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focused Cognitive Behavioral Therapy (TF-CBT) for
Posttraumatic Stress Disorder (PTSD) Management in
Post Conflict Acholi Sub-region**

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Abstract

Purpose: The study aimed at assessing barriers in accessing Community-Based Trauma- Focused Cognitive Behavioral Therapy (TF-CBT) for Posttraumatic Stress Disorder (PTSD) management in post-conflict Acholi sub-region with interest in providing solutions to those barriers.

Methodology: The study adopted a survey approach which was qualitative. This was done through interviews. This was supplemented by the pragmatic paradigm that concerned assessing effectiveness of community-based TF-CBT. The research design used to assess barriers and facilitators of TF-CBT was cross sectional. The use of cross-sectional survey design involved the elements of comparative, exploratory and descriptive approaches. Sample selection of participants involved organizational staff comprising of, social workers, clinical psychologists, Village Health Team (VHTs). Beneficiaries who included 120 men and 299 women. The 419 beneficiaries were interrogated using a questionnaire, 36 participants for Focused Group Discussions (FGDs), four social workers and, one clinical psychologist and 25 in-depth interviews with beneficiaries.

Findings: Results indicated; limited mobilization, stigmatization, lack of enough human resource, alcoholism, lack of commitment and economic crisis amongst others as barriers to accessing TF-CBT for PTSD management. The study suggests that these can be handled through sensitization, radio talk shows, visiting clients in their homes and increasing number of staff. The study suggests community sensitization, recruiting more staff to handle TF-CBT, visitations by staff to clients, family support from spouses & caregivers and increased infrastructure as the recommended measure to handle this problem.

Keywords: *Barriers, disorder, therapy.*

1.0 INTRODUCTION

The sustained insurgency by Lord's Resistance Army (LRA) against the National Resistance Movement (NRM) in Northern Uganda that happened between 1986 and 2013 created conflict dynamics. The protracted nature of the war led to serious traumatic events such as mass displacements, abductions and deaths. Those events resulted in traumatic experiences such as men and boys being forced to; kill, become commanders whereas women and girls were forced to become soldiers' wives, were raped, they also suffered mutilation and physical torture. These resulted in the development of Post-Traumatic Stress Disorder (PTSD) symptoms (Peter, 2019; Schultz & Weisaeth 2015). PTSD as a debilitating mental health condition has been cited in the region among the formerly abducted people and the displaced. This is frequently associated with mental disorder and diminished quality of life which typically follows a chronic, often lifelong. PTSD is a mental disorder sequel to a stressful event or situation of an exceptionally threatening or catastrophic nature (Ovuga & Larroque, 2014).

TF-CBT has been used in Northern Uganda to treat PTSD in Acholi sub region, as well as in the diaspora such as United States of America and African countries such as South Africa, Zambia, Tanzania and Democratic Republic of Congo. Studies carried out indicate that even after seven years of post war conflict in Uganda show that PTSD is still prevalent in Northern Uganda (Mugisha, Muyinda, Wandiembe & Kinyanda, 2015). Traumatic events are often sudden and overwhelming irrespective of their origin or nature though certain traumatic experiences last for a short time while others take a protracted or repeated course, particularly if they are politically motivated or occur in the hands of hostage takers or domestic abusers. With almost no exception, traumatic experience seems so unreal, horrible and unimaginable to most victims that its experience leaves victims helpless with a serious challenge to the human sense of omnipotence over the environment.

Man-made traumatic events cause intense fear, a systematic weakening of the struggle for freedom, the break-up of victim's self-control fabric and a total dependence on the perpetrator of the traumatic experience for survival. In most cases trauma victims may hold society as accomplices in their experience with the development of a sense of abandonment and loss of basic trust in the social order. Furthermore, trauma victims develop self-blame, guilt feelings, loss of self-confidence and self-esteem. Emotional numbness that accompanies the traumatic experience causes severe loss of control over personal routines and dignity with a pervasive loss of sense of the future with the victim living by the day (Ovuga et al., 2014).

1.1 Background to the War in Northern Uganda

The protracted war that affected Acholi and Lango sub regions caused continuous traumatic stress disorders. This was brought up by unrelenting war that started after 1986 led by a rebel commander - Kony under his movement called Lord's Resistance Army (LRA) (Pfeiffer & Elbert, 2011). According to the study that was carried out, nearly people aged 25 years and above had a nasty story to tell about LRA war. The war which was started early 1987 a few months after National Resistance Movement (NRM) came to power was started by Alice Lakwena. When Lakwena gave up, Kony took over the command and continued with gruesome acts against humanity. The war that lasted for two decades left Northern Uganda in tatters; economically, intellectually and psychologically. The survey in line with available literature confirmed that LRA had abducted, raped, killed or even mutilated millions of innocent civilians mostly from Acholi sub - region. The

same survey indicated an increase in the number of mental issues in Gulu, Kitgum and Omoro districts and being handled by health officials as evident by the information about the mental status of Acholi sub region below:

1.2 PTSD and its Occurrence among Former Victims of LRA War in Northern Uganda

PTSD is a series of traumatic events characterized by a range of experiences of avoidance reminders of trauma increased physiological arousal and hyper vigilance. This is contained in the World Health Organization (WHO, 2019) of International Classification of Diseases for mortality and morbidity statistics. After the American war and world wars I and II, awareness about PTSD took center stage. This was further boosted by the occurrence of the Vietnam and Gulf wars. In the modern world, cases of attacks and guerrilla wars that take place in most cities have equally posed threats that have called for PTSD interventions. Such interventions have also been used in Africa like in countries of Egypt, Ivory Coast, Somalia, Tunisia, Kenya, Tanzania, Zambia Uganda inclusive especially Acholi sub region in Northern Uganda (Peter et al., 2019; Corvalan & Klein, 2011).

Acholi sub region was severely affected by the war. It has remained a concern from several researchers due to the ever arising psychological disorders that affects the survivors of the war. Whereas now the region is peaceful, one may wonder why there is need of research on the outcomes of the war. It is important to note that most of the adults of today by the time of the war they were children. Many of these children being boys and girls underwent a nasty experience. Thousands of children were abducted. Boys were forced to serve as young soldiers and forced to kill. Most girls were impregnated by rebels and gave birth to children of their own. Those who survived abduction lived a life of fear and not sure of their future. Some of them saw their dear ones being raped, mutilated and killed. Most of them lost their parents, siblings and lived in abject poverty that has consistently caused continuous mental stress. Important to remember is that survivors found their way in Internally Displaced People's (IDP) camps. These camps had associated effects among them being hunger, diseases like HIV that claimed many people's lives. More than two million people were left displaced and severely stressed (Ovuga et al., 2014).

Causes of mental disorders have not only been reported in Uganda nor out of the LRA war. Way back in 1972 and repeated 2017, citizens of Southern Sudan ran to Uganda due to on and off civil wars that rocked Southern Sudan. These people ran to parts of West Nile in Uganda. Relatedly, around 1993 up to 1996 there was an outbreak of political wars in the Democratic republic of Congo. This was also followed by a big influx of Rwandan nationals to Uganda and refugees due to the genocide that took place in 1994. Events that forced these people to leave their places exposed them to serious horrible events of traumatic mental disorders. These events were characterized by depression, alcohol abuse, anxiety, committing suicide among others (Ovuga et al., 2014).

While suggestions have been put in place on how to deal with PTSD in Northern Uganda, Ovuga et al. (2014) note that post-traumatic stress disorder can be mismanaged. Important to note also is that most published information from war zone affected places in Africa and the diaspora, pay a lot of attention on PTSD causes and how they can be solved. Little has been done on the barriers to Community -based trauma focused cognitive behavioral therapy (TF-CBT) which has been employed to handle PTSD in Northern Uganda. This paper zeroed on barriers to community-based TF-CBT for PTSD management.

A few studies across Europe, USA and Africa reviewed in this literature show that men, women and children benefit from community-based TF-CBT but in Acholi sub-region, there are no archived evidence to show studies that have been done. It is not clear whether men, women and children have equal access to community-based TF-CBT for PTSD management among victims. Little evidence has also been shown that in Acholi sub-region, women, men and children suffering from PTSD benefit equally from the community-based TF-CBT. Existing studies conducted on the management of depression have been done on other therapies which include a study conducted by Sonderegger, Rombouts, Ocen and McKeever (2011) on trauma rehabilitation for war affected people. Similarly, a study conducted by Kane, et al. (2015) on challenges faced by WHO on management of PTSD and acute stress in Northern Uganda reveal that there is rampant occurrence of PTSD symptoms former victims of the LRA war. This makes the study on assessment of community-based TF-CBT useful at this juncture. To understand it further the study identified the need to look at what entails TF-CBT.

1.2.1 TF-CBT and its Application in Northern Uganda

TF-CBT is referred to as an evidence-based treatment model that is designed to help children, adolescents, adults and their families in overcoming the negative effects associated with traumatic experiences (Cohen & Mannarino, 2015). This evidence-based method has been approved for effective treatment of after multiple traumas or a single traumatic event. Therapists trained in TF-CBT are always able to help victims experiencing the emotional effects of trauma in which the addresses these effects. The application of TF-CBT is as a result of the research and clinical work done by Cohen, Mannarino & Deblinger (2011). This was out of the desired need to fully understand difficulties faced by traumatized children and adolescents. This was done by expanding the traditional cognitive behavioral methods which involves incorporating family therapy together with the use of trauma sensitive approach in the therapy of children and youth. Randomized trials on the effectiveness of TF-CBT model on the target population were five. They all proved the efficacy in treating children and adolescents.

Jensen *et al.* (2014) evaluated the effectiveness of TF-CBT in decreasing PTSD and other psychological difficulties in 100 sexually abused children. Subjects were randomly assigned to one of four treatment conditions: child treatment only, mother treatment only, mother and child treatment or usual community care. Children who received the TF-CBT treatment exhibited significantly fewer PTSD symptoms than children who did not receive this treatment. Children whose mothers received TF-CBT exhibited fewer externalizing symptoms and depressive symptoms compared to children whose parents did not receive TF-CBT. This study evaluated barriers and facilitators to accessing TF-CBT towards PTSD management.

In Northern Uganda (Acholi sub region), TF-CBT has been applied in treating adults with PTSD. However, it has been observed that TF-CBT is faced with some barriers though some facilitators have been registered. Whereas its core components such as; psychoeducation, relaxation, affective regulation, cognitive processing of trauma, trauma narrative, in vivo mastery of trauma reminders, conjoint victim caretaker sessions and enhancing future safety and development are there, its effectiveness is still facing barriers. This study therefore intends to look at the barriers and facilitators to community-based TF-CBT for the post-traumatic stress disorder management in Northern Uganda. This study was guided by the Cohen et al. (2012) core TF-CBT principles of treatment which are in phases below:

- (i) Phase and components-based treatment.
- (ii) Component order and proportionality of phases.
- (iii) The use of gradual exposure in TF-CBT and,
- (iv) The importance of integrally including parents or caretakers into TF-CBT treatment.

This study majorly examined the barriers that hindered beneficiaries' benefit from TF-CBT treatment. The study majorly looked at whether the phases were followed. In real terms after phase and component the other three are expected to lead to stabilization, trauma narration and processing and later integration and consolidation normally summarized by the Acronym "PRACTICE". These phases go hand in hand with key points that are supposed to be adhered to. To ensure successful evaluation of TF-CBT in Acholi sub region onto why it is failing, strict assessment onto whether key points are adhered to was taken into consideration. In addition to the principles stated above, these key points by Cohen et al. (2012) that guided this study are:

- TF-CBT is a family focused treatment in which caregivers participate equally with the traumatized people. In this case the traumatized people were adults.
- TF-CBT is a component and phase-based treatment that emphasizes proportionality and incorporate gradual exposure into each component. In this regard this study sought to find out how best this key point was catered for by the people who were carrying out the treatment. The study further sought to find out how the failure to effectively put this into strict adherence could have led to the barriers to successful implementation of TF-CBT in Acholi sub region.
- Care givers and victims of PTSD receive all TF-CBT components in parallel individual sessions which allow caregivers and victims to express their personal thoughts and feelings about the victim's trauma experience, gain skills to help the victim re-regulate trauma responses and master avoidance of trauma reminders and memories. This paper highlights on the sessions, whether they allowed caregivers and victims chance to express their personal thoughts and feelings about victim's experience that could help them gain skills to help the victims to overcome PSTD.
- The study took interest in looking at research done in line with this and find out how the participation of caregivers in the affected area of Acholi sub-region significantly enhances recovery. It is sought to find out whether failure to participate contributes to the barriers of successful implementation of TF-CBT in Northern Uganda.

2.0 METHODS OF DATA COLLECTION

Mixed methods approach was used. This was suitable for this study because it helped in generating a wide range of responses which were needed in detailing opinions necessary for the compilation of the findings of this study. This was supplemented by the pragmatic paradigm that concerned assessing effectiveness of community-based TF-CBT. This was driven by the fact that it helped the researcher in deciding on the right questions to ask and answers to obtain. It involved prolonged engagement and triangulation. This allowed the researcher to pursue personal concerns, as well as capturing the voice of others; in essence, it accommodated multiple stances and values since this study was multipurpose. The method allowed the researcher to address questions that do not sit comfortably within a wholly quantitative or qualitative approach to design and methodology. Using a mixed methods approach and specifically through interviews, this paper examined barriers to benefit of TF-CBT in the management of PTSD in post conflict Northern Uganda.

Cross sectional design was used to establish the barriers of TF-CBT on PTSD management among PTSD victims in Acholi sub-region. The use of cross-sectional survey design involved the elements of comparative, exploratory and descriptive approaches. Comparative approach helped in comparing responses between adult men, women in relation to their level of access to and benefit from the therapy. It helped in guiding the researcher while following up clients from the time of enrolment (baseline assessment, midline and end line assessment to realize the outcome of intervention depending on how much time was spent on therapy) Exploratory approach was used because most of the questions of this study have never been studied and therefore needed to be explored and their outcomes known. On the other hand, the descriptive design was devoted to the gathering of information about prevailing conditions or situations for the purpose of description and interpretation. Therefore, the descriptive design helped in collecting data, tabulating, analysing, interpretation, comparisons, identification of trends and relationships.

The targeted population of the study were administrators and staff of NGO(s) dealing with PTSD victims and the beneficiaries of these organizations. There are 5 organizations (housed under Gulu Regional referral Hospital under Mental Health unit (MHU) dealing with management of PTSD in Gulu, Kitgum and Omoro districts of Acholi sub-region. However, only one (1) organization was visited which is Transcultural Psychosocial Organization (TPO), it was the only organization implementing community-based TF-CBT to treat PTSD. This organization has a well laid- down curriculum for the provision of community-based TF-CBT hence its selection for this study. TPO then had a total of eight (4) social workers, (1) clinical psychologist and several VHTs working with them at every sub-county. The total number of TF-CBT beneficiaries at TPO was 419. The study counted a total of 419 people who participated in giving information useful for compilation of findings for this study.

Despite the fact that there are many organizations in northern Uganda, specifically Acholi sub-region offering care for survivors of PTSD, only patients/clients benefitting from one organization - (TPO) were considered. The criteria for inclusion of mental patients were based on beneficiaries who were adult men and women, aged 18 years and above obtaining treatment from TPO at the time of the study and could substantially report on the benefit of the on-going therapy. The study excluded patients and their caretakers who had PTSD but not on treatment despite the fact that they could report on the behaviours of the patients. Children were also excluded as 90% of children suffering PTSD in Acholi sub-region were being managed using medication as reported by the monitoring and evaluation officer and a social worker implementing TF-CBT for PTSD management at TPO. Adult men and women with PTSD symptoms but mentally incapacitated were as well not considered as they would not be in position to provide accurate information.

Sample selection of participants involved organizational staff comprising; (4) social workers, (1) clinical psychologists, and beneficiaries who included 120 men and 299 women totaling to 419 respondents. All the 419 respondents were interrogated using questionnaires (PTSD -8, PTSD questionnaire-34, and Exposure to Therapy tool. The administrators of the organization were interviewed as key informants (5). Beneficiaries were considered for the 8 focus group discussions where; six (6) groups were composed of women and 2 for men. Each group contained an average of 7 participants. Table 1 shows data collection instruments that were used by participants.

Table 1: Data collection instruments and respondent / participant categories

Instrument	Category of respondents / participants	Total
Questionnaires	Total number of respondents (N)=419 respondents 120 men 299 women	419
Focus Group Discussions (FGDs)	N = 56 participants 8 FGDs 6 women FGDs *7 participants =42 2 men FGDs *7 participants =14	
Key Informant Interviews (KII)	N=6 Participants 4 social workers 1 Program coordinator 1 clinical psychologist	6
IDI	25 beneficiaries; women and men	25
Overall total sample size		419

Source: Field data, 2020.

Table 1 constitutes total number of respondents for both qualitative and quantitative data. Participants from FGDs, KII and IDI are all derived from 419.

The researcher employed purposive/judgmental sampling because it allowed the researcher to select key informants/ persons who seem to have in-depth knowledge related to TF-CBT and PTSD among victims. A non-probability sampling technique in recruiting potential participants for the study was well applied to ensure that all the participants were people affected by the war and fully represented in this study, stratified random sampling of participants was used. Respondents especially those working were stratified according to their different positions in the organization and levels of PTSD among the beneficiaries. Data was collected through, FGDs, document review, observation, questionnaire and interviews. The researcher used an in-depth content analysis of qualitative data analysis since it allows the researcher to systematically organize ‘raw data’ for each interview under a thematic framework, facilitating an analysis of themes without losing sight of the individual cases and language used by participants. At some point, quantitative analysis was used especially when it came to information about participants and facilitators. The methods were boosted by the theory the follows.

3.0 THE GUIDING THEORY OF COGNITIVE BEHAVIORAL THEORY (CBT) BY BECK (1993)

The theory of CBT guided the study. Beck and Ellis in their respect for Behavioral Therapy incorporated components of cognitive into their treatment modalities for treatment of depression. Out of its human functionality, a number of Therapists and Theorists began to emerge between

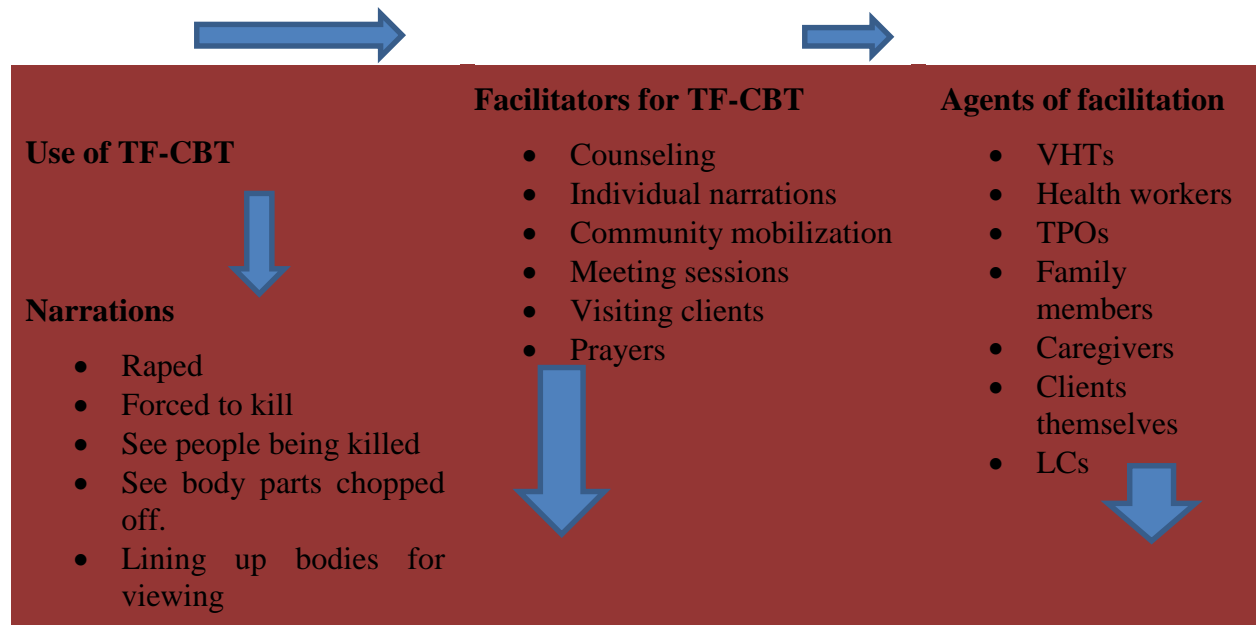
1960s and 1970s. Keegan and Holas (2009) put it that Behaviorists found out that CBT helps in controlling symptoms, forgetting unpleasant experiences like anxiety, emotions, bad memories, images which they refer to as experimental avoidance. CBT according to Dobson and Dozois (2001) put it that it can be viewed as a family of models that share fundamental theoretical assumptions which are similar to CBT-Becks standard Cognitive Therapy for depression and these are:

- (1) Cognitive processes affect behavior. The study found out that clients who had enrolled for TF-CBT had presented with PTSD symptoms.
- (2) Cognitive activity can be monitored and changed. The study acknowledges that TF-CBT was already in the affected area. This paper examined barriers to access and benefit from TF-CBT.
- (3) Changes in people’s cognitive / thoughts; interpretations and assumptions can lead to modification in their actions. In view of assumption two and three, this paper suggested solutions to the barriers.

Dobson and Dozois (2014), say that treatment is based on experience sharing where they derive a sense of meaning. Relatedly, CBT explains time limit of the therapy consisting of 12-16 sessions. The experience sharing was catered for during the study. This helped many clients to recover. The methods in 3.0 and theory in 4.0 helped in arriving at the findings discussed below:

4.0 Findings of the Study and Discussions

The study sought to find out the barriers and facilitators of TF-CBT for management of PTSD. Data was collected from health workers, the victims themselves and community social workers. The findings are summarized in figure 1:



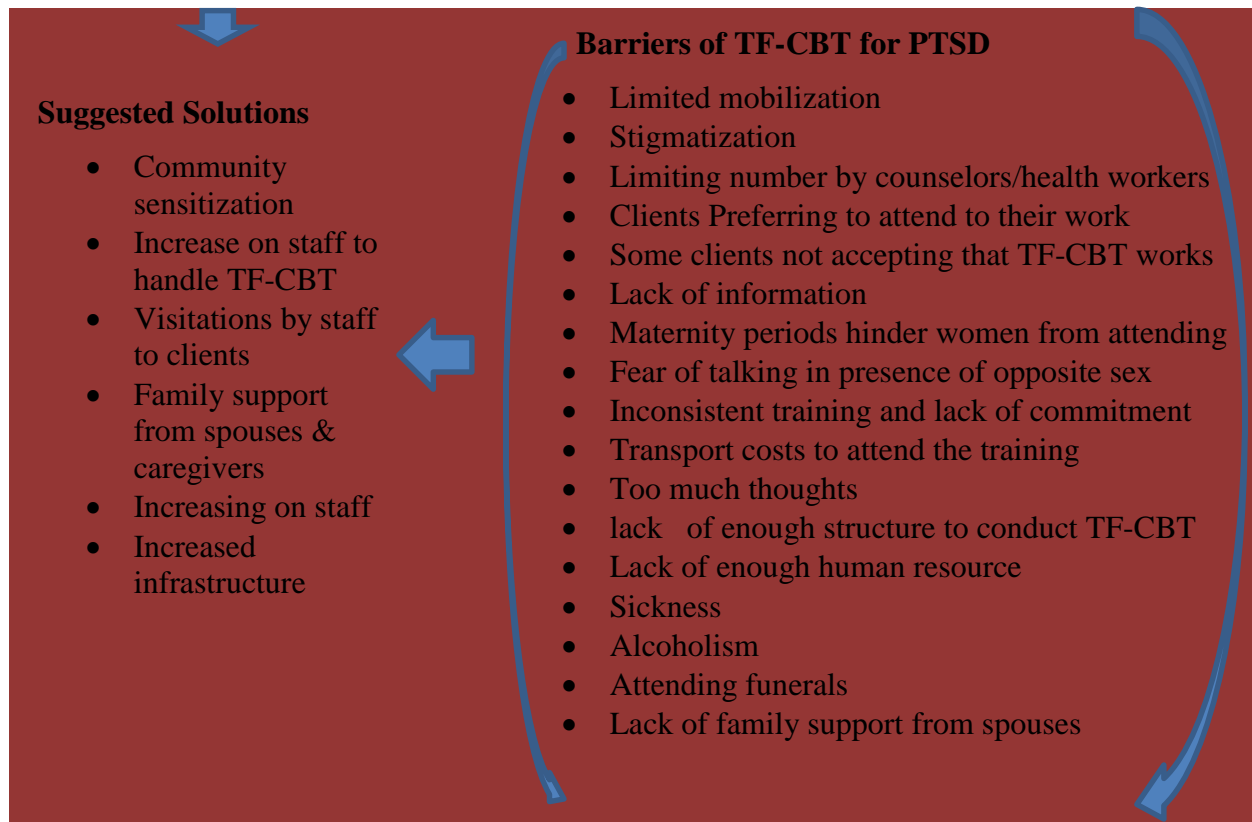


Figure 1: Summary of findings of the study

Source: Field data, 2020.

Figure 1 is a summary of the findings showing how TF-CBT was being conducted in the districts of Gulu, Kitgum and Omoro. This was out of the narrations that were made by various stake holders, facilitators of TF-CBT. The discussion of the findings is as follows:

4.1 Discussion of Findings about Barriers of TF-CBT for PTSD Management

In line with the TF-CBT model, this paper sought to find out barriers of TF-CBT for PTSD management. However, CBT being a model of handling PTSD, the study sought to find out the extent to which its principles were adhered to by the clients. The study found out that at most two core principles of treatment being gradual exposure in the TF-CBT and the importance of integrally including care givers were adhered too. From the narrations of respondents, the adherence of phase-components helped in stabilization, trauma narrations, processing, integration and consolidation. This is in line with Dobson et al. (2014). However, in some cases, some key points of the model that require support from family members were left out from the narrations of respondents. This was evident by narrations that showed some family participants not being supportive, some clients dropped out, some care givers were unsupportive. Also care givers sometimes lacked materials and infrastructures to effectively benefit from TF-CBT. Consequently documentary review reveals successes and barriers. Through the use of interview the barriers are discussed below.

4.1.1 Barriers with Suggested Solutions

The study found out that much as TF-CBT was being implemented, mobilization still needed to be boosted. This was revealed through interview after the researcher had found out that men were fewer compared to women. The study found out that there were many people there who were traumatized and depressed due to the LRA post conflict issues yet they had not gotten TF-CBT services due to limited mobilization. Out of interviews, it was revealed that more women were attending TF-CBT services compared to men. The response is quoted here as:

“There are many men faced with trauma and depression but they were not mobilized well.”

The study suggests that staff should come up with more methods like sensitization on radios, use of flyers so that people can know the importance of TF-CBT and be able to benefit from it. If this is done, it will also help sort out the issue of lack of information. This is because lack of information was found out to be a barrier. Ovuga et al., (2014) fell short of this while Baguma, (2001) found positive relationship in this as a solution. During interactions between the researcher and the respondents this statement was given as a response to the study in seeking to know the barriers. The respondent was quoted saying:

“A barrier or challenge I can think of would be lack of information for some people. I believe even up to now some people are not aware that such a training has been organized for people with PTSD and that such a training can be easily accessed here in the community”

Mobilization would still be helpful to iron out the issue of refusal to believe that TF-CBT works in treating PTSD. Colon et al (2012) attests to this when he indeed suggests involvement of caregivers in mobilization. This is supported by Cohen, Mannarina and Deblinger (2011) who propose that this exercise needs to be handled by experienced people. Through interviewing it was revealed that most people do not believe that TF-CBT works on PTSD. This was disclosed by a respondent as:

“In my opinion, some people do not believe that they can achieve healing by just talking or discussions like it is done in the group. Most people believe that to be healed one should go to the hospital and receive drugs or injections in order to be healed. So you find that some people with PTSD are in the community but they do not believe in this form of therapy. The other challenge is that some people especially the men have not accepted that they have mental health problems. You know the way this training was organized is on voluntary basis so it is upon each individual to decide whether they need help and that is how we got here but some people refused even though we can see that they have problems and they need support.”

This assertion shows that indeed people lack sensitization and mobilization. Up to the time the study was carried out they still had such beliefs. CBT theory guides that all ways should be employed to make sure clients contribute to the solution through attending sessions. This is why sensitization remains key aspect to be zeroed on. Stigmatizations as a barrier can still be solved by sensitizing the community about TF-CT for PTSD treatment. Through interactions with respondents, the researcher found out that stigmatization was another barrier to access and benefit from TF-CBT. One of the respondents was cited saying:

“Community is always there to stigmatize us e.g. when we were beginning the sessions, they used to say in the local language” icitu ka cokke ituk wic wunii”? i.e .going to meeting with the mad people and this is really stigmatizing. This made some members drop out.

While Corvalan and Klein (2011) point out stigmatization as a barrier to attainment of TF-CBT, their study suggests that all affected people as a result of the war are obliged to attend TF-CBT sessions without fear of stigmatization. This study avows to this because sensitization as suggested by clients solves this barrier. Additionally, the study found out that there was a barrier brought about by limiting the number of participants. This was clearly brought out by some respondents cited saying:

“His home was near the venue, he heard about it and then came and joined us. Other men came later and were told that the number of people required has been reached”

This was in response to the question they were asked whether when they heard about the training, they all went and registered. The researcher suggests that this can be solved by the recruiting more staff to do the training/counseling. Even then, some staff decried a big number of clients that also calls for more staff. Ovuga et al. (2014) term this kind of limiting the number as mismanaging implementation of TF-CBT, but their argument falls short of the standards for total number per group. While Peter & Steele suggest involvement of all affected people, the study found out that some failed to enroll because of limiting the numbers.

The findings further revealed that whereas some clients would wish to attend TF-CBT sessions, respondents in this study spelt out that another barrier is caused by clients' economic hardships that necessitate some of them to opt for work other than attending TF-CBT sessions. In one of the verbatims it was said by a respondent that:

“Others have gone to their gardens. Food insecurity stopped people from attending the training and VSLA because getting money for VSLA contribution became very difficult during the wet season. Now they want to resume the VSLA. Food insecurity also made some people to miss the sessions in order to go and look for food. We have food insecurity here because of drought, and people here are not supported in agriculture, they use hand hoe which can make them dig few gardens compared to those who use ox-plough and tractors.”

They further reported:

“For the women I think the biggest issue is farming in long distance because for us here the fertile farmland is 15km away and when we go there, people spend more than a week and this affects the training and some people missed because of that. For the men they can just ride a bicycle and come back but for the women they have to walk which makes it difficult for them to catch up with the training program.”

Women who had children and those pregnant equally reported a challenge of missing out on some sessions especially when they go for antenatal services. They reported that when they could feel they are too heavy while pregnant they sometimes opt out of TF-CBT sessions. This equally accounts for inconsistent attendance that poses another challenge. This goes hand in hand with sicknesses for children and old people whenever they fall sick and trainers miss because they attend to the sick. This was revealed by trainers when they were asked why some of the trainers dropped out, one of the responses was:

“That woman missed very many times because her daughter gave birth and the child kept falling sick and before the child could start walking she got pregnant again, she then gave birth to a child with sickle cell. So, the mother was attending to her and the children and that made her miss many sessions.”

For such a challenge, the study suggests that trainers should consider extending services to the affected individual homes to cater for women who have given birth or are sick, at the same time clients be sensitized on devising means to attend sessions at the same time while caring for their sick ones. This does not deviate from Colon et al. (2012) who calls for sensitization. While Ovuga et al. (2014) call for involvement of caregivers. CBT as well points out that they play a big role. The study advocates for sensitization in this context, which should not only involve care givers of the traumatized but those who miss sessions as well due to farming. The challenge of some trainers fearing to talk about their experiences in presence of people of opposite sex was discovered to be a barrier to TF-CBT in effectively handling PTSD. This goes hand in hand with a lot of negative thoughts that remain a barrier because people fear to narrate and share their nasty traumatic experiences. The researcher found out from respondents who were quoted saying:

“we sometimes fear talking of being raped before a teacher of opposite sex. But when we are women to women we share such experience.”

Out of this, Ovuga et al. (2014) advocate that there is need of more trained personnel that is experienced in helping clients open up. CBT suggests that clients should be given time to speak about their worries so as to be helped to overcome them. Related to the above, clients were quoted saying:

“A lot of thoughts may make them miss sessions When you have a lot of thoughts in your mind, it can make you miss the sessions. A teacher may be talking but when you are thinking a lot you can't understand what are being toughs. You could be thinking about economic problem at home, food insecurity”

Lack of commitment was observed as a challenge as well. This was discovered when the researcher found out why some people healed and other did not. Lack of commitment was found out to be a barrier. The issue of thoughts and lack of commitment had been earlier talked of by Sonderegger, et al. (2011). Related to their findings, the study through respondents revealed that:

“If you are not committed then it becomes difficult for you to heal. Voluntarily stopping. There were some people who were receiving this medication but they stopped voluntarily and some are saying that their problem have restarted and yet the doctor is the one to recommend someone to quit drug”

These barriers still Ovuga et al., (2014) put it that personnel needs to make sure that these challenges are no more through training clients well. The trainers decried a barrier of lacking enough facilities to use in counseling sessions. This is because some staff complained of not having enough resources. This was in response to the question the respondents were asked to find out whether the resources were enough. They responded negatively showing displeasure with infrastructure sometimes affecting their work. Their responses were:

“No, because sometimes we do it under the tree and when it rains you first take shelter, chairs are even not enough but we have built the capacity of counselors and they are now working well.”

Another one was quoted saying:

“Not really, we do counseling during clinic out reaches and in Namokora we have only one health center in the entire sub county and that makes it difficult for some people to move long distances e.g., 22 km and come every month for drugs, this is a challenge on their side because they don't

have the money for bodaboda and where the family is not supportive that client suffers drugs adherence.

Even within the facilities we don't have isolated safe place for counseling and we don't have admission ward for people with mental illnesses and this are very challenging. There are no health center II for us to make outreaches."

The suggestions above that were suggested by clients are directly related to Sonderegger et al (2011)'s suggestions. Alcoholism and lack of family support from a spouse were reported to be part of the barriers affecting to TF-CBT. This was also revealed interactions with a research team and respondents. The study found out that those who are alcoholic take a lot of time to recover or may not recover at all. Pfeiffer and Elbert (2011), in their study about PTSD, depression and anxiety among former abductees in Northern Uganda, their study had a positive linkage with this as a reason for some clients failing to access PTSD treatment. Concerning attendance of TF-CBT sessions, the study found out that due to alcohol they take more time in bars and fail to attend sessions. It was quoted being talked of as:

"Alcoholism is very rampant and men may not come if there is alcohol nearby"

It was reported that people fail to attend TF-CBT sessions because of attending funerals; every time they attend funeral, they fail to get time to attend sessions much as the lost time is compensated for later. This was said as follows.

"For issues like funeral in our culture you cannot really miss so when that one happened, we had to reschedule some of the sessions which we had planned. This actually happened and we informed the trainer about it and he agreed to postpone the session to another time when everyone is around."

In Africa if you are a person who does not attend funerals, then one is viewed as a bad person. This is in support of Baloyi (2014) whose study views death as a uniting factor in Africa. However, people still need to be sensitized all the time so that they desist from missing TF-CBT sessions as it affects recovery process.

4.2 Conclusion

To sum it up, the whole study found out that barrier to TF-CBT in treatment are many despite appreciation from some respondents. The study recommended solutions to these as being; commitment, sensitization, exposure to TF-CBT related sessions. Each barrier has been discussed alongside a recommendation that can curb down the identified barrier.

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