 2019). In addition, the instrument showed a high test-retest reliability, with the intra-class correlations measuring (ICC = 0.90) and semantic equivalence (ICC= 0.90) (Ho et al., 2019).

The WHO has provided two scoring methods for score analysis of the 29 items in the ACEs-IQ. The first method is the binary approach and it examines whether the participant experienced a certain type of adversity growing up. This method consists of assigning a ‘yes’ to the participant’s affirmative answer (whether it occurred once, a few

times, or many times). Such a response is circled and a 1 is placed in the final column. If the participant answers affirmatively to multiple items under one category, that still counts as a one yes, hence a score of only one (1) is attributed to the category. For the emotional neglect category, it is the 'no' that counts as an affirmative, therefore as a 1. Once completed scores should range from 0 to 13. The second method is frequency approach, which is used to look at the level of occurrence of the type of adversity.

The semi-structured interview guide on emotional well-being was inspired by the Emotional Well-Being Scale (EWBS) (Şimşek, 2011), which comprised 14 questions, seven for the positive emotional well-being (PEWB) and seven for the negative emotional well-being (NEWB). The interview questions were adapted from the EWBS in that one question was formulated in a way that combined the seven questions from the PEWB and another that combined the other seven from the NEWB. The third and last question on the interview questionnaire inquired about participants' coping strategies (See appendix B).

Procedure

In the month of September 2020, during the ILU fall semester, participants were informed of the research study using notice boards along with announcements from the university instructors. The advertisement included information on the topic of research, a short rationale for conducting the study, and guidance on how to complete the survey. The announcements also included information regarding an incentive of the amount of 10000 Burundian Francs (i.e., USD 5.19) per participant for the 100 respondents. Interested subjects were able to provide their email addresses and were sent a link to access the ACE-IQ survey platform.

Upon data collection, the researcher generated the list of the names of the 100 respondents and provided it to the University administration for incentive distribution. To ensure that incentives were delivered as promised, the researcher transferred the funds from her bank account in Burundi to the University bank account and individual envelopes were made and distributed to participants by the university administration by December 2020 before the holidays.

Throughout both quantitative and qualitative data collection processes, the university authority ensured that precautions among students were taken as always to eliminate the risks of COVID-19. These precautions included social distancing among students, mandatory mask wearing, as well as hand sanitation/washing. These measures were at observed at all times as participants entered and used the administration office space to provide their emails, complete the survey, or participate in the interview.

Once 100 surveys were completed, analysis was conducted to screen for the highest and lowest scores on the ACE-IQ. Eight students from among these scores, i.e., four with high scores and four with low scores, were contacted to participate in the interview. Participants were interviewed for approximately 30 minutes and interview data was collected over a period of one week via Webex. Interviews were audio-recorded with permission of participants to ensure that everything said was preserved for analysis purposes. Notes were also taken in-between interviews to document participants' non-verbal expressions, as well as interviewer's thoughts and impressions. Audio recordings were then stored in a detachable, external drive and the researcher ensured that icloud was turned off on the computer for the entirety of the interview.

Further, additional incentive of 10,000 Burundian Francs (i.e., USD 5.19) was provided to interviewees following their feedback on the researcher's interpretations of the collected qualitative data. Incentive distribution occurred in the same fashion as with the first round of incentives.

Participants were informed, prior to the interview, that they were free to stop participating at any given point, should they feel uncomfortable and that this would not affect the incentive obtainment. In the event that a participant was to withdraw while being interviewed, the researcher would proceed to selecting a new subject within the relevant range of ACE-IQ scores. Of the eight interviewees, no one withdrew through the interview process.

Data Collection and Analysis

Quantitative data were collected using the ACE-IQ instrument, screened for accuracy, inputted in an electronic database, and analyzed through SPSS. The screening process involved verification of accurate matching between students and their scores, as well as accuracy of the collected scores, i.e., evaluating completion of all survey questions. Data were also transferred into digital form with no identifiable information. This means that only the Question-Pro generated codes and the calculated scores were transferred into SPSS for quantitative analysis. Further, descriptive analyses were conducted to determine the distribution of scores.

Regarding the emotional well-being portion, interviews were utilized in a semi-structured fashion to allow for flexibility of the questions as well as probes. Audio-recorded interviews were transcribed following each interview. The researcher transcribed collected data to become fully familiarized with the content and to generate

insights. Analysis was ongoing as field notes and memos were created along the qualitative data collection process.

Qualitative data analysis was conducted according to Braun and Clarke (2008) thematic analysis model. Interview transcripts were thoroughly reviewed in order to acquire familiarity with the data. Next, data were coded by highlighting sections (e.g., phrases or sentences) that pointed to reoccurring content that seemed to be emerging from the interaction/conversation with participants. These codes were marked in the margins next to the identified content and reviewed to identify patterns and generate themes that seemed to be responsive to the relevant research questions.

Next, the identified themes were reviewed to ensure their usefulness and accurate representation of the data. Once the main themes were identified and their accuracy with the collected data was confirmed, there was a defining and naming process of these themes, formulating precisely what was meant by each theme, how it helped to interpret the data, as well as phrasing themes in a simple, succinct way. For instance, phrases, such as: “Mmmm, let me see! I can’t seem to pinpoint any recent happy experience for me” or “Can we start with the recent negative experiences instead?” and the like, were often used by high-scoring interviewees when requested to share about their most recent happy experiences and the generated theme for these responses was: “Difficulty remembering positive experiences.” The final step consisted of writing up the data analysis. All qualitative data units were transferred in a privately stored notebook under their respective categories/findings (depending on how they were coded) for easy reference during results discussion.

Risk Management

To abide by the James Madison University's Institution Review Board (IRB) protocol, efforts were made to minimize the risks involved in recollecting traumatic events for both survey and interview participants. Considering that the researcher was not physically present during data collection, students were recommended to participate in the survey completion and the interview process while on campus. This arrangement also entailed that the vice-chancellor would be present during students' participation and available to offer mental health care and guidance to students who might be in distress either during or after completing the survey or the interview. The university vice-chancellor has a master's degree in professional counseling and extensive experience in trauma assistance, as well as skills in risk assessment.

Moreover, the researcher remained in close contact with the vice-chancellor secretary who oversaw the screening process of the participants needing assistance. She screened for this need by asking participants if they needed to speak to the vice-chancellor for further support following their participation. Participants were also informed of the opportunity of a follow-up support session with the researcher and the researcher's chair, if needed. In the event that a student may be significantly triggered and have a psychotic episode, the vice-chancellor would then connect this person to a psychiatric center. Additionally, participants were also encouraged to reach out to some of the common and familiar resources in the community, including family and church.

Trustworthiness

The researcher took proper measures to ensure trustworthiness during the interview process by identifying and optimally eliminating possible bias. Biases were expected as the study was conducted in the researcher's home country and within her

culture of origin. Some of these preconceived notions included the belief that experiences with childhood adversity are prevalent and hence, many of the participants would score high on the ACE-IQ survey. Another expectation was that most participants struggled with a sense of emotional well-being due to these early traumatic experiences. It was also believed that most coping mechanisms were not necessarily healthy due to a lack of mental health support in Burundian communities.

Identifying such beliefs/biases helped promote more openness to the interactive experience itself while interviewing participants. For this purpose, bracketing was used throughout the process of data collection, mainly by taking memos and keeping a bracketing journal. In addition, the researcher's interpretations of the qualitative data were sent back to the participants for confirmation of accuracy to ensure maximal elimination of bias. A short report of biases is included in the discussion section to allow readers to be aware of the researcher's biases while reading the results and interpretations of the data.

Chapter IV

Results

Adverse Childhood Experiences International Questionnaire Scores

ACEs-IQ contains 29 questions on different types of adversities in childhood. These 29 items were organized by the WHO into 13 categories of childhood adversity, including emotional abuse; physical abuse; sexual abuse; violence against household members; living with household members who were substance abusers; living with household members who were mentally ill or suicidal; living with household members who were imprisoned; one or no parents, parental separation, or divorce; emotional neglect; physical neglect; bullying; community violence; and collective violence, which differs from community violence in that it involves groups fighting to achieve political, economic or social objectives.

As shown below in Table 1, a total number of 100 students at the International Leadership University in Burundi participated in filling out the World Health Organization version of the Adverse Childhood Experience International Questionnaire. The average score was 5.2 out of 13, the minimum score was 0 and the maximum was 10. The standard deviation was 2.

Table 1

Mean, Standard Deviation, Minimum and Maximum ACE-IQ Scores

	n	**Mean**	**SD**	**Min.**	**Max.**
ACE-IQ Scores	100	5.29	2.01	.00	10.00

Table 2 below displays the frequency of the ACE-IQ scores, with the two most reocurring scores being 5 and 7. One participant scored 0 out of 13 categories and two participants scored 10 out of 13. The cumulative frequency showed that only three participants scored 1 and 2 each, and only two participants scored 9 and 10 each. Such a distribution indicates that smaller numbers of participants scored at the extremes, whereas the majority of the scores are located towards the center of the score distribution as shown in the box plot below (See Figure 3).

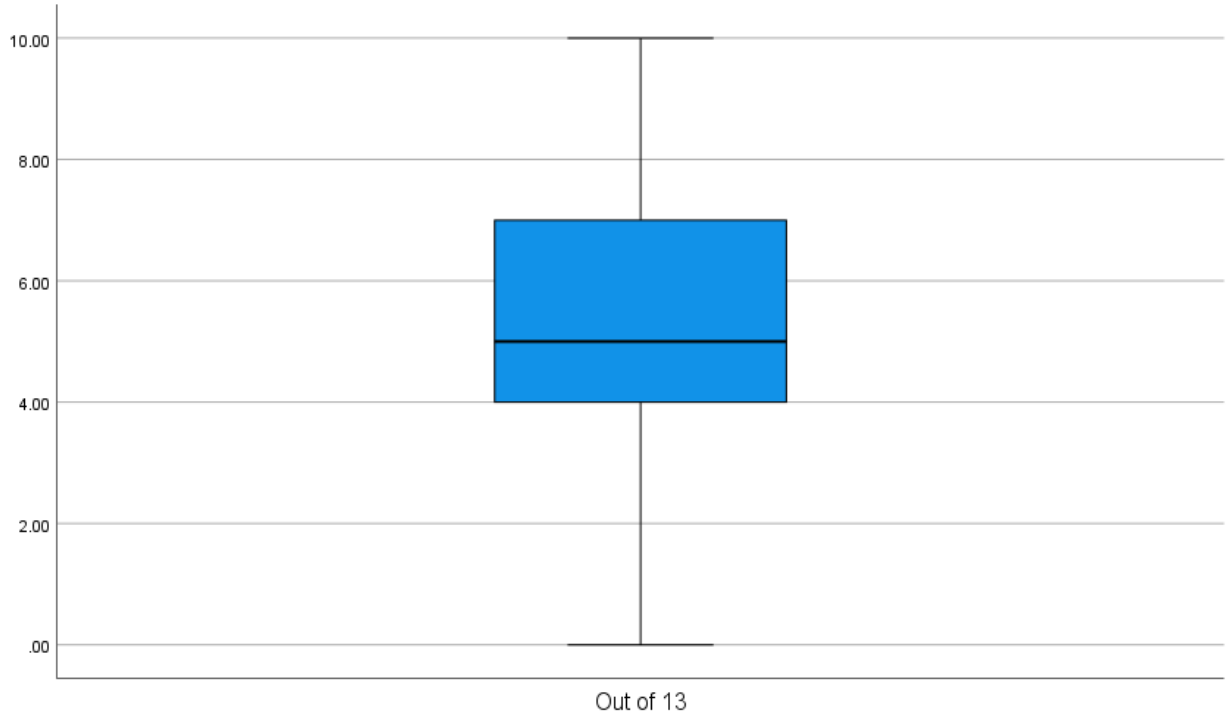
Table 2

Frequency of ACE-IQ Scores

	Frequency	**Percent**	**Valid Percent**	**Cumulative Percent**	**Frequency**
Valid	0	1	1	1	1
	1	3	3	3	4
	2	3	3	3	7
	3	12	12	12	19
	4	16	16	16	35
	5	19	19	19	54
	6	15	15	15	69
	7	19	19	19	88
	8	8	8	8	96
	9	2	2	2	98
	10	2	2	2	100
	Total	100	100	100	

Figure 3

Box Plot of ACE-IQ scores



Note: The numbers on the left represent participants' ACE-IQ scores, with the mean being 5.29.

In Table 3, percentages of respondents who reported having experienced each of the 13 categories of adverse childhood experiences from the ACE-IQ are presented as well.

Table 3

Percentages of Responses in Each Category

Category	**Percentage of Respondents**
Community Violence	95%
Emotional Neglect	69%

Physical Abuse	62%
Household Member Treated Violently	61%
Collective Violence	60%
Emotional Abuse	51%
Contact Sexual Abuse	31%
One or no Parents, Parental Separation, or Divorce	29%
Alcohol and/or Drug Abuser in the Household	19%
Incarcerated Household Member	18%
Someone Chronically Depressed, Mentally Ill, Institutionalized, or Suicidal	16%
Bullying	13%
Physical Neglect	5%

As shown in Table 3, of the 100 Burundian college students who participated in the survey, a large majority (95%) witnessed community violence while growing up. As far as collective violence adversity, 60 Burundian participants were either displaced, saw their home being destroyed, were beaten, or had a family member or a friend killed or beaten due to the community violence. Eighteen of the participants had a family member who was incarcerated. Sixty-one participants witnessed a family member being treated violently, including seeing or hearing the family member being punched, hit, etc.

Respondents also indicated that they had experienced adversities that fell into other ACE-IQ categories. Twenty-nine (29) out of 100 participants grew up in a household with either one/no parent or parents separated/divorced; and 16 lived with a household member who was depressed, mentally ill or suicidal; 69 grew up feeling that their parents or caretakers did not understand their problems or worries; 51 reported that they were emotionally abused, including being screamed/yelled at, insulted, or humiliated; 62 were physically abused. Five participants were physically neglected; 31 were forced to engage in a sexual way, including intercourse; and 13 participants were bullied.

In sum, the ACEs-IQ survey documented that many of the 100 Burundian college students reported adverse childhood experiences, including 95% reporting that they had witnessed community violence. Most respondents also suffered emotional abuse, physical abuse, and neglect. The least reported types of adversity included, mental illness in the household, bullying, and physical neglect. Moreover, 72.5% of the Burundian participants suffered adverse experiences in the form of childhood maltreatment, compared with 17.47% US respondents reporting the same adversity (Lee et al., 2020); 47.5% Burundian students reported growing up exposed to household/family dysfunction, compared with only14.39% of the US respondents; and 56% indicated that they experienced violence outside of the home, compared with only 5.36% of US respondents.

Interview Reports

Procedures

I interviewed eight students, four who had relatively low ACE-IQ scores and four with high scores. Among these interviewees were two who had scored two, and two who scored three on the 13-point scale. On the higher end, one interviewee scored eight, one scored nine, and two scored ten. Of the eight selected for interview, four were female and four were male, with their ages ranging from 22 to 26. Most interviewees were in their last year of college and nearing graduation, which some of them pointed out as a significant point of pride and joy. Finally, all eight interviewees lived in Burundi for the entirety of their childhood. Below is a table that shows ACE-IQ categories selected by low versus high scorers. Interviewees score distribution is shown in the table below.

Table 4

ACE-IQ Categories for Low Versus High Scoring Interviewees

Low Score Interviewees (2 females & 2 males)	**High score Interviewees (2 females & 2 males)**
Sexual abuse, physical abuse, emotional abuse and neglect, substance abuser in the household, community violence, and collective violence.	Emotional abuse and neglect; physical abuse and neglect; sexual abuse; substance abuse, violence, and mental illness in the home, parent(s) deceased or separated, bullying, incarceration of a family member, community, and collective violence. violence in the home, community, and collective violence.

All interviewees but one reported witnessing community violence and six reported collective violence. Five out of eight interviewees reported emotional neglect and four reported physical and emotional abuse. Only three interviewees reported substance abuse in the family and/or sexual abuse.

Prior to the interview, I proceeded to discuss with interviewees the confidentiality parameters of the interview session, including the recording in progress and the privacy of every identifying information. I introduced the interview questionnaire, as well as the rationale for the qualitative aspect of the study. I also ensured to maintain the interview process in a semi-structured fashion to allow the interviewee enough space to share. I then concluded each interview with a few debriefing questions, such as exploring some of the feelings and thoughts that came up for the interviewee as we were discussing, talking about what their support is like, and allowing them to ask me questions they might have.

After I collected all the data in this regard, I followed the Braun and Clarke (2008) thematic analysis model. I started with writing interview transcripts, then I reviewed them thoroughly to generate codes emerging from the data, which I marked in the margins next to the data. I then proceeded with reviewing the codes to identify patterns and generate themes that were more relevant and representative of the qualitative research question, which consisted of exploring the different ways that college students in Burundi with a background of childhood adversity experience their current emotional well-being. Below are the different themes identified, including themes that pertained more to high scorers/low scorers, as well as those that seemed to be more common to both groups.

Identified Themes

A number of themes were identified that characterized the interviews of those who reported higher adverse childhood experiences. These themes included:

Difficulty remembering happy experiences. Most high-scoring interviewees, when asked to share about their recent happy experiences, expressed difficulty pinpointing what experiences those could be. One student from this group, when asked to share about some of his more recent happy experiences, sat back and said: "I don't remember the last time I felt happy! But I'm used to it." Another high scoring interviewee, after a while reflecting about what happy experiences he has had recently, asked: "Is it okay if I start with my recent unhappy experiences? Those are the ones I don't need to dig deeper for."

Strained relationships. Most participants from the high end of the scores acknowledged that they were struggling in their relationships, whether those were with long-term friends or with family members. One participant expressed dreading going home every day because of the strain that has marked the family relationship dynamic due to a family member's mental illness. She said: "My older sibling has struggled with depression ever since we were younger. I feel so bad that I have gotten this far with my education while for years, all he does is stay in his bed at home. I also feel bad for my mom. It's affected her so much and everyone else at home. I dread going home because it's always such a sad environment."

Relying on alcohol or smoking. Those reporting more adverse childhood experiences were likely to turn to substance abuse as a way of coping. One interviewee who reported experiencing several types of abuse, including emotionally, physically, and sexually as a child, said, "When I'm alone, I cry, I smoke weed, and I drink a lot. I hate

my life." Another one from the same background experience said with tears running down her face and her voice cracking: "All about life makes me feel down. So, I drink and smoke quite a bit."

The main theme that characterized the current experiences of low-scoring interviewees was the following:

Relying on hope. Hope was mentioned by those who reported fewer adverse childhood experiences. One respondent, for example, expressed, "I hang on to hope and tell myself that tomorrow things will be different. This helps me to not get depressed." Another low scoring student stated, "You have to cling to hope in life. If you don't, then you will have too many negative thoughts and attract bad things in your life."

Finally, major themes characterized the responses of all the Burundian interviewees, both those with relatively low scores and those with the highest scores. These themes included:

Feelings of pride resulting from accomplishment. Most interviewees, when asked to share about their recent happy feelings, described events and instances of accomplishment, such as wrapping up a semester, making an important sale, or finding a job. This theme was common to all interviewees, no matter if their adverse childhood experiences were numerous or relatively few. One low scoring participant related how she was proud of a sale she had made, and she said with a sudden smile on her face: "For a long time, I have sold shoes for my siblings to try and earn a little bit of money. Then one day, I decided I was going to dare selling my own shoes and recently I realized I did a much better job with it, as I gained even more money than they were gaining." Another high scoring student pointed out that: "After six years of pushing through school and

through the means to afford it, I have finally finished my course load. I feel happy and relieved."

Tendency to retreat, process, and resolve alone when faced with adversity. Nearly all of the interviewees expressed that when they are feeling unhappy, whether it is about the death of a loved one, a fight with a friend, family difficulties, etc., the approach they take is to retreat into themselves, as opposed to reaching out for support and try to find solutions themselves or distract themselves. One low scoring student, when asked to share how he copes with difficulties in his life, took a deep breath and said: "I don't talk too much. I don't trust people that much. When I feel upset or down, I just hang out alone in my room and either see if it's something I can resolve myself or will just try to forget about it and move on." Another low scoring student affirmed: "You have to be strong in life. Because if you break down, then people start talking about you and it reflects bad on you." When asked how she felt as she was sharing this, she smiled and said: "It's just life! There's nothing you can do about it."

Trust issues and discomfort with emotional vulnerability. Another running theme was that of trust. Most participants expressed feeling untrusting of their social circles, mostly based on fear of judgment or past experiences of perceived mild to severe betrayal. That being said, most low scorers seemed to try and confront their friends first when there was conflict. One low scorer expressed confidently that: "When I have a disagreement with a friend, I take my time away from this person, reflect, and seek advice. Then I reach out to confront the issue and try to talk it out."

Most high scorers, on the other hand, expressed not having anyone they could trust and reach out to for support. One student from this group said: "I have a lot of

friends, but it's only because we hang out together, drink, and have fun. I can't really think of someone I could reach out to if I wanted to get talk about my problems. Plus, I'm a guy, you know! That's just awkward!" Further, for participants from both groups, difficulty trusting people was related to their own discomfort of being emotionally vulnerable with a friend as well as to distrust and past experiences of betrayal.

Emotional avoidance. Distancing oneself from powerful emotions manifested with most interviewees from both ends of scoring as well. Most students disclosed that they retreated from others when they were navigating difficult times. Furthermore, their coping style was characterized as solution-orientation, minimization, or normalization of the issue. Absent from their processing was emotional attunement, self-compassion, and self-soothing. Most students affirmed their perceived need to be strong and not let problems affect them.

An example of this need to be strong that may be related to emotional avoidance was illustrated in the confident sharing of one of the low-scoring interviewees, saying: "I have learned that you have to keep it together. I hang on to hope and tell myself that tomorrow things will be different. This helps me to not get depressed. Plus, what you believe is what ends up happening to you, so instead of ruminating on the bad that happened, I try and focus on the positive, so I don't attract bad luck."

Prayer and faith. One common theme was that of prayer and faith. Most interviewees expressed that their faith was important and that they valued going to church. One high scoring student shared: "I have been through a lot of abuse in my childhood, but I'm a born again now. And although sometimes I feel a little bit of sadness, it doesn't really linger because I pray and feel better afterwards."

Below is a table that categorizes themes pertaining to high scoring versus low scoring students.

Table 5

Themes for ACE-IQ High and Low Scorers

High Scorers Themes	Shared Themes	Low Scorers Themes
• Difficulty remembering happy experiences, • Substance use, • Strained relationships.	• Feelings of pride related to accomplishment, • Retreating into self when faced with adversity and attempting to resolve alone, • Trust issues & discomfort with emotional vulnerability, • Emotional avoidance, • Distraction, • Prayer & faith.	• Hope.

All eight interviewees shared most of the identified themes, except for difficulty remembering positive experiences, substance use, and strained relationships, which pertained to high scorers, whereas hope was an identified theme for relatively low scorers. Overall, these themes revealed interviewees' general sense of mistrust and poor reliance on support, discomfort with emotional vulnerability with others and self, and a sense of happiness that depended on accomplishments and achievements. ACE-IQ high scoring interviewees were less likely to recall any recent happy experiences and reported more struggles with relationships and with substance use, while low scoring students seemed to rely more on hope.

Towards the end of the interview, students shared their experience about their participation. One high scoring student commented about her experience of being interviewed and said: "I struggle with trust and am mostly closed off. It certainly felt unusual to reveal so much about me. But I guess I can trust you." Another high scorer expressed: "When you first contacted me to participate in the interview, I was scared. I felt suspicious about why my personal experience was needed. But then I decided to take it easy and I'm really glad I was able to talk to you. It's been a long time." Most students expressed their appreciation to have a professional with whom they could share their vulnerable, personal experiences.

The interviewees' initial reluctance to participate may indicate the identified theme of lack of trust in others, which was one of the main findings from the interview process. Alternately, most interviewees expressed their appreciation of the opportunity to connect and share their experiences. The positive emotion described by students during

the interviews demonstrates that even though it may be challenging, there is value in opening up and processing life experiences with another person.

Interviewees were also able to describe their experience of participating in the survey. One low scoring student said: “As I was answering the questions, certain past memories resurfaced and brought a bit of sadness.” Another high scoring student expressed: “It was a bit uncomfortable for me to revisit certain experiences from my past.” In contrast to reporting some discomfort, a third interviewee with a low score shared positive emotions while completing the form: “I appreciated filling out the survey, knowing that my privacy would not be violated. It also made me feel like I finally had a voice and a safe space to express what happened to me without fearing that I was going to be disregarded.”

In an effort to emphasize the intention of providing further support, I reiterated with interviewees the opportunity of a follow-up session and invited more discussion regarding locally available resources, including the assistance from the university vice-chancellor if needed. Likewise, for the same purpose, an email was sent out to all survey participants to inquire about their experience and remind them of the different avenues for further support. No student reported distress following participation and only two of the survey students expressed interest in a follow-up session. The follow-up sessions took place and focused mainly on the need for mental health care they see within the community.

Conclusion

In the section above, quantitative and qualitative results were presented. The most common childhood adversity was community violence (95%) for the Burundian college

students, followed by emotional neglect (69%) and physical abuse (62%). Selected interviewees consisted of highest and lowest scoring students, whose emotional well-being, as well as coping strategies, were explored. Common themes included trust issues, emotional avoidance, and difficulty relying on others' support. The following chapter is a discussion of the implications of the effects of childhood adversities on the well-being of Burundian college students.

Chapter V

Discussion

Key Findings

Despite participants' apparent moderate to high functioning, as illustrated by academic achievement, a higher percentage of Burundian college students reported adverse childhood experiences than US respondents on all three ACE-IQ domains: childhood maltreatment, family dysfunction, and violence outside the home.

The scores collected from the administration of the ACES-IQ with the 100 Burundian college students have indicated that there were more participants with multiple types of childhood adversity experiences on the higher end of the average (Mean=5.29). In other words, a large number of students experienced more than the average amount of childhood adverse conditions. This supports past findings that pointed out that not only such adversities tend to occur together, but they also occur in a variety of forms (SAMHSA, 2016).

It is safe to assume that with a wider variety of such adversities, adverse effects on mental/emotional and physical health would be more significant as well (Overstreet et al., 2017). In this study, only emotional well-being was examined for Burundian college students and the effects of experienced trauma in their early years of life seemed to be associated with an unsteady sense of emotional well-being, as shown throughout the themes identified during qualitative analysis.

Some of the highlighted themes regarding the consequences of adverse childhood experiences on participants' emotional well-being have included difficulty developing trusting relationships where the person feels safe to lean on support during hard times. In

addition, high scoring interviewees, in addition to a much easier recollection of recent negative experiences, they were less likely to access any recent happy experiences as spontaneously.

Interviewees from this group also reported struggling more with relationships and dealing with a constant threat of rupture because of an unresolved, lingering conflict that conveyed a feeling of betrayal or rejection in most instances. These difficulties resonate with the belief that individuals with childhood psychological wounds can have that no one is safe and that it is best to just shut down or keep to self (Sheffler et al., 2019).

Similarly, both high and low scoring students showed a tendency to retreat into themselves when faced with adversity and to try to resolve it alone. This tendency may have important implications for mental health service providers in Burundi who might face strong resistance when providing counseling services to Burundians due to discomfort to reach out for help.

Implications for Attachment Theory

Difficulties such as relational mistrust, excessive self-reliance, and discomfort with emotional vulnerability highlight a sense of insecure attachment at play that a person may develop as a result of past childhood trauma. As mentioned before, insecure attachment has shown to contribute to strained relationships later in adulthood, in that the ingrained fear of rejection and of a meaningful relational connection creates an inability to form and maintain healthier and more trusting relationships (Saunders, 2019). As they move along in life, these young adults continue to have unresolved and complicated relationship experiences, which is more likely to negatively affect their own families in the future (Crombach et al., 2015).

The pervasive insecure attachments not only undermine relationships, but they can also increase the risk of depression for student-participants and simultaneously, may sabotage their motivation to seek out help from the community or engage openly in counseling. One high scoring interviewee said with a nervous smile: “I am always scared to talk to my parents and family because I fear being judged by them, so I push everything down and just carry on.” Such a broad sense of insecure community attachment may indicate the tremendous need for mental health services in Burundi, even for well-educated, high-functioning populations. In fact, this weakened sense of social attachment was described in the pioneering work of Emile Durkheim (1951) as a profound sense of anomie that led to high rates of suicide.

The childhood trauma endured by participants as well as the reported current issues of mistrust indicate the likelihood of persistent insecure relationship attachments, the possibility of perpetuation of relationship difficulties, and the need to understand better how to effectively support them. Further, implications for participants’ emotional responses are discussed.

Implications for Emotion Dysregulation

Poole et al. (2018) suggested that the link between interpersonal difficulties in adulthood and childhood adversity experiences is mediated by emotion dysregulation in that early traumatic experiences may cause an impaired ability to identify, interpret, and regulate emotions when faced with various stressors. This can be taxing on relationships and eventually break them. This phenomenon points to the fact that emotion dysregulation is the mechanism through which the association between childhood adversity and interpersonal difficulties in adulthood occurs (Poole et al., 2018).

As discussed in the literature review, emotion dysregulation is described as a display of either limited or heightened affect as opposed to the ability to integrate both positive and negative affect and to tolerate distress (Cassidy, 1994). More concretely, such dynamics manifest in the form of emotional over reactivity or shutting down. This difficulty showed to be the experience of most interviewees from both scoring groups in that emotional reactivity interfered with healthy conflict resolutions, which resulted in strained relationships. Likewise, as a response to the failed resolution, participants became more emotionally avoidant of the impact that watching a cherished relationship dissolve had on them.

In the following passage, the interviewee shared an experience that illustrated the combination of a strained relationship and the tendency to distance self from powerful emotions. This student said, with tears forming in her eyes:

> I recently had a really bad argument with my childhood friend where I felt betrayed. We had a really strong bond and she was there for me when life was hard. She was my family. It's been a few weeks now and we still don't talk. I feel sad that I've lost her as a friend and at the same time, I feel really disappointed that she was never who I thought she was. But it's okay, I guess. Life goes on, you know.

Substance Abuse Risk

Further, substance use was identified as another theme and coping strategy for participants who experienced more adversities growing up. Findings have consistently indicated that adverse childhood experiences are strongly associated with substance use and mental illness (Hugues et al., 2019). It has also been discussed that substance use can

consist of a self-destructive behavior as one tries to cope with or distract him or herself from emotional distress (Boppre et al., 2019). As discussed earlier, one of the high scoring interviewees confided and said, “When I’m alone, I cry, I smoke weed, and I drink a lot. I hate my life.” Another high scorer heartbreakingly expressed, “all about life makes me feel down. So, I drink and smoke quite a bit.”

Past research has also indicated that substance abuse is a prevalent and concerning issue across Burundi (WHO, 2016). This prevalence may serve as further indication of both the pervasiveness of the deep scars of childhood adversity in the Burundian society as well as the widespread intergenerational community violence (Crombach et al., 2015).

Implications for Self-Concept

In addition to implications for substance abuse, experiences with childhood adversities may have implications for self-concept as abuse can cause a sense of intrinsic defect in self-view as well as in evaluation of self and life (Peckels, 2017). The adverse experiences endured during childhood create the belief that the abused individual is worthless and powerless of any positive change. This self-defeating belief may not necessarily be fully known to the wounded person but is deeply ingrained and can cause a sense of lingering uneasiness that still transpires even after experiencing happier moments.

This was illustrated by interviewees as they shared about positive feelings of pride after an experience of meaningful accomplishment that seemed to foster conditional positive self-regard, which was short-lived because the happy experiences were mostly circumstance-based. For instance, one student expressed feeling good about herself for finally wrapping up her university courses, although this happy feeling slowly dissolved

as the heaviness around a family member struggling with mental illness creeped back in. Overall, a sense of dissatisfaction with life in general can develop from a poor sense of self-concept and perpetuate unhealthy coping mechanisms.

Spirituality

Another theme that served as a coping strategy for many participants was religious engagement, faith, and prayer. Previous research has identified that spirituality and prayer can also be coping ways for individuals with a complex trauma history in that they foster hope, purpose, meaning, and forgiveness (Brewer-Smyth et al., 2014), all of which are important to a person's emotional well-being.

Most participants expressed valuing their faith in God and praying to Him either on a regular basis or when navigating life difficulties. One example for this was the participant mentioned earlier who has experienced significant child abuse and adversity but experiences prayer as a soothing activity when she feels sad. Another student expressed with joy on his face: "On new year day, I was happy I went to church after for the first time in a long time. I feel like that's set me on a more positive path as I started the new year."

Although spirituality has been viewed as a healthy coping mechanism for many individuals with childhood adversity, more research could also be done to shed more light on whether spirituality can serve the function of avoidance of emotional distress as well. Such a function would then imply that spirituality may represent the role of a distraction in some cases, whereby life's hurts are dissociated from as one strives to engage in a spiritual experience instead. Lastly, another important point to note is that the common

theme of faith and religious values suggests that Burundians may be more accepting of more faith-based therapeutic programs.

Summary

In sum, the results provide important data regarding the childhood adversities of high functioning populations in Burundi. These college students represent the future families, communities, and leadership of the country. However, they have endured adverse childhood experiences that are significantly affecting their lives. This study documents that a large number of students have endured significant childhood adverse conditions and that the current effect of such experiences on participants' emotional well-being may consist of several issues, including trust concerns, difficulty being emotionally vulnerable, attachment avoidance tendencies, and substance abuse.

Limitations

As a mixed method study, this research has several limitations associated with both the quantitative and the qualitative phases of the study. One of the limitations is the researcher's own bias that could interfere with the qualitative data collection as well as its interpretation. To minimize such bias, the researcher maintained an ongoing awareness of her own bias, given that the study was conducted in her own culture of origin. As stated earlier, bias was likely to occur both through the interpretation of the data as well as through interaction with interviewees. In both instances, the researcher ensured that her interpretations were confirmed by participants before moving forward with the study.

Quantitatively, the study's primary limitation is that, because the sampling method followed a convenience procedure, the possibility to participate was not equal for all qualified students, which can create an under- or over-representation of the

population. Similarly, the study results may be biased due to the unknown reasons why some students chose to participate, and others did not.

Qualitatively, the limitation involves that the current study relied heavily on self-reported data, with no observation or confirmation of the reported experiences. At the same time, the results were aligned with previous findings in that, early adverse experiences can bear significant consequences on a person's life later, and in this case, college students' emotional well-being.

Lastly, another potential limitation is that the current study is preliminary research with no measure of well-being, which could be added to similar future research.

Implications for Practice, Policy, and Public Health Education

As suggested in the study results and in previous literature, mental health problems are prevalent across the country of Burundi. In 2000, a non-governmental organization (NGO) called HealthNet TPO sought to launch mental health services and psychosocial support in Burundi (Ventevogel et al., 2011). This program included training and supervising health workers, such as nurses and doctors, social workers, as well as psychosocial volunteers. Training topics included advocacy and awareness raising, client referrals, group interventions and self-help group facilitation, psychosocial education for clients and families, crisis intervention, as well as networking with other stakeholders, such as the local administration.

These researchers conducted an evaluation of the program after eight years from its implementation and found that, on one hand, funding problems and internal political instability had interfered with the Burundian authorities' commitment to continuing mental health and psychosocial services (Ventevogel et al., 2011). In addition, it has been

noted that in most low and middle-income countries, mental health is given a low priority. On the other hand, the trained individuals and community-based organizations felt empowered to engage in mediation, referral, support, and advice.

Although the existing help structures, such as churches, community support groups, and traditional healers, can give basic support, they are not likely to provide all the psychosocial assistance needed (Ventevogel et al., 2011). For instance, a project that provides lay counseling training in key areas, such as schools, churches, and community leadership domains might help provide a safe, professional environment for people to seek mental/emotional help in Burundi. The lay counselors would then commit to ongoing education, supervision, and evaluation.

A more effective mental health assistance would include: a more specialized level of psychosocial assistance for referral in case of complicated problems, ongoing clinical supervision and refresher courses, and an efficient system of monitoring and evaluation. These recommendations may particularly apply to college students in Burundi. Therefore, student support services to enhance their well-being may serve a crucial part in promoting mental health and preventing mental illness.

Similarly, education may serve as a powerful tool that would contribute to effecting change at a systemic level regarding the state and the need for mental health care services in Burundi. For example, classes on subjects such as parenting and child emotional development could be incorporated in universities' curriculum. Additionally, appropriate advocacy steps could significantly contribute to positive change in the national policy and public health realm. These steps would include: Facilitating unity and training among local professional and lay counselors, researching and

providing/presenting data on Burundian families' mental health wellness to the local authorities, developing alliances with other mental health professions, engaging in public health campaigns on mental health, psycho-educating leaders and communities and assisting families toward empowerment, and reaching out for support from relevant government entities (Gibson, 2014).

The recommendations discussed above highlight the main elements that need to guide the implementations in mental health assistance practice in Burundi. In fact, many of the participants interviewed in the current study expressed a deep desire to talk to a mental health professional on a regular basis and have the opportunity to sort out their issues instead of continually ignoring them and struggling alone.

Conclusion

Childhood adversity experiences have shown to be related to mental health problems in later life. In this study of Burundian college students, we identified that childhood adversity encompasses child abuse, family dysfunction, and adverse community environments. This was consistent with research literature that developing countries generally carry more risk factors for childhood adversity, including poor parenting due to cultural/traditional beliefs, economic hardships, financial stress, etc., with little to no mental health assistance or treatment.

It was also discussed that the prospects of mental health in a developing country, such as Burundi can be met with challenges, such as community violence, socio-economic status, and poor legislation policies that reflect for instance insufficient incorporation of child assistance, mental health, and psychosocial support in government policies and actions.

The coping strategies identified in the literature as well as in the study results included the fact that people who are victims of childhood adversities and struggling with their emotional well-being may engage in solution-oriented and/or emotion avoidant tendencies and spirituality

as a coping way. In addition to these coping strategies, personality traits and community support have also shown to affect positively a person's potential for resilience.

The purpose of the current study was to assess the well-educated population in Burundi may also be subject of high rates of childhood adversity experiences as well as difficulty leading a life marked with a healthy sense of emotional well-being. The study also sought to explore this population coping mechanisms in this regard. As stated before, most ACEs-related studies conducted in Burundi and in Africa as a whole, focused mainly on exceptional populations, such as minor soldiers, homeless children, refugee camps, and extremely disadvantaged communities.

Findings in the current study indicate that, indeed, in similar ways as with the at-risk populations studied in previous research, the well-educated and high functioning population in Burundi may also significantly carry the wounds of a broken upbringing and struggle to lead a more emotionally balanced life even as they aspire to accomplish more. Further, this impaired sense of emotional well-being ability and the unhealthy coping ways can adversely affect their relationships and ability to establish healthier families and communities of their own, leading then to a perpetuation of hurt and dysfunction throughout generations.

The researcher's hope in conducting this study is that more is done in the country of Burundi to support Burundians' mental health to help reduce the stigma of mental

illness, to put in place efficient psychoeducation training, and to professionally assist people dealing with various mental health problems. Additionally, since college students generally represent the future leaders nationwide, with a positive experience of effective mental health assistance, this population has unique potential to be actively involved with changing the stigmatized social attitude towards mental illness in the long run and improve mental health care services across the country.

To move towards this direction, the Ventevogel et al. (2011) recommendations discussed above can be reiterated here. These included specialized mental health assistance, clinical supervision and ongoing training, as well as effective monitoring and evaluation systems in place. Moreover, future research can also conduct studies on families of the well-educated people in Burundi to gain a better understanding of dysfunctional family dynamics and mental health of the family members.

It is important to keep in mind that the more mental health assistance is focused on outlying populations with extreme cases of mental illness, such as epilepsy or schizophrenia, mental illness will more likely always be stigmatized and disregarded at the expense of the large majority of people in dire need for effective mental health assistance, hence the need to bring to awareness through education and advocacy what these mental health needs consist of and why it is important to address them.

Appendix A

The Adverse Childhood Experiences-International Questionnaire

Purpose:

The purpose of this questionnaire is to measure participants' exposure to the following dimensions of adverse childhood experiences: Childhood maltreatment (emotional neglect, physical neglect, emotional abuse, physical abuse, and sexual abuse); Family/household dysfunction (living with substance abuser, living with household member who was mentally ill or suicidal, living with household member who was imprisoned, parental death, separation, or divorce, and domestic violence); and Violence outside the home (bullying, witnessed community violence, and exposure to war/collective violence).

Test Format:

You are asked to respond to the 29 questions based on your experiences during the first 18 years of your life. Response options for each question may be dichotomous (i.e. Yes/ No; Items F1-F5), based on a 5-point Likert scale ranging from “Never” to “Always” (i.e. Never-Rarely-A few times-Many times-Always; Items P1-P2), or based on a 4-point Likert scale ranging from “Never” to “Many times” (all remaining items).

Childhood Maltreatment

P1 Did your parents/guardians understand your problems and worries?

P2 Did your parents/guardians really know what you were doing with your free time when you were not at school or work?

P3 How often did your parents/guardians not give you enough food even when they could easily have done so?

P4 Were your parents/guardians too drunk or intoxicated by drugs to take care of you?

P5 How often did your parents/guardians not send you to school even when it was available?

A1 Did a parent, guardian or other household member yell, scream or swear at you, insult or humiliate you?

A2 Did a parent, guardian or other household member threaten to, or actually, abandon you or throw you out of the house?

A3 Did a parent, guardian or other household member spank, slap, kick, punch or beat you?

A4 Did a parent, guardian or other household member hit or cut you with an object, such as a stick (or cane), bottle, club, knife, whip, etc?

A5 Did someone touch or fondle you in a sexual way when you did not want them to?

A6 Did someone make you touch their body in a sexual way when you did not want them to?

A7 Did someone attempt oral, anal, or vaginal intercourse with you when you did not want them to?

A8 Did someone actually have oral, anal, or vaginal intercourse with you when you did not want them to?

Family/ Household Dysfunction

F1 Did you live with a household member who was a problem drinker or alcoholic, or misused street or prescription drugs?

F2 Did you live with a household member who was depressed, mentally ill or suicidal?

F3 Did you live with a household member who was ever sent to jail or prison?

F4 Were your parents ever separated or divorced?

F5 Did your mother, father or guardian die?

F6 Did you see or hear a parent or household member in your home being yelled at, screamed at, sworn at, insulted or humiliated?

F7 Did you see or hear a parent or household member in your home being slapped, kicked, punched or beaten up?

F8 Did you see or hear a parent or household member in your home being hit or cut with an object, such as a stick (or cane), bottle, club, knife, whip etc.?

Violence Outside the Home

V1 How often were you bullied?

V4 Did you see or hear someone being beaten up in real life?

V5 Did you see or hear someone being stabbed or shot in real life?

V6 Did you see or hear someone being threatened with a knife or gun in real life?

V7 Were you forced to go and live in another place due to any of these events?

V8 Did you experience the deliberate destruction of your home due to any of these events?

V9 Were you beaten up by soldiers, police, militia, or gangs?

V10 Was a family member or friend killed or beaten up by soldiers, police, militia, or gangs?

Appendix B

Emotional Well-Being: Interview Guide

Introduction:

I have a series of questions related to some of your most recent emotional experiences and the different ways you have navigated them. First, please state your name and age. (Response time.) Thank you.

Now, I will briefly review your scores from the ACEs-IQ you recently completed. As I do, I invite you to remember and begin to reflect on your experience as you filled out the survey. (Review scores.) I will now start asking you open-ended questions about your emotional well-being and coping and we will develop a discussion from there.

Interview Questions:

1. Tell me about some of the happy feelings you've experienced lately with regards to excitement, satisfaction, and appreciation of the life you lead.
2. Tell me about some of the unhappy feelings you've experienced lately with regards to sadness, lack of motivation, fear, or even a sense of waste regarding the life you lead.
3. What do you do to deal with negative feelings and how does that work for you?

Debriefing:

Thank you very much for participating in this interview. I will now take a few minutes to discuss with you your feelings about having participated in this interview.

1. What was your experience answering some of the questions?
2. Were there any negative feelings or thoughts brought up for you?
3. Who do you have in your life that provides support for you? And do you feel you need additional support?

4. How can/will you lean on the support you have to help you with negative feelings?

Appendix C

Consent to Participate in Research (ACEs-IQ)

Identification of Investigators and Purpose of Research

You are being asked to participate in a research study conducted by Peace Ningabire from James Madison University, under the supervision of Dr. Lennis Echterling. The purpose of the study is to evaluate the emotional/psychological well-being of Burundian college students as it relates to childhood trauma experiences. I am conducting this research in partial fulfillment of the requirements for the Ph.D. in Counseling and Supervision at James Madison University, and to make a contribution to my field of study.

Research Procedures

Should you decide to participate in this research study, you will be asked to sign this consent form once all your questions have been answered to your satisfaction. Participating in this research study consists of filling out the Adverse Childhood Experiences International Questionnaire (ACEs=IQ). In addition, some of the low, the average and the high scoring respondents will also participate in a half an hour-long, face-to-face virtual interview with the researcher to discuss current emotional well-being and coping strategies. There will be a separate consent form for this section. An overview of the scores will be made available upon your request.

Time Required

Participation in this study will require your completion of the ACEs-IQ, which will take about 15 minutes.

Risks

There are no perceived risks to your participation in this study. In the event participating in this study raises uncomfortable/disturbing feelings for you and you feel you need debriefing after filling out the survey, you will contact me via email and I will offer a 30 minute ZOOM meeting for therapeutic support and we will discuss what further support may consist of for you, including local resources, such as counseling services available locally.

Benefits

While on the one hand, you might feel personally triggered by some of the questions on the survey, on the other hand, such an engagement also carries potential benefits for you, such as gaining a greater awareness of the past childhood experiences that might have affected you adversely and a deeper recognition of your own process for subsequent emotional development. Another potential benefit is to be provided with the opportunity to share your voice on your past experiences with childhood adversity and contribute to helping raise awareness about its negative impact in later life.

Confidentiality

No personal identifying information about any participant will be released. Your identity will not be disclosed. Pseudonyms will be used in place of participant names, and no identifying information will be attached to the pseudonym. Upon completion of the study, all information that matches up individual respondents with their answers, including participant lists, will be destroyed.

The researcher reserves the right to use and publish non-identifiable data. While individual responses are confidential, aggregate data will be presented regarding generalizations about the responses as a whole.

Participation and Withdrawal

Your participation is entirely voluntary. You are free to choose to not participate. Should you choose to participate, you can withdraw at any time without consequences of any kind, except for the incentive.

Questions about the Study

If you have any questions or concerns during the time of your participation in the study, or after its completion, or would like to receive a copy of the final aggregate results, please contact:

Researcher:	Academic Advisor:	Institutional Review Board:
Peace Ningabire	Dr. Lennis Echterling	Dr. David Cockley
James Madison University	James Madison University	James Madison University
(240) 422 1976	(540) 568-6522	(540) 568-2834
pningabire@jmu.edu	echterlg@jmu.edu	cocklede@jmu.edu

Giving of Consent

I have read this consent form and I understand what is being requested of me as a participant in this study. I freely consent to participate. I have been given satisfactory answers to my questions. The researcher provided me with a copy of this form. I certify that I am at least 18 years of age.

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Name of Participant (printed)	Name of Participant (signed)	Date

| --- | --- | --- |
| Name of Researcher (printed) | Name of Researcher (signed) | Date |

Appendix D

Consent to Participate in Research (EWB Interview)

Identification of Investigators and Purpose of Research

You are being asked to participate in a research study conducted by Peace Ningabire from James Madison University, under the supervision of Dr. Lennis Echterling. The purpose of the study is to evaluate the emotional/psychological well-being of Burundian college students as it relates to childhood trauma experiences. I am conducting this research in partial fulfillment of the requirements for the Ph.D. in Counseling and Supervision at James Madison University, and to make a contribution to my field of study.

Research Procedures

Should you decide to participate in this research study, you will be asked to sign this consent form once all your questions have been answered to your satisfaction. Participating in this research study consists of engaging in a 30-minute individual face-to-face virtual interview a few days following the completion of the Adverse Childhood Experiences-International Questionnaire. In the interview, you will be asked a series of questions related to your current emotional well-being state as well as your coping mechanisms. This interview will be digitally audio recorded with your permission and transcribed by me. Transcripts will be sent to you via secure email, for review of accuracy. Participants will also be sent aggregate analysis of the interviews, and will be asked to comment on their accuracy. I will make changes to the analysis, based upon participant feedback. A summary of the results will be made available to you upon your request.

Time Required

Participation in this portion of the study will require participating in an interview with the researcher lasting approximately 30 minutes.

Risks

There are no perceived risks to your participation in this study. However, you may experience some discomfort while reporting painful events in your past. Therefore, after participating in this interview, I will provide 15 extra minutes to discuss with you some of the uncomfortable/disturbing feelings and thoughts that came up for you as well as ways for you to continue getting the support you need in this regard.

Benefits

While on the one hand, you might feel personally triggered by some of the questions we discuss, on the other hand, such an engagement also carries potential benefits for you, such as gaining a greater awareness of your current emotional well-being state as well as your coping strategies. Another benefit is that you are provided with the opportunity to

share your voice on your experiences with emotional well-being and coping processes, and contribute in helping raise awareness about the challenges Burundian college students might face in this regard.

Confidentiality

No personal identifying information about any participant will be released. Your identity will not be disclosed. Pseudonyms will be used in place of participant names, and no identifying information including department will be attached to the pseudonym. The recording and transcript of the interviews will be stored in a locked cabinet in the investigator's home office. Upon completion of the study, all information that matches up individual respondents with their answers, including digital audio files and participant lists, will be destroyed.

The researcher reserves the right to use and publish non-identifiable data. While individual responses are confidential, aggregate data will be presented regarding generalizations about the responses as a whole. Quotes from the transcript may be used in the formal report to demonstrate themes. Any quotes used in the report will be attributed to pseudonyms, and not contain any identifying information.

Participation and Withdrawal

Your participation is entirely voluntary. You are free to choose to not participate. Should you choose to participate, you can withdraw at any time without consequences of any kind, including the incentive.

Questions about the Study

If you have any questions or concerns during the time of your participation in the study, or after its completion, or would like to receive a copy of the final aggregate results, please contact:

Researcher:	Academic Advisor:	Institutional Review Board:
Peace Ningabire	Dr. Lennis Echterling	Dr. David Cockley
James Madison University	James Madison University	James Madison University
(240) 422-1976	(540) 568-6522	(540) 568-2834
pningabire@jmu.edu	echterlg@jmu.edu	cocklede@jmu.edu

Giving of Consent

I have read this consent form and I understand what is being requested of me as a participant in this study. I freely consent to participate. I have been given satisfactory answers to my questions. The researcher provided me with a copy of this form. I certify that I am at least 18 years of age.

☐ I give consent to be audio taped during my interview. _____ (initials)

| --- | --- | --- |
| Name of Participant (printed) | Name of Participant (signed) | Date |

| --- | --- | --- |
| Name of Researcher (printed) | Name of Researcher (signed) | Date |

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