MA Human Rights

‘Children, Mental Health and the United Nations Convention on the Rights of the Child: Investigating the Efficacy of Delivering Trauma Therapy through a Child-Rights Framework’

Reflection for Luna Children’s Charity

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Abstract

This dissertation is based on a research placement with Luna Children's Charity; a UK based mental health and human rights advocacy charity that work with children suffering from the acute symptoms of post-traumatic stress disorder. Luna teaches mental health professionals in the UK to train individuals to use Children's Accelerated Trauma Therapy or 'CATT' in international areas of need. This dissertation is based on primary research in the UK and in Tanzania, and is conducted with participants on Level 2 or 3 of CATT, with the aim of analysing the efficacy of delivering this western-style therapy through a child-rights framework in an international context.

Contents

Abbreviations

CATT – Children's Accelerated Trauma Therapy

Luna – Luna Children's Charity

UNCRC – United Nations Convention on the Rights of the Child

ACRWC – African Charter on the Rights and Welfare of the Child

L1, L2 and L3 – Level 1, 2 and 3 of CATT Training

PTSD – Post Traumatic Stress Disorder

CRIES-8 – Children's Revised Impact of Events Scale for children aged 8 or above.

DSM – III – Diagnostic and Statistical Manual for Mental Disorders Volume 3

CAMHS – Children and Adolescent Mental Health Service (UK)

CBT – Cognitive Behavioural Therapy

LRA – Lord's Resistance Army

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Preface

This research is concerned with the application of a child rights framework to the delivery of humanitarian psychological assistance in a cross-cultural context, in order to evaluate the efficacy of this framework. The focus is sub-Saharan Africa, namely Rwanda, Uganda and Tanzania, but will also take into account the UK, where the treatment originated, and briefly on Luna's training in Turkey, with Syrian mental health professionals attending to children in refugee camps. This research uses primary sources in order to evaluate the efficacy of this child-rights framework and the way these ideas are interpreted, understood and applied. The principle sources used are interviews with Level 2 and Level 3 CATT trainees, and participant observation of a Level 2 course in Tanzania. Supplementing this is variety of secondary sources from books, journals and webpages that cover the relevant discussions on childhood, children's rights, mental health in the developing world and post-traumatic stress disorder.

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This research is dedicated to my brother, Matthew.

1.0 Introduction

Goldman, Grob (2006) define mental health as a state of successful performance of mental functioning. In contrast, mental illness is the term that refers collectively to all diagnosable mental disorders, typically characterised by alterations in thinking, mood, or behavior and often associated with distress and impaired functioning. Mental illness is a global problem, affecting millions worldwide.

The World Health Organisation (2010) state depression in low income countries represents almost as large a problem as malaria, yet funds invested to combat mental illness are a tiny fraction in comparison to physical health budgets. Despite the high prevalence of conditions, the economic impact on families and communities and the associated stigmatisation, discrimination and exclusion, mental health has largely been excluded from the development agenda. For children and adolescents in sub-Saharan Africa, Robertson et al (2004) claim less than 40% of countries have special mental health programs for children and adolescents, despite the large demographic proportion of children within this setting.

1.1 Outline

This research is based on a placement with Luna Children's Charity, a child-centered voluntary organisation that exists to *'*advance the rights, education and health of children and young people affected by conflict and trauma.' (Luna Website 2014) The main aim of the charity is to provide training to therapists and those who work with children in the CATT technique, designed by the clinical director and founder of the charity. CATT aims to treat children with post-traumatic stress disorder (officially recognised in 1980 by the diagnostic and statistical manual of mental disorders III) in a child-centred way. Luna works internationally, in areas where access to treatment may not be readily available, and in particularly traumatic environments.

CATT therapy has a child rights focus, and pays particular attention to Articles 12 and 13 of the United Nations Convention on the Rights of the Child, which emphasise placing children at the centre of their care and involving them in decision-making (Edwards, Raby 2011). This research aims to analyse the ethical and clinical benefits of Luna's adoption of a child rights framework whilst delivering CATT, a framework that also extends to more general

discussions of advancing child rights as a moral basis for the charity. CATT is a relatively new technique, and has not been subjected to any qualitative research from a child rights perspective. This research will ultimately produce a report on the problems, consequences and positive outcomes of utilising a child-rights framework to deliver CATT.

1.2 Methods

This study is based on qualitative research, and aims to draw on participant's understandings, practices and experiences of mental health and child rights using semi-structured interviews, conducted in person with established CATT trainers and those being trained at the time of interview. This method allowed interviewees to answer questions and create discussions in a comfortable and supportive environment. Interviews are supplemented with participant observation from a Level 2 CATT course in Arusha, Tanzania, allowing more data to be gathered on the delivery of the course, and the way in which ideas were translated and received.

Luna's use of a child rights framework will be contextualized by examining secondary literature on existing debates concerning children's rights and participation, the cultural politics of childhood and cross-cultural understandings of mental health. I have used thematic analysis of the qualitative data gathered to draw out important points for discussion and consideration. Transcripts were coded to find re-occurring themes and indicators of importance, and the main research findings have been collaborated under the following categories in chapter 6:

1. Mental Health, Education and Understandings
2. Stigma
3. Children and Childhood
4. Vulnerability
5. Children as Individuals
6. Child Right Understandings and Limitations
7. Working in a Child-Centred Way
8. Children's Participation and Voices

1.3 Participants

There are 20 interviewed participants in this study, and each is referred to by an anonymised letter. Six of these participants are trained in CATT L3, and have taught CATT in an international context, including Rwanda, Uganda and Tanzania. These include 'Q,' the creator of CATT, and 'T,' chair of trustees. Of the four remaining trainers, three are based in the UK and one in Uganda. The remaining 14 participants are trained in CATT L2, attending courses either in Arusha, Tanzania or in Kampala, Uganda. Demographically, eight of these trainees are Tanzanian nationals, two are Ugandan and the remaining four are European or American, but were working in Arusha or Kampala at the time of training. Notably, three of these trained in L2 are qualified mental health professionals, five are trained social workers working in mental health or children, and the remaining six participants work with children at different national NGOs or small charities.

1.4 Limitations of Methodology

A proportionately larger amount of analysis focuses on Tanzania, as this was the only country in which I observed CATT training. Discussions on Rwanda and Syria are derived only from experiences described by the UK based trainers, and I acknowledge the limits of this. I believe the depth of the interviews conducted provide sufficient insight and information to report on these issues satisfactorily. Due to time and ethical limitations I could not observe the technique used with children, nor discuss this research with children who have received CATT. This subject matter revolves around children's participation and I am aware of the limitations of research that discusses, but does not include, children's perspectives (Mizen, Ofosu-Kusi, 2010 and Spyrou 2011).

This subject is complex and sensitive and interviews were designed to draw out individual and subjective personal understandings and experiences. Generalisations of particular countries and cultures, whether 'developed' or 'developing' are drawn from participants interviews, and are not my own. I have kept these generalisations in my research findings to ensure that lived experience of the individual participants is not delegitimised.

1.5 Ethics

This research is not undertaken directly with a vulnerable group of people. All participants have given their full consent to be interviewed or part of the participant observation. This research has been granted ethical permission from the University of Sussex, following the university guidelines closely (University of Sussex Research Governance, 2014).

1.6 Structure of Research

This research covers a wide area geographically and theoretically. Firstly, it provides the necessary background to Luna Children's Charity, their commitment to child rights, and CATT therapy in detail. It considers the theoretical literature and arguments on the UNCRC, the application of certain articles, and existing debates on the globalisation of childhood, grounding these debates with applied theory on mental health, PTSD and the victimising 'trauma discourse' that is dichotomous to the understanding of children as rights-holders. This research considers the countries in context and in relation to Luna's work, and finally collates the research findings under the identified themes, with the aim of summing up the outcome of this research and making recommendations for the future.

2.0 Luna Children's Charity

Luna was created to teach CATT to countries in need of PTSD treatment, and since being established in 2008 has been taught in Rwanda, South Africa, Pakistan, Uganda, Turkey and Tanzania. Training partners are generally non-governmental organisations, which provide direct services or support others to care for children in need. The modest budget of the charity is used to facilitate L2 training overseas, by sending UK based therapists to the country in question, or by sponsoring mental health professionals from areas of need to be trained in L3 in the UK. The training model is both sustainable and effective in that it does not require the ongoing presence of Luna in the country in question.

2.1 CATT Explained

CATT is a trademarked model designed to treat the acute symptoms of PTSD in children through a memory based approach grown from psychotherapy, art therapy and CBT. CATT training is facilitated on 3 levels; L1 for non-health professionals, L2 for qualified health professionals and L3 to trains those who have already participated in CATT to teach overseas. CATT protocol has 12 steps (see Figure 1 and Appendix B for a more detailed description) designed to be easy to follow, understandable for the lay person, but setting a standard which must be upheld in any place where CATT is used.

With PTSD, sufferers feel stressed or frightened even when they are no longer in danger, as the bodies 'natural' and 'healthy' reaction to (actual or perceived) life-threatening events has been changed or damaged. CATT therapy works by helping to process the traumatic memory from the short-term to long-term memory, in a different section of the brain, so that the extreme reactions associated with PTSD are no longer triggered.

This memory work is achieved in Phase 8 – 9 of protocol, in which the child creates the characters, backgrounds and 'safe place' of the story that led to PTSD, using art and craft material. The child names the story, and acts this out with the characters under the instruction of the therapist, who is not involved but looking for physical reactions to the traumatic story in the child, called 'hotspots.' Once finished, the child then acts the story backwards until they reach the 'safe place.' They then go forward and backwards with the

story, until the trauma hotspots subside - the working memory has been overloaded and the traumatic memory has processed.

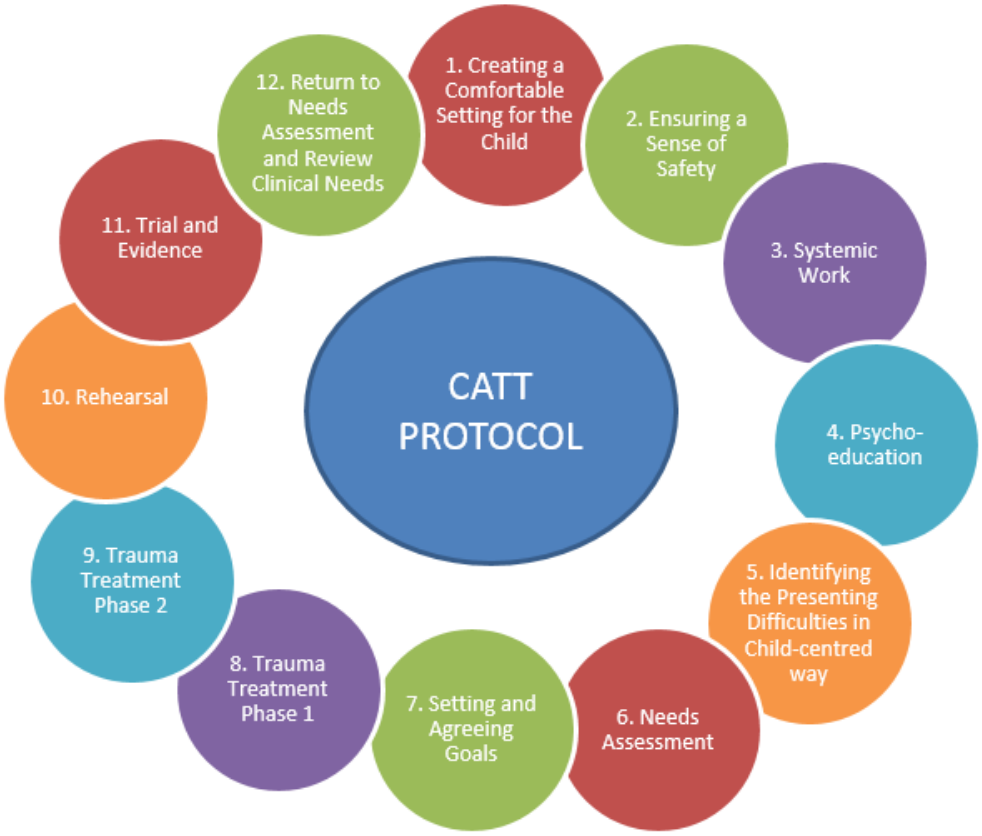

Figure 1: CATT Protocol Diagram (CATT Training Manual 2014)

Phase 2 involves the creation of an imaginary character, which changes the outcome of the story for the better, but not the event itself. This enables the child to regain a sense of power and hope, but does not introduce unrealistic expectations or distress at the fact that this was not the actual outcome. The therapist then trials a situation in the child that would have triggered their symptom before, to see if the memory has been processed effectively. In order to assess this physically, the CRIES-8 assessments is made before and after treatment (see Appendix C).

2.3 Child Rights Commitments

The CATT protocol is based in Article 12 and 13 of the UNCRC, which states that children have the right to freedom of expression and to have a voice in the care that they receive. Treatment also requires that the child's basic needs are met before starting. CATT training is designed to translate these rights to practitioners clinically and socially by adopting a 'child-centred' approach to treatment (Edwards, Raby 2011). The relationship between the therapist and child is a respectful partnership; treatment is centred on the child, who is viewed as both an individual and an agent. Whilst all 12 sections of the CATT protocol treat the child in this way, Stage 5 references these ideas explicitly, bringing in the UNCRC and the ACRWC (see Figure 2). L3 trainers working overseas should adapt these slides to the given cultural context, and facilitate discussions on the difficulties and realities of realising child rights. Working in a child centred way should be a collaborative decision on the part of the trainees.

Figure 2: CATT Training Slides on UNCRC/ACRWC (CATT Training Manual 2014)

3.0 Child Rights, Issues and Application

All children have rights as a value of being human (Howard 1995) and the Universal Declaration of Human Rights Article 25.2 states 'motherhood and childhood are entitled to special care and assistance' (United Nations 1989: Article 25). Acknowledgement of children's additional rights and needs are addressed in the 1989 UNCRC, ratified by all but two UN states. Legislative activity was most intense in the 1990s, in which Article 3, outlining the best interests of the child and Article 12 on freedom of expression, featured heavily within the creation and adoption of new legislation and normative reform as 'the new pillars of this children's rights approach.' (Mauras 2011:52)

The child envisaged by the convention is ideally an 'individual, autonomous being, an inheritor of the liberal, humanist ideals of the enlightenment' (Montgomery 2009:6), an imagining highlighted as particularly problematic in terms of universal interpretation and implementation. In this vision, children are seen less as the property of their parents and as objects of protection, and more as independent entities and rights bearers themselves. This transformation has been slow, and although this conceptualisation of children may be more prevalent in fields that are more obviously child-focused, such as education, there is 'little evidence that children's rights are of much concern in the realm of mental health.' (Damodaran, Sherlock 2013: 723)

The UNCRC has forty-one substantive articles, thirty-five of which protect, secure and guarantee welfare rights for children. The six remaining articles specify some, arguably limited, legal and political rights of children, including provisions for freedom of expression, thought, conscience, religious association, privacy and access to information. Rehfield (2011) argues that these six articles treat children more as a protected class than as active agents, subordinate to their parents views, particularly in the areas of religion and privacy, and in this way the 'UNCRC reflects the widely held view that children are in need of protection and should not be treated as full citizens of a democratic polity' (Rehfield 2011: 142). Elaborating on this point, Article 12 is identified as particular exemplification of this prioritisation of welfare over citizenship as it limits the expression of children's voices to cases in which they have direct personal interest.

3.1 Realising Participation Rights

Actualising participation rights for children hosts a large number of theoretical problems, and the political commitment to realise these rights by many states is questionable. Kjorjolt (2008) explains that the degree to which children are regarded as subjects with participation rights is relative to their age and maturity, and depends in part on the emphasis put on other rights in the UNCRC, since 'the best interests of the child' enshrined in Article 3 is an overarching principle. As Rehfield (2011) outlines, the UNCRC 'justifiably' emphasises welfare over participation rights because children are inherently 'at risk' and lack the cognitive and emotional capacity that democratic citizenship requires.

The construction of children as subjects with rights make it imperative to consider the nature of the relationships between children and adults, and the extent to which the emphasis on children as new citizens also implies making them responsible for their own lives and choices. Agency in children is a consideration; Honwana (2005) questions whether children can ever be 'real agents' as agency is inextricably related to power, and power is constrained by multiple circumstances. Despite being agents within certain situations, the nature of this agency in children is a complex one as it disassembles the traditional binary opposition of child and adult and challenges the power-knowledge relationship between these groups (James, James 2008).

Article 3 similarly has similar issues, as Damodaran, Sherlock (2013) identify. The principle of 'best interest' is difficult to implement due to the debate over who decides what the child's best interests are, but Ungar (2008:19) argues the UNCRC has enshrined the adult responsibility to know what is good or bad for children in international law. Thus, the principle of the best interest of the child is not a neutral and global standard; rather, 'it is one that involved normative and ethical assessments, anchored in cultural contexts and notions of (good) childhood and quality of life.' (Kjorjolt 2008:30)

Discourses that construct children as competent social actors with rights to participate in society, and to have a voice in matters that affect their lives have been flourishing over the last 15-20 years amongst childhood researchers, NGO's and actors within the field of international and national child policy. The positon still depends, however, 'on the extent to which changed political and social practices eventually emerge from this incorporation.'

(Kjorjolt 2008:20) Ultimately, Kjorjolt explains how the fulfilment of participation rights requires adult caretakers who do not construct autonomy and dependency as opposites but as mutually dependant, dynamic and fluctuating.

3.2 Concepts of Children and Childhood

The perception of what a child is and what constitutes a 'good' childhood is also highly important to the cultural conceptualisation and application of child rights. Montgomery (2003) explains how children and youth are often perceived through opposition to adulthood in the convention, as people in the process of becoming rather than being. They are 'pre-social' and 'passive' recipients of experience, portrayed as dependant, immature and incapable of assuming responsibility. This view predominates in international law on children rights, and arguably, the need to establish a global standard of child protection led to the universalisation of a specific definition of childhood.

The discipline of anthropology has been critical of this universalising notion of the 'child' proposing the idea that childhood and youth is something constructed as much by historical and cultural factors as it is by biology, highlighting the importance of cultural relativism within these debates. Aries (1962) argues that the concept of 'childhood' is a social construction that has only existed in the past 200 years and Bourdieu (1993) insists that youth is 'just a word'. Social and cultural variables such as gender, religion, class, responsibility, expectations, race and ethnicity play important parts in defining who are regarded as or consider themselves children or youth, and it is important to note that *'*the ways young persons are perceived do not necessarily coincide with their self-definitions' (Honwana, De Boeck 2005:4).

Chin (2013) identifies this as a 'form of globalisation' enabled by the spread of the UNCRC's dominant discourse of childhood. These ideas are problematic for the context in which this research takes place, as Chin elaborates specifically that the 'western ideas about children, including the scientifically articulated notions of child development, are culturally and historically specific rather than timeless and universal*.'* (Chin 2013: 311). The 'dominant' or 'western' form of childhood, Chin explains, is neither universally practiced nor valued. Yet, due to the universal character and hegemonic position of the discourses on children's rights, Kjorjolt (2008:31) explains that is seldom discussed openly.

4.0 Mental Health and PTSD

Context-specific understandings of mental health are incredibly important in this research. The general concept of 'trauma' is one that is seemingly understood and applied individually and collectively in the 21st century (Fassin, Rechtman 2009). Since the official recognition of PTSD as a psychiatric diagnosis in 1980, Summerfield (1991) identifies how terms like stress, trauma and emotional scarring are used commonly in the public, both metaphorically and as indication for professional help.

According to NICE (2005) guidelines, PTSD is a disorder than can affect people of all ages, and around 25 – 30% of people experiencing a traumatic event may go on to develop PTSD. Sufferers involuntarily re-experience aspects of the traumatic event in a vivid and distressing way, including flashbacks, nightmares and repetitive and distressing intrusive images or other sensory impression from the event. These reminders of the traumatic event arouse intense distress and/or psychological reactions within sufferers, and in children, re-experiencing symptoms may take the form of re-enacting the experience, repetitive play or frightening dreams with recognisable content (NICE 2005). Sufferers avoid this memory in any way they can, and may also experience symptoms of sensory hyper-arousal or extreme of 'emotional numbing'.

There exists an academic argument against the cross-cultural applicability of a PTSD diagnosis, which claims that the idea of trauma is a modern, culturally specific creation (Young 1995, Brewin 2003). In this view, PTSD is seen as a response unique to European and North American culture, not a form of universal pathology. Whilst this dissertation does not intend to elaborate on this discussion, and the work of Luna serves to highlight the need internationally for child-centred PTSD treatment, including research on the cross-cultural applicability of CATT (Weston 2013), these discussions have brought with them interesting insights into concepts of children, trauma and vulnerability as discussed below.

4.1 The Trauma Discourse

The label of trauma is particularly powerful and Fassin and D'Halluin (2005) have also identified how the presence of PTSD can work to legitimise asylum seekers and refugee's

persecution by adding weight to their claimed experience. Eyer, Ager (2004) argue that the widespread acceptance of concepts such as trauma have created a 'trauma discourse' in the West and as Young (1995) explains, this discourse is frequently used in connection with understanding the impact of war and violence on individuals and communities. The favouring of victimhood over resilience present within this discourse can arguably be based on ideas on the 'social utility' of this position in terms of political, social and legal leverage (Summerfield 2001). It can also be seen as a product of assumptions of how children and young people live their lives and cope with distressing experiences. These assumptions are argued to fundamentally derive from popular conceptualisations of childhood in the West, as identified previously, in which 'children are frequently regarded as vulnerable, passive beings who need to be protected and cared for rather than active members of their community' (Eyer, Ager 2004: 189).

4.2 The African Child and PTSD

The concept of victimhood is a deeply entrenched idea, one that is particularly potent when examining the spread of the trauma discourse towards children and childhood in a non-western context (see Harrel-Bond 2002). Perceptions of the African child are particularly interesting to work with due to the challenging nature of the continent and the influence this has over general perceptions of child vulnerability. African children and youth are routinely portrayed as innocent, vulnerable and in need of adult protection, yet this is a view that disregards the multiplicity of positions that young people express. Anthropological insights (Honwana 2005, Rosen 2005, 2007) into children's agency and victimhood have attempted to challenge these notions of children as passive recipients of adult agency. Within this setting Honwana, De Boeck (2005) explain how despite young people constituting the majority of the population in Africa, and placing themselves at the centre of societal interactions and transformations, they are often placed in the 'margins of the public sphere and major political and socio-economic and cultural processes' (Honwana, De Boeck 2005:2).

The idea of children as inherently vulnerable and dependant has long been associated with the development paradigm, criticised for being adult-centric and failing to recognise children as rights-holders. Chin (2013) elaborates how, when considering the globalisation

of childhood perceptions inherent within this paradigm, certain cases have become emblematic of a deviation from the 'norms' of childhood, such as street children, child sex workers and child soldiers. Considering this discourse, 'traumatised' children can also be seen as a similar deviation.

4.3 Trauma and Rights

The UNCRC endows children with three types of rights: provision, protection and participation. However, Kjorjolt (2008:21) discusses how participation rights are often presented through a dichotomous understanding of the child as either vulnerable or as a competent social actor. Vulnerability as discussed, is associated with the development paradigm, which often dismisses children as social actors. The movement for empowering children is anchored to the universal discourses on child rights, yet Kjorjolt (2004) explains that these discourses, by contrast, seem to lack any approaches that can take account of children's dependence on the cultural and political context they exist in. In focusing on both PTSD and children rights, Luna's methods seemingly bridge this dichotomous understanding of children as vulnerable, susceptible to trauma and in need of protection by imagining them in this way *and* as rights holder with agency, capable of making decisions and leading their own treatment. The outcomes of this approach are elaborated within the research findings section.

5.0 Countries in Context

In the UK, there have been wider movements and campaigns aiming to involve youth and children within mental health projects, decisions and advocacy. Despite this, Damodaran, Sherlock's (2013: 724) study on children's participation within mental health services in the UK shows how the decision to commence medication is sometimes taken unilaterally, issues around children's assent are often not negotiated, and information available is not always provided to children. These results raise questions of participation and rights based approaches to service provision, but these are often overlooked due to insufficient time and lack of resources within services. 'The voices of service users need to be sought, welcomed, truly heard; in absence of asking questions of children and young people rights can often be violated.' (Damodaran Sherlock 2013: 727)

In defining the existence of PTSD, trauma and appropriate treatments, questions of cultural appropriateness are considered within this research. Definitions of illness vary from culture to culture, and attempting to make medical diagnosis using western standards, and without considering cultural references can be misleading (Summerfield 2001, Brewin 2003). Despite this, Sebit (2013) an author in the established 'African Journal of Traumatic Stress' identifies how traumatic incidents are indeed common in Central and Eastern Africa, the area in focus for this research.

5.1 Rwanda

An estimated one million people lost their lives in less than one hundred days during the Rwandan genocide of 1994. In the years that have passed, Favila (2009) claims that comprehensive studies of PTSD in post conflict scenarios in sub-Saharan Africa, and more specifically in post-genocide Rwanda, are extremely rare. Neugebauer et al (2009, in Favila 2009:2) claim that only four studies have investigated PTSD in the aftermath of the Rwandan genocide, yet this study analyses the 1995 National Trauma Survey of 1,547 Rwandan children aged 8 – 19 and found that between 54 and 62% (depending on the sample used) of interviewed children exhibited probable PTSD.

The genocide also destroyed much of the existing infrastructure that could have potentially addressed the mental health needs of the devastated nation; the only psychiatric hospital in

the country was not operational after this period of unimaginable violence as the majority of patients and staff were killed (Favila 2009). As a result of the need overwhelmingly exceeding the available provision, most programmes targeting trauma represented a western philosophy, and were often the efforts of international NGOs. CATT training was developed in the UK and first pioneered in Rwanda, where Luna worked with the charity REACH (Reconciliation Evangelism and Christian Healing) to provide L2 training.

5.2 Uganda

Uganda itself has a history of violence, and Northern Uganda in particular has suffered much from consequent conflict and displacement. Most recently, the Lord's Resistance Army has been a focus, with increasingly international notoriety for the usage of child soldiers. Children have been targets of the abductions (see Allen 2006) throughout the conflict between the LRA and the Ugandan government in northern Uganda and Sawyer (2012) places the estimated number of children abducted at 20,000.

Whilst statistics on levels of PTSD are unclear throughout this area, Finnstrom (2008) has highlighted the need for context specific approaches with regards to local cultural understandings of PTSD and symptoms. The idea of 'cen,' conceptualised as the haunting spirits of people who have died violently, is experienced by those subjected to, perpetrating or witnessing the violence of death in war. Those with cen may be suffering from what could be recognised as PTSD, yet Finnstrom highlights the importance of framing and articulating these ideas in locally informed fields of stressful and negative experiences.

Luna works alongside East London CAMHS to provide L2 CATT training at a national hospital in Kampala, Uganda. CATT training has allowed Ugandan mental health professionals to utilise these skills with child soldiers, refugees from South Sudan, and children suffering from a multitude of hardships (M Interview 07/06/14). Research findings indicated the challenges that exist in Uganda, in terms of contrasting views about mental health, the prevalence of traditional and faith healers and the social construction of childhood, yet case studies from Stein, Nalugya (2013) have indicated the successful CATT treatment of a teenage girl in this setting.

5.3 Tanzania

Mental health services and professionals have historically been sparse within Tanzania (Sebit 2013). A 2009 UNICEF report on the violence committed against children highlights the sexual, physical and emotional violence that children growing up in this country face, and this report dedicates a chapter to explaining the mental health consequences of this abuse in situations of prevailing poverty. Similar challenges existed here as they did in Uganda, and are discussed in depth in the following chapter. Luna worked in partnership with the Arusha Mental Health Trust whilst teaching a L2 course in Tanzania, the only mental health service in the region.

6.0 Research Findings

Research questions were designed to draw on participant's experiences, understandings and observations in order to highlight important considerations for analysing the efficacy of Luna's child right framework. I have used thematic analysis of the qualitative data gathered to logistically break down this information and draw out the areas of concern. These have been identified, and thus form the different sections of these chapters. Sections 6.1 – 6.3 provide the contextual background to the delivery of trauma therapy in the areas of analysis, indicating the foundation from which these CATT trainees must work, and highlighting important barriers for children's mental health and participation rights. The remaining sections cover important discussions that highlight strengths and weaknesses of using this framework within the given context. This includes perceptions of children's individuality, participation, vulnerability and voices alongside participants understanding and attitudes towards child rights and working in a child centred way.

6.1 Mental Health, Education and Understandings

A key theme from participants was the lack of education and awareness in the field of mental health. Mental health disorders were discussed as largely 'misunderstood', meaning the symptoms were rarely framed in the same way as they were understood and discussed by mental health professionals and CATT trainees. Discussion about the result of the lack of education in this field swayed towards notions of 'inappropriate' treatment, abusive behaviour or a distinct lack of response.

Tanzanian participants who discussed mental health in detail explained how the presence of physical symptoms of illness or abnormal behaviour is often required for recognition that someone may be mentally unwell. F, a European social worker who has been working with a local NGO for the past two years, spoke about the difficulties in explaining mental health to her colleagues, as symptoms such as headaches, nightmares or bad behaviour are often associated with behavioural problems or a lack of intelligence in children (F interview 04/06/14). Similarly, the head psychiatrist of the Arusha Mental Health Trust explained how trauma and depression symptoms could be understood as personality traits, rather than diagnosed as mental illness; *'*no one looks after them really because those mental health conditions are perceived as normal phenomenon.*'* (K Interview 06/06/14)

This reliance on physicality to determine mental illness creates other problems, as outlined by 'P' who works in a special needs school, and spoke about the confusion between learning disability, mental health and other physical issues such as epilepsy (P Interview 11/06/14). R, a UK based CATT trainer, also highlights these ideas in Uganda, explaining how most of the children on the mental health ward actually had learning disabilities, epilepsy or brain damage from malaria or HIV/AIDS. (R Interview 06/08)

In Rwanda, where CATT was first practiced and established, mental illness was seemingly understood within the group of trainees, yet the difficulty lay in applying this diagnosis to children. Q, the creator of CATT, explains how children were not seen as individuals who could suffer from mental illness, particularly PTSD, and instead their symptoms were framed as bad behaviour, often resulting in punishment. She discusses how this was similar to the UK 10-15 years ago, and as a trainer she was able to move from Rwandan trainees laughing at the suggestion that children can have mental health problems, to opening up a discussion about this by sharing cross-cultural research on traumatic incidences and children (Q Interview 21/07).

Participants spoke of the ways in which individuals and communities within all countries studied had created their own explanations and contexts for mental illness. T, chair of Trustees at Luna and a trainer herself, explains how PTSD was interesting to work with in Uganda, as it is often seen as different to other types of mental health problems in the sense that an adverse reaction to traumatic incidence is not necessarily outside the 'normal' range of behaviour (T Interview 22/08/14). T locates this argument to the Ugandan notion of 'cen,' as discussed in chapter 5.2.

The creation of own explanations and context also led to different ideas of cures and treatments. In a Tanzanian and Ugandan context, witch doctors and faith healers were widely discussed in interviews, and often seen as obstacles to accessing professional treatment (see Dillip et al, 2012). Visiting a mental health department was repeatedly conceptualised as a 'last resort' for particularly rural communities, and the social acceptability of these actions were low. These ideas were not exclusive to the African context however, as CATT trainers N and R discussed: Both of these participants work in an area with a large Bangladeshi immigrant population, and ideas about 'spirit possession'

were in place with regards to mental illness (Interviews N 07/06/14 and R 06/06/14). These understandings and obstacles often perpetuate stigma within the given communities.

6.2 Stigma

All participants emphasised the stigma accompanying mental health, and discussed how this was often a result of the explanations individuals and communities have assigned to explain mental health symptoms A, a Tanzanian national who works as a child rights consultant, illustrates this with an anecdote about her journey to the Arusha Mental Health Trust; 'The taxi driver that drove me here yesterday, when I explained about the training, some of the words don't even exist in Swahili. He said 'you're going to the department where the crazies are?!' (A Interview 03/06/14)

Tanzanian interviewees spoke of how parents and relatives would often hide a child with mental illness or disability within the house to limit their interactions with the outside world. The reasons for this were varied; these children could be seen as a curse, the level of acceptance in this instance were very low (D Interview, 04/06/14) and in situations where the family relied on children having responsibilities, conditions resulting in 'idleness' perpetuated the devaluing of these children (O Interview, 09/06/14). Discussing a child who was part of the scholarship programme she ran, L speaks of a conversation she had with the mother; 'She said 'I have a hopeless child, he is 14 years old and he cannot read or write, he is just there at home.'' (L Interview 06/06/14). The stigma, shame and strain of living with and providing for a child affected by these issues is apparent within these discussions, yet these views often referred to a lesser-educated, 'rural' population who are unrepresented within this research.

P locates the lack of government initiative to tackle this stigma within the wider struggles of Tanzanian life, claiming mental health is forgotten due to the huge variety of issues in the country that the government is already contending with. Illustrating this struggle on an individual level, P gestures towards the child who had come to sit with us whilst the interview took place at her school. He appears to have quite severe learning disabilities and is largely unable to communicate verbally;

‘He is hit by his own father, he is kicked, he is treated very badly and his own mother cannot do anything because she has to survive herself … many people are sympathetic, because they don’t know the explanation of what is wrong, but there is a lot of stigma and fear. It is often associated with witchcraft and people are afraid and they don’t know what to do. They are held back by the stigma of mental health and the idea that they can ‘catch’ it.’ (P Interview 11/06)

Discussions on stigma in Uganda wielded similar results, serving to highlight the blurring of lines between mental illness, learning disabilities and physical symptoms. C, a church volunteer who works in a holistic manner with the children on a Ugandan mental health ward extended this stigma towards the parents and family of the child. They could be seen as bewitched or as having made a sacrifice of their own child (C Interview 03/06/14).

Talking about his work in rural Uganda, M, a Ugandan psychologist and CATT trainer, reflects on a project in Eastern Uganda, and tells the story about his discovery of a young boy who was kept in a pit in his back garden by his parents, who believed the child’s epilepsy was contagious. M has also worked previously with a young child with learning disabilities and epilepsy, who, as a result of these difficulties, was kept in a pig sty owned by the parents until he was rescued and taken to hospital. As a result of the child’s time here, part of his buttocks and arm had been partially eaten and this was discussed as the desired outcome for the parents (M Interview 06/06). M attributed these incidents towards the lack of education, particularly in this rural area of Uganda.

In a UK context, discussion centred on the fact that stigma, despite movements and campaigns to reduce it, was very much apparent. The level of understanding and tolerance was particularly dependant on the specific type of disorder, and the services available differentiated depending on their location and distribution of (limited) funding and priorities. Q discusses how children with ‘loud’ disorders resulting in extroverted behaviours, such as PTSD or conduct disorder, are often seen as naughty or difficult, but more internalised problems such as anxiety illicit a more compassionate response, if spotted (Q Interview 21/07). From these discussions, it seems apparent that stigma was pervasive in all contexts; however, the severity and the consequences of this differed significantly.

6.3 Children and Childhood

The concept of the child and 'childhood' is particularly important for the imagining and implementation of child rights and the effective delivery of CATT therapy. Amongst the 20 participants in this study, there was little uniformity in answers when asked to define the 'child'; an interesting position given the guidelines for a universal notion of the child set out by the UNCRC, which defines childhood as beginning at birth and ending at 18 (United Nations 1989: Article 1).

When defining childhood in terms of biological age, participants were aware of the legal standard of '18' however many chose to offer more nuanced explanations that fit in with contextual understandings. For example, the 'Law of the Child Act' implemented in Tanzania in 2009 aimed to define children nationally as under 18 years, and supersede other laws in place in the country that counteracts this (Government of Tanzania 2009). Whilst approximately half of Tanzanian participants defined childhood as a period of time below 18, other Tanzanian participants were either unaware of this law or chose to not incorporate this into their definitions: K based his response in medical terms and located childhood as below 12 (K Interview 06/06/14), ideas of mental ages and life starting at conception or birth were evoked (P Interview 11/06/14) and relational aspects of personhood discussed, such as being considered a child no matter what age if you are unmarried and in parental care (E Interview 04/06/14).

In a UK context, CATT trainers defined children from a more developmental point of view, in which children were not yet physically or emotionally developed and lacked lived experience to make sense of the world (J Interview 05/06/14). Arguably because of this, there existed an idea about an appropriate level of responsibility for children. In contrast, Reynolds (1990 in Honwana, Boeck 2005:11) explains the reality in which very few African children and young people enjoy the 'luxury' of care until the age of 18 either by a parent or state, and there exists an expectation to work and assume social responsibility at an early age. Tanzanian and Ugandan participants, and discussions on children in Rwanda, reflected this statement. Again, the concept of a 'western model' of childhood in which there is a unidirectional relationship of children having needs and parents meeting these, appear out of place. K explains how responsibilities for children depended on the social status and

location of the family, again highlighting the juxtaposition between the 'modern' urban setting and the underdeveloped - both financially and educationally - rural communities. This explanation is tied into his own upbringing in a rural community, as he acknowledged the change in discourses surrounding child responsibility;

'In recent terms it was more or less like child labour … I was on the receiving end based on what the situation was, either my parents or at school I was subjected to receive commands and guidance.' (K Interview 06/06/14)

The responsibilities discussed by participants include - but should not be restricted to - active participation in productive tasks, paid labour, household chores and care of younger siblings. The prevailing notion of the importance of education, and the responsibility of children for their academic attendance, organisation and progress was apparent. Despite the existing rhetoric in development, as discussed by Montgomery (2003) that an ideal childhood should be a period in which there is little - if any – responsibility, the discussions encountered on children's responsibility were rarely approached in a negative light. Montgomery (ibid) also highlights the tension of rights vs duties in terms of cultural expectations, and identifies how the African Charter on the Rights of the Child recognises this within their slightly altered construction of 'childhood.' Illustrating this, O explains how the idea of 'childhood' as having no responsibilities actually results in reduced respect for this chronological group, due to their lack of contribution to society (O Interview 09/06/14).

During the Tanzanian training, some of the more vocal members of the group identified the prevailing idea that children in a Ugandan or Tanzanian context, occasionally generalised to an African context, lacked imagination. This was discussed as a difficulty when approaching areas of the CATT protocol (see Figure 1) in which the child would make up 'imaginary' characters or play out scenes with little help from the adult present.

'I've been very struck by how much of a struggle it has been for [adults] to get down to that [child] level. I think there is a struggle to appreciate that children have the capacity to use their imagination and thinking minds. I think children can and that is universal. *(*J Interview 05/06/14)

The preoccupation with play and imagination often takes a central role within modern western conceptualisation of childhood, and play is frequently seen as a precursor for individual development (James, Allison 2000). Participant A linked these ideas to the reality that some children faced; 'Play is not a priority, it's helping out, it's taking part in responsibilities, it is surviving.' (A Interview 03/06/14).

These different imaginings of childhood should not be problematic for the application of CATT in theory, as R explains, but exist to 'highlight how important it is to really spend a long time discussing childhood and cultural differences before you get into teaching CATT' (R Interview 06/08/14).

6.4 Children as Individuals

Luna wishes participants adhere to the right's protocol (as identified in chapter 2.3) when implementing CATT: The child as an individual should have given consent to the treatment, have a significant level of autonomy within processes, and set goals with the therapist in a safe, secure and comfortable setting as decided by the child. In terms of cultural constructions of the individual, T, discusses the idea that the UK was different from the places she had visited with Luna, namely Rwanda and Uganda (T Interview 22/08). There was disagreement on children as individuals within a UK context, however - Q believes that, despite the 'strong rights culture' in the UK, movements towards children's individuality in the past few years were seen as 'tokenistic' and were often still situated around the responsible adult. (Q Interview 21/07/14)

Burr (2002) discusses how the child within a larger community is less of an individual, and thus the UNCRC is grounded in a particular form of child rights by an individualistic sense of self, disregarding the idea that in some contexts, obligations to the community trump individual needs. Anthropological perspectives on the creation of personhood have stressed considerations on the constitution of individuals, and how processes of becoming highly individualised can be profoundly different between societies. F elaborates: 'You never talk about one person as an individual you always see the one person as in his community, in her family. You look at the whole thing not the individual.' (F Interview 04/06/14)

During the Tanzanian training, issues of individuality and the concept of children as the autonomous, independent individual that CATT therapy requires were evidently conflicted with participant's ideas about the cultural norms of the setting. Individuality was discussed as a difficult concept due to large family sizes and the pervasive issue of poverty (P Interview 11/06/14). S acknowledges the different concept of individuality in Uganda, illustrating this through a discussion on the lack of formal registration for individuals such as ID, or birth certificates commonplace in the UK (S Interview 06/06). Despite these discrepancies, the therapeutic benefits of seeing a child as an individual were acknowledged by all participants in interviews.

6.5 Vulnerability

The concept of vulnerability repeatedly underpinned descriptions of children, alongside the notion that they were under-developed and unable to make sense of the world in which they lived.

'My definition of children would be that they are emotionally and physically not yet fully developed and they are dependent on adults, to care and look after them and protect them. They are very vulnerable and exposed.' (J Interview 05/06/14)

This preoccupation with children and vulnerability persisted when linked to mental illness and trauma (T Interview 22/08/14), and nearly ¾ of participants conceptualised children as more susceptible than adults to developing PTSD. Participants with psychological training alluded to academic reasoning concerning this susceptibility, believing that children have significantly less control in traumatic situations, a precursor to developing PTSD (Q Interview, 21/07/14, R Interview 06/08/14). Those without this psychological context often presumed vulnerability, a research finding linked significantly with the existing debate discussed in chapter 4.1 – 4.3.

In line with this, those who worked with patients in asylum/ refugee situations acknowledged the benefits of a PTSD diagnosis. R discusses how PTSD legitimises the traumatic experience of the person in question, confirming their inability to give a concise account of their experiences (R Interview 06/06/14), ideas supported by Fassin, D'Halluin (2005). The ability and power of this label in legitimising experiences is evidenced in the

discussion of patients exaggerating or fabricating learnt symptoms. M highlights the case of a South Sudanese refugee mother who neglected to give her child medication for physical wounds and allow treatment for PTSD to occur, as she believed the child's condition may have aided them financially or in terms of resettlement (M Interview 06/06/14). N also speaks of a patient in the UK who fabricated his symptoms after successful PTSD treatment on the advice of his brother, believing that this would result in his case for asylum being viewed more sympathetically (N Interview 07/06/2014). These examples are indicative of the power that exists in the trauma label, which consistently evokes ideas of vulnerability and victimhood to legitimise the traumatic experience in different contexts.

6.6 Child Rights Understandings and Limitations

The political implications of referencing the UNCRC directly has become apparent for Luna trainers whilst working with Syrian mental health professionals, who appeared annoyed and disinterested at the inclusion of training material associated with the United Nations and 'switched off' at this point (T Interview 22/08/14). This reaction was conceptualised by trainers as a product of the current political climate in Syria, level of UN involvement/ inaction, and the resulting humanitarian crisis and protracted refugee situation in which they are working. Talking about this experience, R comments, *'*It's important to get the idea of child rights across, but we risk alienating some people if we talk about the UN.*'* (R Interview 06/06/14)

Going back to the roots of the approach, Q explains how Luna Children's Charity was designed to be wary of a 'western imperialist' approach, particularly with regards to child rights. These concepts are included not to impose or dictate practices, but to indicate a way of working; to treat children as individuals and view them as the right people to address their problems (Q Interview 21/07/14). Elaborating on this discussion, Q notes that the decision to include the UNCRC within training is designed as a way of referencing how this works for CATT practitioners in the UK. The African Charter on the Rights and Welfare of the Child is also referenced when working in an African context for the same reason. In this way, the decision to work in a child-centred way should be a collaborative decision with the group of trainees, and discussions around the difficulties and realities of this should be facilitated and included within the training (Q Interview, 21/07/14). T adds to these ideas,

talking about how rights gives CATT trainees a moral context with which to work from, and justifies the work that both Luna and CATT trainees are involved in, alongside the idea that this produces a better outcome for children, morally and clinically:

'It's actually the way in which we internationally have agreed we should relate to each other and the ideal standards that we should try and provide in our communities and societies. The problem comes when those rights conventions are not enforced, unenforceable or are too far from a child's lived reality.*' (T Interview 22/08/14)*

For CATT trainees in Tanzania, understandings of child rights, debates and issues was varied and multifaceted in this sample, and, post-delivery of this section of the training did not necessarily reflect the desired outcome identified by CATT creator 'Q' or the in depth discussion by 'T'. The trainer who delivered these slides suggested that she was underprepared to deliver this section, and the connection between the rights discussed and the aims of Luna were not made. Notably, direct reference to Article 12 and 13 of the UNCRC was not included (a result of the previously discussed reactions in Syria) yet Article 13 and 14 of the ACRWC was. Some participants offered more positive views on these references;

'It gives me the whole picture on why and how CATT is child-centred. Because now I can reflect back on child rights, human rights, the United Nations and the African charter whatever, and I'm like this is the reason I have to use CATT. There is a valid reason for being child-centred.' (I Interview 05/06/14)

Arguably due to the nature of their work with children and the globalising legal discourse, all participants of this study were explicitly aware of concepts of child rights and able to discuss this, but their involvement and understanding ranged significantly. For example participant L has recently undergone child protection training and is implementing an extra curriculum programme in local schools to teach children about their rights as part of her work with an NGO. Other participants indicated simpler understandings of child rights, centred on the idea of meeting basic needs and care. Most responses leant more towards ideas of provision and occasionally protection, and less towards identifying or actualising children's participation. A captures this within the context of Tanzania and explains that the language

of human rights is still quite new; because of this child participation rights are seen as somewhat of a 'luxury' (Interview with 'A' 03/06).

Discussions with M also reflected these findings in a Ugandan context. Many adults think of evasive situations of abuse when conceptualising rights, and may envisage education and freedom of expression as secondary, if considered at all (M Interview 06/06/14). C, a Ugandan national explains how parents limited understanding and unwillingness to let their child be independent and in control may construct barriers for children accessing a treatment based in child-rights (C Interview 03/06/14). C also highlights the importance of cultural relativity, explaining how some behaviour seen as abusive in one context is deemed normal and acceptable in another.

In theory, this serves to highlight the differences in issues when actualising children's rights between the CATT country of origin, and the country receiving the training. Limited relevance, overstretched resources, prevailing health and structural problems, issues of corruption and a lack of an enforceable and accessible child protection system were identified in both Tanzanian and Ugandan contexts as blockades to the full realisation of the legal requirements of the UNCRC. A and K also indicate specifically the need for parental consent for treatment in Tanzania, and K discusses his problematic experience of children being pulled out of treatment by parents, on the basis that the child is revealing the family set up, which may perhaps be dysfunctional or violent (K Interview 06/06/14).

In terms of delivery, M offered an insight into how to emphasise the importance of actualising these child rights, even with the discussed difficulties in mind. As a psychologist, he gives an interesting analogy of how the more 'evasive' ideas on abuse - which some adults may immediately conceptualise when thinking about rights - can be used to highlight the importance of other rights, such as freedom of expression. If children cannot speak out about abuse it will continue to happen;

'We call it slow poison, when you beat someone's esteem. It doesn't kill them immediately, it could over time. It could kill them indirectly, if someone's voice has always been put down they will keep quiet, even when they need to use their words'. (M Interview 06/06/14)

When teaching the idea of child rights, M explains how he leaves the direct reference towards the UNCRC or ACRWC out in initial discussion due to the fact that many people will have already read the literature. He explains how it is better to discuss, to tap into people's emotions and to attach concepts of rights to basic concept of humanity and dignity, rather than 'fighting things in a book that they didn't actually read' (M Interview 06/06/14). These discussions address the importance of working in a cultural relative way when approaching the reality of actualising children's rights, and facilitating the time for discussion on limitations and frustrations of the participants within the cultural context.

6.7 Participation and Voice

The previously discussed debates (Rehfield 2011, Damodaran, Sherlock 2013) on the slow transformation of child rights are indicative of the existing conflict between the need to protect children and the need for children to have their voices heard. This resonated with the comments of participants J, N, Q and R (all mental health professionals based in the UK and involved with Luna to differing degrees) made when discussing the difficulties of actualising child rights within their work setting, in particular Article 12 on the freedom of expression of the child.

'There were stand-up rows at conferences about the idea of really listening to children, people were really offended … by the idea that they should have a voice in their own mental health care.' (Q 21/07/14)

In terms of practical implementation, Article 12 requires the creation of a systematic practice of consulting children and listening to them in matters that affect them, which implies a state obligation to produce an environment for this (Mauras 2011: 60). There appears to be little, if any, state movement towards creating these practices within Tanzania, and the idea of children having voices remained problematic within this context, as P discusses; 'You see you need to be heard, and then you need to be understood, and then someone needs to have the space for you, before your voice can be valued' (P Interview 11/06/14). H, a mental health professional currently working in Tanzania with a western background, spoke about how this voicelessness could affect the success of the therapy - questions such as 'what are our goals?' could be very intimidating for a child not usually considered in this manner. Another potential barrier for CATT existed within the idea

that adults may be actively against allowing a children to have a voice that facilitates their participation.

> 'There's a lot of fear about educating children too much or empowering children too much or giving them too much of voice that they rebel. There is very much a desire to control children.' (A Interview 03/06/14)

Honwana's (2005) previous discussion on the traditional binary opposition of child and adult relates to the clash identified between child participation and professional standards that can stand in the way of children's voices being recognised and legitimised; *'It can be threatening as it reduces the power of that professional … it gives the power to the child'* (T Interview 22/08/14). Yet Q insisted that CATT is not about lowering professional standards to ask a child something, but about recognising that children themselves are in a better situation to address these issues as individuals, providing better clinical outcomes (Q Interview, 21/07/14).

6.8 Working in a Child-Centred Way

Despite the complexity of responses from participants when discussing child rights, all interviewees unanimously expressed their positive feelings towards the concept of working in a child-centred way, whether they had just learnt about this or whether they had been working in this way for years. In line with this, this element of the training is arguably the most important, more so than the child rights section, due to the clinical outcomes, as UK trainer R implies:

> 'What's important is forgetting who said this right and that right but recognising that these are the rights we need to give children, this is what children need to feel comfortable and involved and engaged and for the treatment to work successfully.' (R Interview 06/08/14)

In Tanzania, whilst the difficulties of working in this way were acknowledged in terms of convincing the escorting adult, the acceptance towards ideas of working in a child centred way was apparent.

'When working with children we need to put the children at the front, we need to work on the best interest of the child. And we as adults cannot know the best interest of the child unless we are child-centred.' (D Interview 04/06/14)

Interestingly, A notes how this agreement towards working in a child centred way (in terms of child participation, involvement and inclusion of voices) could be taken as a reflection of the externally driven movement from donor agencies, development rhetoric and the commitments made by Tanzania to the UNCRC (A Interview 03/06/14). In other settings, T explains the difficulties with a child-centred focus in a highly religious context which privileges obedience over autonomy, here referencing her experiences in Uganda and Syria. T also mentions how, in both trainings there were people in the room who found this concept more difficult than others, and those who instinctively wanted to work, or already did, in this way, an important observation which was also in place during the Tanzanian training (T Interview 22/08/14).

Participants felt it necessary to talk about child centeredness in a culturally relative and reflective way. A prevailing theme was the dependency of the therapy on the adult therapist or caregiver, what they defined as a priority and/or benefit, and whether they could overcome initial personal and cultural resistance to ideas of working in this way. (M Interview 06/06/14). Within discussions on working in a child-centred way, a key finding indicated that participants felt that working in this way benefitted the children not just clinically and therapeutically, but in terms of facilitating a relatively new experience in which the child is involved, respected and participating as in settings such as Tanzania, the locus of control is often outside of children themselves (H Interview 05/06/14).

'In most of our culture, children are marginalised and not taken as a person to make decisions – so if you formulate something to centre the child I think what happens is that the child will love it, and take it and enjoy it.' (K Interview 06/06/14)

7.0 Conclusion

This research has aimed to analyse the efficacy of delivering trauma therapy through a child rights framework using examples from Rwanda, Uganda and Tanzania by outlining the ethical and clinical benefits of this approach. This framework covers both the adoption of Article 12 and 13 as a way of working therapeutically, and extends to more general ideas of advancing child rights as a moral basis for the charity. This research proved challenging within attempts to refine discussions and analysis with regards to both of these commitments.

I was only able to witness one training session in an international context, and research questions were designed so participants could draw on personal experiences and understandings. Due to these limitations, research findings are based on individual and subjective opinions. Ethical limitation also means that practices of CATT trainees were not studied, thus a fuller consideration of the impact of this framework is unavailable.

With this in mind, the results of the study have indicated how the dynamics between the global discourses on children's rights, national political and the cultural politics of childhood is complex and multi-directional. As discussed, Luna's methods have successfully bridged the dichotomous understanding of children as vulnerable, susceptible to trauma and in need of protection but also as right holders with agency, capable of making decisions and leading their own treatment. This is not always the case in the contexts in which Luna has worked. The degree to which children's rights, as stated in the convention, will be guaranteed is dependent on how these are emphasized in different contexts and the extent to which they are consistent, or come into conflict, with other cultural and political interests and aims in any society.

The discussions with participants surrounding the themes of children's individuality, vulnerability, participation and voices have exemplified how cultural differences can impact the way in which CATT is received in different countries. This research has also touched on issues that are beyond the scope of Luna's training, such as the wider structural limitations within a given setting that provide barriers for children accessing mental health treatment they need.

As discussed, the way in which Q described the intent behind the inclusion of child rights within the CATT protocol could indicate that the delivery of this framework in Tanzania lacked the necessary discussions on the complexity and limitations of child rights and perceptions of the child within this cultural context, and arguably appeared 'tokenistic.' However, the desired outcome of this framework as I understand it, is that participants need to 'buy in' to the ideas that children can, and do, suffer from mental health problems, and that treating children in a child-centred way will produce better therapeutic outcomes, as well as upholding various child rights and providing a more holistic experience by giving the child autonomy within their participation.

The collaborative decision to work in this way is ultimately what is required for CATT training to be successful in terms of this framework, and research findings have strongly indicated that this 'buy in' was the case in Rwanda, Uganda and Tanzania. Participants in all contexts came to recognise the clinical, therapeutic and moral benefits for the children by working in this way over time. This research therefore indicates that it is not the CATT technique itself that is particularly problematic when based in child rights, but the training and delivery of CATT that presents the biggest cultural barriers, an idea supported by Weston's (2013) previous study.

Although this research has focused on sub-Saharan Africa for analytical clarity, these findings should be kept in mind for Luna in their future work around the world. It is recommended that more emphasis is made in L3 training on incorporating the facilitation of discussion in L2 training overseas. These discussions should include the cultural constructions of the child and childhood, the degree of implementation of the UNCRC and participation rights, and the limitations of existing structures. Participants should have the chance to discuss their own lived realities and the cultural context they work in. Participant M has offered a good example of how this can achieved in cultures with different ideas on child rights than the UK (see chapter 6.6).

The rights that CATT training is based in, namely freedom of expression for children and a voice in their care do not necessarily have to be based within a rights convention if this is politically difficult, but should be referenced as a way of working and upholding rights on a professional, rather than international, level. Before delivering CATT overseas, trainers

need to be prepared for the given context, and clearer on why this section is included, important and what the intended outcome of this framework is.

Luna is a small, voluntary charity so a lack of uniformity or at least discussion on these important issues could be detrimental. These issues discussed here show an opportunity for the refinement of the L3 and L2 training: Incorporating the experiences, understandings and practices utilised in this research into these refinements would anchor the work of Luna not just in theory and conventions, but also with people, facilitating a more complex, considered and multifaceted usage of the child rights framework.

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Interviews

1.) Interview with 'A' (03/06/2014)
2.) Interview with 'B' (03/06/2014)
3.) Interview with 'C' (03/06/2014)
4.) Interview with 'D' (04/06/2014)
5.) Interview with 'E' (04/06/14 and 05/06/2014)
6.) Interview with 'F' (04/06/14)
7.) Interview with 'G' (05/06/2014)
8.) Interview with 'H' (05/06/2014)
9.) Interview with 'I' (05/06/2014)
10.) Interview with 'J' (05 /06/2014)
11.) Interview with 'K' (06/06/2014)
12.) Interview with 'L' (06/06/ 2014)
13.) Interview with 'M' (06/06/2014)
14.) Interview with 'N' (07/06/2014)
15.) Interview with 'O' (09/06/2014)
16.) Interview with 'P' (11/06/2014)
17.) Interview with 'Q' (21/07/2014)
18.) Interview with 'R' (06/08/2014)
19.) Interview with 'S' (06/08/2014)
20.) Interview with 'T' (22/082014)

Appendix A - Research Questions (Semi Structured Interview Questions for CATT trainees / trainers)

1.) Can you give me a brief introduction of yourself and your work?
2.) What, in your view, is the definition of 'children'?
3.) From your experiences, what kind of responsibilities do children have?
4.) Do you think children are viewed as individuals in (country)?
5.) Are children's voices valued in (country)?
6.) What do you understand by the term 'childhood'?
7.) What do you think makes a childhood 'good' or 'bad'?
8.) How much autonomy did you have as a child?
9.) In what ways do you think local views on childhood will influence perceptions of CATT as a viable treatment option?
10.) In your view, what position do children with mental health issues have in society?
11.) From your experience, how do children with mental health issues tend to be treated and/or cared for?
12.) Do you think children are more of less susceptible to suffering from PTSD than adults?
13.) Do you think that there are any benefits for children that can come from the diagnosis of PTSD?
14.) How do you feel about the idea of a child-centred approach to treatment? Do you foresee any issues with using this in a (country) context?
15.) Would you want to implement this in your practices? If yes, how?
16.) Do you think that reference to the UNCRC / ACRWC helps you to understand child-centeredness?

Additional Questions for CATT trainers:

17.) In what ways have you implemented the concept of 'child-centred' treatment in your CATT practices?
18.) Have you experienced any particular difficulties with using the UNCRC or ACRWC whilst teaching CATT?
19.) What was the response of trainees during this section?
20.) How did you communicate these slides to this particular group of trainees?
21.) In what ways do you feel this section will shape the treatment that children ultimately receive?
22.) Did anything emerge from discussions around this area which you felt was interesting?

Appendix B – CATT Protocol in Detail (Weston 2013)

1. Creation of a setting where a child feels comfortable and trusts their therapist.

2. Creating a Safe environment. People with PTSD face a number of factors which can trigger a reaction, and often have high levels of anxiety. Creating an environment which is safe and secure will mean treatment can be implemented effectively.

3. Systemic work to create a trusting relationship with the child to identify adult and wider support networks.

4. Psycho education means that a child has an understanding of why their brain and body is reacting in the way that it is. Once they gain this understanding it is easier for them to comprehend their treatment.

5. Child Centeredness. CATT is very much a child centred technique whereby the child's own feelings and opinions are placed as the most important, and the child is able to have an impact on their own treatment. This helps with sense of trust, sense of control, as well as making the treatment itself more effective.

6. Need Assessment. The therapist must gauge whether the child is having their basic needs met outside of the therapy, for example what his or her home life is like can affect the treatment, and if a child is hungry or lacking sleep because of their quality of life it is important that the therapist has awareness of this before proceeding with treatment.

7. Agreeing goals with the child again focuses on the child centred model but also gives both the child and therapist something to aim towards.

8. Trauma treatment phase one is the process of creating characters, setting the scene, naming the story, and then finally the process of telling it backwards and forwards looking out for trauma hotspots.

9. Trauma treatment phase two is the introduction of the new imaginary character who couldn't possibly have been there who will come in and affect the story providing a different ending. This gives the child a sense of control and hope.

10. Rehearsal and Guided Imagery. The therapist uses guided imagery to ensure that the child can think through a situation which they will have to face which would have previously produced triggers and been very distressing. The therapist looks out for any trauma hotspots or problems to ensure that the child is able to face it.

11. Trial. The trial is where the child has to face the difficult situation in reality without experiencing the symptoms of PTSD which would have previously presented themselves

12. Return to Needs Assessment and any other clinical needs. This is the final step where the therapist reviews any needs the child still has outside of therapy, as well as any other issues which might need further treatment (for example OCD or depression which haven't been diminished in the treatment of their PTSD).

Appendix C – CRIES-8 Form

CHILDREN AND WAR FOUNDATION

THE CHILDREN'S IMPACT OF EVENTS SCALE (8)

CRIES-8

The Impact of Events Scale (IES) was originally developed by Horowitz et al (1979) to monitor the main phenomena of re-experiencing the traumatic event and of avoidance of that event and the feelings to which it gave rise. Hence, the original 15 item, four point scale, has two subscales of Intrusion and Avoidance.

It was not originally designed to be used with children, but it has been successfully used in a number of studies with children aged 8 years and older. However, two separate large scale studies (Yule's of 334 adolescent survivors of a shipping disaster, and Dyregrov's of children in Croatia) found that a number of items are misinterpreted by children. These separate studies identified identical factor structures of the IES and these were used to select eight items that best reflected the underlying factor structure and so produced a shortened version – the IES-8 for children.

The present version is designed for use with children aged 8 years and above who are able to read independently. It consists of 4 items measuring Intrusion and 4 items measuring Avoidance - hence it is called the CRIES-8.

The development of this instrument has been largely undertaken by colleagues working under the auspices of the Children and War Foundation which was established to support good quality research studies into the effects of war and disasters on children. Good studies require good, accessible measures. We are most grateful to Dr Mardi Horowitz for agreeing to allow us to make this version freely available to clinicians and researchers through this web-site.

In making this children's IES-8 freely available, all we ask is that those who use it send us copies of their results so that we can continue to improve the measure for the benefit of children.

We will make available copies of the instrument in different languages as the scale is properly translated and back-translated. Any clinician or researcher wishing to make such a translation should get in touch with us first in case a translation is already underway.

Administration

The IES is self completed and can therefore be administered in groups.

Scoring

There are 8 items that are scored on a four point scale:

Not at all = 0

Rarely = 1

Sometimes = 3

Often = 5

There are two sub-scales:

Intrusion = sum of items 1+3+6+7

Avoidance = sum of items 2+4+5+8

The lay-out has been designed so that scoring can be easily done in the two columns on the right hand side. The total for each sub-scale can be entered at the bottom of each column. Wherever possible, we have done this in all the languages into which the scale has been translated.

Evaluation and psychometric status

Psychometric data relevant to the reliability and validity of the 8-item version were presented in Yule (1997). There, it was reported that the total score on the 8-item IES correlated highly with the total score on the 15-item version of which it was part ($r = +0.95$, $P < .001$).

In an analysis of the scores of 87 survivors of the sinking of the Jupiter, it was found that the 62 children who received a DSM diagnosis of PTSD scored 26.0 on the 8-item version while the 25 who did not reach DSM criteria for a diagnosis of PTSD only scored 7.8 ($P < 0.001$). Using these data, it was found that a combined score (Intrusion + Avoidance) of 17 or more misclassified fewer than 10% of the children.

Despite the theoretical criticisms often made against using such self-completed scales in different cultures, the IES has now been applied in a variety of cultures, including studies with children. It is now clear that post traumatic stress symptoms in children are more similar across cultures than they are different. Indeed, Intrusion and Arousal are robust factors of the Impact of Event Scale in children from different cultures.

We remind people using the scales that one cannot make a clinical diagnosis from scores on the self-completed scales alone. A proper clinical diagnosis relies on much more detailed information obtained from a structured interview that assesses not only the presence and severity of stress symptoms, but also the impact on the child's overall social functioning.

Perrin, Meiser-Stedman and Smith (2005) reviewed the use of CRIES-8 and provide validity data from two samples of children (52 attending a PTSD clinic, and 63 attending an Accident and Emergency Clinic). In both samples a cut-off score of 17 maximised sensitivity and minimised the rate of false negatives, 75-83% of children were correctly classified as having PTSD (as separately judged from the Anxiety Disorder Interview Schedule) or not on the basis of their CRIES-8 score.

CRIES-13

The Foundation has also developed a 13 item version of the IES for children, adding 5 items to evaluate Arousal. As Horowitz predicted, these items do not always load on a separate factor and as the Perrin et al (2005) paper illustrates, the CRIES-8 performs equally well as the CRIES-13. We therefore recommend using the CRIES-8 as a screening tool.

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C-IES-8

Revised Child Impact of Events Scale

Below is a list of comments made by people after stressful life events. Please tick each item showing how frequently these comments were true for you *during the past seven days*. If they did not occur during that time please tick the 'not at all' box.

Name: …… Date: ……

		Not at all	Rarely	Some-times	Often
1.	Do you think about it even when you don't mean to?	[ ]	[ ]	[ ]	[ ]
2.	Do you try to remove it from your memory	[ ]	[ ]	[ ]	[ ]
3.	Do you have waves of strong feelings about it	[ ]	[ ]	[ ]	[ ]
4.	Do you stay away from reminders of it (e.g. places or situations)	[ ]	[ ]	[ ]	[ ]
5.	Do you try not talk about it	[ ]	[ ]	[ ]	[ ]
6.	Do pictures about it pop into your mind?	[ ]	[ ]	[ ]	[ ]
7.	Do other things keep making you think about it?	[ ]	[ ]	[ ]	[ ]
8.	Do you try not to think about it?	[ ]	[ ]	[ ]	[ ]

Children and War Website (2014) [online] available <at www.childrenandwar.org>