Evaluation of the Attachment Theory Program in Sierra Leone, Africa

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EVALUATION OF THE ATTACHMENT THEORY PROGRAM
IN SIERRA LEONE, AFRICA

by

Alexander Reppond

A Thesis Submitted in Partial Fulfillment of the Requirements for a Degree in Honors (Psychology)

The Honors College
University of Maine
May 2019

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ABSTRACT

The purpose of this thesis is to evaluate the Attachment Theory Program currently ongoing in Sierra Leone, Africa. Specifically, the evaluation focuses on whether the program was implemented correctly and whether it was effective in its goal to teach attachment theory and related behaviors to the caregivers. To determine whether the program was promising, eight evaluation questions with benchmarks for achievement were created with input from primary stakeholders, the donors.

This thesis includes a literature review of trauma, attachment, Sierra Leone, program evaluations, and WEIRD (Western, Educated, Industrialized, Rich, and Democratic) populations. After undertaking the review of literature, the caregivers in Sierra Leone were given surveys after participating in the trainings. Data was then collected from 46 questionnaires in the first batch of data and 64 questionnaires in the second batch of data. Results showed that benchmarks were tentatively, at face value, achieved on seven out of eight of the evaluation questions, although with limitations that impacted the results. With consideration towards those limitations, it was found that two benchmarks were achieved, one benchmark was not achieved, and five were deemed inconclusive. This was interpreted to mean that the program was has shown early promise but needs further follow-up evaluation to truly determine its impact. Finally, a discussion on limitations and recommendations for improvement to the program were provided.
I wish to thank The University of Maine Honors College and Psychology Department, and Servant Heart Fellowship for helping make this thesis possible. I would also like to thank my family and friends for their invaluable support. Lastly, but certainly not least, I would like to thank my two wonderful advisors, Dr. Julie DellaMattera and Dr. Rebecca Schwartz-Mette for their seemingly never-ending support and guidance for me through this process.
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CHAPTER 1

INTRODUCTION

Conceptualization of Trauma

Trauma is a broad concept that encompasses both emotional and physical aspects. While it may be somewhat difficult to define, according to the SAMHSA, a majority of adults in the United States have experienced a traumatic event (“Substance Abuse and Mental Health Services Administration,” n.d.). Some studies have put that number closer to 90% (Kilpatrick et al, 2013). In addition to the adult population, it is estimated that 47.9% of all children have experienced at least one traumatic family experience (“National Survey of Children's Health,” 2011/12). Regardless of the precise number, it is clear that trauma has affected a wide amount of the general United States population.

Conceptualization of Attachment

Attachment is an extremely important aspect of a young child’s development. Secure attachment has shown to have benefits to development, such as better relationships with peers and higher scores on communication, cognitive engagement, and mastery motivation (Miller & Commons, 2010; Moss & St-Laurent, 2001). On the other hand, there are potentially severe effects that insecure attachment can bring to a child’s life. According to a report done by Sutton Trust in March 2014, insecure attachment leads to a myriad of issues, such as slow language development and less resilience to mental illness (Moulin, Waldfogel, & Washbrook, 2014). These problems also continue into
adulthood as insecure attachment has been shown to be a predictor for homelessness, substance abuse, early pregnancy and criminality (Rees, 2007).

**Conceptualization of Sierra Leone and Trauma**

Sierra Leone has a rapidly growing population of over six million people (Central Intelligence Agency, 2019). However, the largest section of their population are those under 14, at 41.71% (Central Intelligence Agency, 2019). Sierra Leone has a long history of traumatic events such as war, disease, natural disasters, and the effects of abject poverty. Starting most notably with their decade-long civil war, in 1991-2002, which displaced nearly half of their population (Central Intelligence Agency, 2019). The Ebola epidemic of 2014-2015 caused the deaths of over 3,000 people and devastated families and the community at large (Nordström, 2015). Additionally, a devastating mudslide in 2017 affected nearly 6000 people (Harris et al., 2018). Finally, in addition to the war, diseases, and disasters, over 70% of the population is below the poverty line (Central Intelligence Agency, 2019). All of these events are causes of trauma in many of the country’s residents.

**Conceptualization of The Servant Heart Research Collaborative**

The Servant Heart Research Collaborative (SHRC) was created through the Honors College at the University of Maine to address specific educational and experiential challenges facing children in Sierra Leone whose lives have been disrupted by war, disease, natural disaster, and poverty (Central Intelligence Agency, 2019; Nordström, 2015; Harris, Wurie, Baingana, Sevalie, & Beynon, 2018). For three years,
the collaborative has been working to address the effects of trauma on the children in Sierra Leone. This author worked with a team of three other students to create a 6-part interactive program on attachment theory for caregivers working with these displaced and orphaned children.

**Conceptualization of Program Evaluations**

Program evaluations are crucial to modern-day interventions, as they help distinguish between which programs are effective and which are not (Rossi, Lipsey, & Freeman, 2004). They have been defined by the Centers for Disease Control as “the systematic collection of information about the activities, characteristics, and outcomes of programs to make judgments about the program, improve program effectiveness, and/or inform decisions about future program development” (Centers for Disease Control and Prevention, 2012, p. 3). The CDC has developed a six-step guide, which has been around since 1999, to accomplishing a program evaluation (2012).

**Conceptualization of WEIRD**

Western, educated, industrialized, rich, and democratic populations make up the bulk of the samples in psychological research (Arnett, 2008). These populations, otherwise known as WEIRD, are overrepresented in the sense that they account for nearly 96% of the populations studied in research, despite only making up 12% of the world’s population (Henrich, Heine, & Norenzayan, 2010; Arnett, 2008). Additionally, Africa, which accounts for 16% of the world’s population, is extremely underrepresented as it accounts for less than 1% of the samples used in psychological research (Arnett, 2008).
Research Questions

The purpose of this research is to evaluate the Attachment Theory Program in Sierra Leone, Africa. In order to properly evaluate the program, questions must be asked about its implementation and its effectiveness. To that end, this thesis is guided by the following research questions:

1. To what extent was the Attachment Theory Program implemented appropriately?
2. To what extent was the Attachment Theory Program effective in teaching attachment theory and related behaviors to the participants?
Chapter 2

LITERATURE REVIEW

Trauma

Overview of Trauma

Trauma can come in many different forms such as emotional or physical and is defined as “A deeply distressing or disturbing experience” or “Physical injury” (“Trauma, 2019”). While both these definitions are correct, for the purpose of this research project this author shall use the former one as this is dealing with a population that is mostly affected by emotional trauma. There are also many different types of emotional trauma. Twelve separate and distinct types have been identified according to The National Child Traumatic Stress Network. They are as follows: Bullying, Community Violence, Complex Trauma, Disasters, Domestic Violence, Early Childhood Trauma, Medical Trauma, Physical Abuse, Refugee Trauma, Sexual Abuse, Terrorism and Violence, and Traumatic Grief.

Types of Trauma

Bullying is “a deliberate and unsolicited action that occurs with the intent of inflicting social, emotional, physical, and/or psychological harm to someone who often is perceived as being less powerful” (The National Child Traumatic Stress Network, n.d., “Bullying,” para. 1). It typically occurs frequently and can prevent someone from enjoying a safe environment. Bullying can also be physical, social, or emotional. It can
have many effects, with the most common being anxiety, anger, loneliness, and poor self-esteem.

Community Violence is “exposure to intentional acts of interpersonal violence committed in public areas by individuals who are not intimately related to the victim” (The National Child Traumatic Stress Network, n.d., “Community Violence,” para. 1). Common types of community violence are fights among gangs and civil wars. The effects of community violence on children are varied, but typically include a loss of perceived safety and hyper-arousal.

Complex Trauma involves a child being exposed to multiple traumatic events over a long period of time. These events are usually of an invasive nature and severe. The most common examples of complex trauma are abuse and neglect. The effects of complex trauma can be extreme, with adverse effects on a child’s development and ability to form a secure attachment.

Disasters are extreme weather events such as tsunamis, earthquakes, and mudslides. These can lead to many disturbing events for children, such as displacement, loss of home and injuries or deaths to loved ones. Common effects of children affected by disasters are experiencing distress when being separated from caregivers, having difficulty concentrating, and worrying that another disaster will occur.

Domestic Violence is abuse towards a partner or spouse. This typically occurs as a coercive, controlling pattern of behavior toward a partner or spouse and can be physical, sexual, emotional or financial in nature. Children who have been exposed to domestic violence are more likely to experience emotional abuse, neglect, physical abuse, and community violence.
Early Childhood Trauma is trauma that occurs to a child who is six years old or younger. Since children under six may not be developed enough to properly verbalize their reactions, their reactions to trauma may be different than older children. Children who are under two may scream or cry excessively or have a poor appetite and low weight. Children who are between the ages of three and six who experience a traumatic event may have delayed social development, have difficulty trusting others, or blame themselves for the event.

Medical Trauma is “a set of psychological and physiological responses of children and their families to pain, injury, serious illness, and medical procedures” (The National Child Traumatic Stress Network, n.d., “Medical Trauma,” para. 1). After a serious illness, a child may re-experience the trauma, where they have nightmares or flashbacks about the event. A child may also experience hyper-arousal, where they lose their sense of safety and security and have a ‘fight-or-flight’ reaction constantly.

Physical Abuse is when a parent or caregiver commits an intentional act that causes physical injury to the child. Children may blame themselves for this abuse, become anxious and withdrawn, or in turn become aggressive and bully other children.

Refugee Trauma is trauma that is related to the war or persecution that results in them being refugees. This trauma can occur when they are in their country of origin or after they are displaced. The effects of refugee trauma can have an effect on a child’s daily life, such as hopelessness, anxiety, sadness, and difficulty sleeping.

Sexual Abuse is “any interaction between a child and an adult (or another child) in which the child is used for the sexual stimulation of the perpetrator or an observer” (The National Child Traumatic Stress Network, n.d., “Sexual Abuse,” para. 1). Children
who have been sexually abused may exhibit a wide variety of reactions. These can range from anxiety and depression to a loss of trust in adults.

Terrorism and violence can impact a child immensely. Depending on the scope and scale of the event, many children may witness terrible violence and injuries, or be injured themselves. Since an event of this nature is usually sudden and severe, a child may become hyper-aroused and be unable to relax. Children may also experience traumatic grief if they lose a loved one or caregiver.

Traumatic Grief is a type of trauma that a child may experience after losing a loved one. This loss may be unexpectedly, such as an accident or violence, or expected, such as a long illness. Regardless of the reason, a child may experience withdrawal, anger/outbursts, or irrational fears about safety.

Effects of Trauma

The effects of trauma on children are multifaceted and can oftentimes be long lasting (Lubit, Rovine, Defrancisci, and Eth, 2003). It has been shown in the literature that children experience trauma very differently than adults, and the effects can be either in the short term or long term (Dye, 2018). This dichotomy would well be represented by the two clinical diagnoses Acute Stress Disorder (ASD) and Post-Traumatic Stress Disorder (PTSD). Both are similarly defined as “a disorder that follows experiencing, witnessing, or being confronted with events involving actual or threatened death, physical injury, or other threats to the physical integrity of the self or others. In addition, to meet the definition of an appropriate stressor, the person’s response has to involve intense fear, helplessness, or horror” (Brewin, Andrews, Rose, & Kirk, 1999). However, the difference
between these two disorders is their timeframe (Brewin et al., 1999). Acute Stress Disorder, or ASD, can be diagnosed no sooner than two days after the event and up to a month after the event (Brewin et al., 1999). Post-Traumatic Stress Disorder can be diagnosed only if the symptoms have lasted for more than one month (Brewin et al., 1999).

In the short term, which is considered to be one month or less, a diagnosis of Acute Stress Disorder is possible (Brewin et al., 1999). In children, the diagnostic criteria come from eight criterion clusters (Brewin et al., 1999; Winston et al., 2002). Cluster A is the ‘Stressor Criterion,’ which as referenced before involves being exposed to a traumatic event that threatened serious harm and their response involved fear, helplessness, or horror (Brewin et al., 1999; Winston et al., 2002). Cluster B is the ‘Dissociation Criterion’ which requires the child to have three or more of the following symptoms (Brewin et al., 1999; Winston et al., 2002). Those possible symptoms are: Subjective sense of numbing, detachment, or absence of emotional responsiveness; Reduction in awareness of surroundings; Derealization; Depersonalization; Dissociative Amnesia (Winston et al., 2002). Cluster C is the ‘Reexperiencing Criterion’ which requires the child to re-experience the event in one of the following ways (Brewin et al., 1999; Winston et al., 2002). Those ways are recurrent images, thoughts, dreams, illusions, flashbacks, a sense of reliving the experience, or distress to reminders of the event (Winston et al., 2002). Cluster D is the ‘Avoidance Criterion’ which is marked avoidance of stimuli that remind the child of the trauma (Brewin et al., 1999; Winston et al., 2002). Cluster E is the ‘Arousal Criterion’ which includes marked symptoms of anxiety (Brewin et al., 1999; Winston et al., 2002). Some of the most common symptoms in this cluster
are: irritability, difficulty sleeping, poor concentration, or hypervigilance (Winston et al., 2002). Cluster F is the ‘Impairment Criterion’ which is whether the child has clinically significant distress or impairment in their life (Brewin et al., 1999; Winston et al., 2002). That impairment can come either in a social realm or an occupational realm, but it has to cause impairment to be considered for this cluster (Winston et al., 2002). Cluster G is the requirement that the traumatic event must have not occurred less than two days or more than four weeks before diagnosis with Acute Stress Disorder (Winston et al., 2002). Cluster H is the requirement that the disturbance is not due to another disorder, a medical condition, or a substance (Winston et al., 2002).

In the long term, which is considered to be more than one month, a diagnosis of Post-Traumatic Stress Disorder is possible (Foa, Asnaani, Zang, Capaldi, & Yeh, 2018). While a diagnosis of PTSD doesn’t differ dramatically from a diagnosis of ASD, in terms of criterion with the exception of the timeframe, if left untreated in childhood and adolescence, the consequences are potentially severe. Children and adolescents with untreated PTSD have been shown to be at higher risk for substance abuse, suicide, and various mental health problems (Foa et al., 2018).

**Attachment**

**History of Attachment Theory**

Attachment Theory is one of the most popular and empirically grounded related to parenting in use today (Benoit, 2004). It is the joint work of two psychologists, John Bowlby and Mary Ainsworth (Bretherton, 1992).
It began in 1948 with Bowlby’s work with hospitalized children who had been separated from their parents (Bretherton, 1992). Bowlby began to theorize about what would eventually become attachment theory, by writing, “the infant and young child should experience a warm, intimate, and continuous relationship with his mother (or permanent mother substitute) in which both find satisfaction and enjoyment” (Bowlby, as cited in Bretherton, 1992, p. 7). In addition, Bowlby took great interest with Lorenz’s paper on imprinting in geese and how it suggested that the social bond was not only due to nourishment (Bretherton, 1992).

If John Bowlby was the ‘father’ of attachment theory, then Mary Ainsworth must surely be its mother. She worked under Bowlby when he was developing attachment theory and soon, she set off to better refine and define it (Bretherton, 1992). Once in Baltimore, she developed a laboratory procedure that would become known as the ‘Strange Situation’ (Bretherton, 1992). This situation goes as follows: first, mother and child are introduced to a playroom and the child uses the mother as a secure base to explore the room (Bretherton, 1992). Secondly, the mother and child are joined by an unfamiliar woman (Bretherton, 1992). While the stranger interacts with the child, the mother leaves the room and then returns (Bretherton, 1992). Then both the mother and the stranger leave the room and the child is left alone. Finally, the mother and stranger return (Bretherton, 1992). Ainsworth became interested in how these children reacted when they were reunited with their mothers, later classifying these behaviors into secure attachment and several distinct insecure attachment types (Bretherton, 1992).
Current Psychological Perspectives on Attachment

While Bowlby and Ainsworth were no doubt influential, much more recent work has been done on the subject of attachment theory, including why insecure attachment may develop in place of secure attachment and vice versa. Additionally, many different perspectives on attachment theory have emerged.

From a psychodynamic perspective, the belief is that attachment occurs because the child seeks closeness from their mother or caregiver when they experience anxiety (Brisch, 2012). This anxiety may result from things such as pain, separation from caregiver, or due to an unfamiliar situation (Brisch, 2012). When seeking out this closeness, the child hopes to attain security, safety, and protection (Brisch, 2012). The child will also always be an active participant in this relationship by sending out signals, such as crying, to indicate to the caregiver that they require closeness (Brisch, 2012). According to the psychodynamic perspective development of secure attachment is dependent upon the caregiver attuning to a child’s signals and reacting appropriately (Brisch, 2012). However, if a caregiver either does not respond to these signals or does so inconsistently, then an insecure attachment is likely to develop (Brisch, 2012). In the field of cyclical psychodynamics, a subset to the psychodynamic approach, attachment is considered to be the result of internal working models generated by early attachment experiences which are then either confirmed or revised due to later life experiences (Wachtel, 2017). In essence, the person's earliest attachment experiences cause them to react to other, later events in life, in line with their prior experiences (Wachtel, 2017). Thus, a person’s earliest experiences create a feedback loop in which future experiences
can strengthen the pattern of attachment that was development in early childhood, both secure and insecure (Wachtel, 2017).

From a cognitive-behavioral perspective, attachment is seen as a product of one’s environment and relationships (Blaustein & Kinniburgh, 2010). Attachment is also further defined and refined by the child through their experiences during three crucial life stages: Early Childhood (0-6 years old), Middle Childhood (7-12 years old), and Adolescence (12+ years old) (Blaustein & Kinniburgh, 2010). During early childhood, the child gradually develops communicative skills as their needs are met by their primary caregiver (Blaustein & Kinniburgh, 2010). In a securely attached relationship, whenever the child is upset, the caregiver gives consistent and sensitive responses to the child in order to soothe them (Blaustein & Kinniburgh, 2010). The child also learns through this soothing process techniques on how to soothe themselves (Blaustein & Kinniburgh, 2010). However, in a insecure relationship, the child has no context on which to interpret communicative experiences (Blaustein & Kinniburgh, 2010). During middle childhood, the child in a secure attachment still maintains a primary caregiver, such as their mother, but peers become an influential presence in their lives (Blaustein & Kinniburgh, 2010). Also, during this time, filters through which the children interpret experiences are being developed (Blaustein & Kinniburgh, 2010). In an insecure relationship during this time, the child will struggle adapting to their new environment (Blaustein & Kinniburgh, 2010). Their belief system will be more rigid then their securely attached counterpart and they may view new relationships with distrust (Blaustein & Kinniburgh, 2010). Finally, during adolescence, a securely attached adolescent will develop a healthy separation from their caregiver, but still be able to rely on them in times of need (Blaustein & Kinniburgh,
However, in an insecurely attached adolescent, they may develop a negative self-
identity and must rely on primitive coping mechanisms due to not learning them in
previous stages (Blaustein & Kinniburgh, 2010). This psychological perspective also
believes that an insecure relationship in a previous life stage will have a ‘snowball’ effect
that will make each subsequent life stage exponentially worse unless corrected (Blaustein
& Kinniburgh, 2010). As the child becomes an adult and has children of their own, it
should be noted that the single strongest predictor of insecure attachment has been shown
to be the attachment style of their primary caregiver (Moulin et al., 2014).

Importance of Attachment

Many different psychological perspectives believe that attachment is crucial to
the development of a child (Blaustein & Kinniburgh, 2010; Brisch, 2012; Wachtel, 2017). It is widely believed that there are four main types of attachment, along with a separate and independent disorder that is somewhat controversial and will be discussed later (Benoit, 2004; Kay & Green, 2013; Mikic & Terradas, 2018). Of those four types, three are considered insecure and one is considered secure (Benoit, 2004). Additionally, of these four types, three are considered ‘organized’, which means that the child knows how to respond to their caregiver, even if insecurely attached. Secure attachment, the most beneficial type of attachment (Moulin et al., 2014), is prevalent in about 60%-70% of the population (Andreassen & Fletcher, 2007). Secure attachment comes from a sensitive and loving caregiver and is also classified as ‘organized’ because the child knows to approach the caregiver when they are distressed (Benoit, 2004). Secure attachment has been shown to help a child develop a sense of self-confidence and also been shown to have fewer
behavioral problems and better social skills compared to their insecure peers (Moulin et al., 2014). The first of three insecure attachments is called avoidant, and is prevalent in about 20%-30% of the population (Andreassen & Fletcher, 2007). It is called avoidant because the caregiver responds to the child in an insensitive and rejecting way (Benoit, 2004). This causes the child to learn that they must avoid their caregiver when they are distressed, and in this way, it is considered to be an ‘organized’ response (Benoit, 2004). The second insecure attachment is called ambivalent and is prevalent in about 10-15% of the population (Andreassen & Fletcher, 2007). It is so named because it results from a caregiver who responds to the child insensitively and inconsistently (Benoit, 2004). This causes the child to overreact in the hope that their extreme display will get the attention of the caregiver, so this is an organized response (Benoit, 2004). Finally, the last insecure attachment type is disorganized attachment, which is estimated to be prevalent in around 10%-15%, although it should be noted that a large scale, nationally representative sample has never been collected (Benoit, 2004; Andreassen & Fletcher, 2007). As the name suggests, this pattern of attachment is considered to be an ‘disorganized’ response, due to the atypical behavior of their caregiver (Benoit, 2004). While there is no exact reason, it is hypothesized that these disorganized children were exposed to frightening, traumatic or abusive behaviors by their caregivers (Benoit, 2004; Van IJzendoorn & Bakermans-Kranenburg, 2003). Out of the three types of insecure attachment discussed here, disorganized attachment is considered to be the one most associated with negative outcomes (Andreassen & Fletcher, 2007). With that said, all types of insecure attachment lead to an increased chance of mental illness, childhood obesity, delayed cognitive development (Moulin et al., 2014). Finally, a different type of attachment style is the
most controversial and potentially severe (Benoit, 2004). Known as Reactive Attachment Disorder, it differs from the four attachment styles listed before in the sense that it is officially classified as a disorder (Mikic & Terradas, 2018). Furthermore, it is considered to be somewhat independent from the four attachment styles because some research has shown that children with Reactive Attachment Disorder also possess one of the four attachment styles, including 30% who were securely attached (Minnis et al., 2009). While more research needs to be done, Reactive Attachment Disorder is seen as the byproduct of severe abuse, maltreatment, neglect, extended separation from primary attachment figures, and living in a group home (such as an orphanage), or changing primary caregivers consistently (such as in the foster care system) (Mayo Clinic, 2017; Mikic & Terradas, 2018; Kay & Green, 2013). However, there is no definitive measure with which to diagnose Reactive Attachment Disorder, making estimates of prevalence challenging (Kay & Green, 2013; Mikic & Terradas, 2018). Adding to this difficulty is the possibility that children with Reactive Attachment Disorder may have it disguised by other psychiatric disorders, such as conduct disorder (Hong et al., 2018; Mikic & Terradas, 2018). With all of that said, prevalence rates have ranged from 1% in the general population to 45% of the foster care population (Mikic & Terradas, 2018). While the exact rates are unknown, the general consensus is that children in institutionalized care (such as foster care or orphanages) are at a much higher risk of having Reactive Attachment Disorder (Mikic & Terradas, 2018). While it is unclear if Reactive Attachment Disorder can occur in children over 5 (Hong et al., 2018; Mayo Clinic, 2017), there is evidence that having Reactive Attachment Disorder earlier in life can lead to poor social outcomes and severe functional impairments in adolescents (Kay & Green, 2013).
As seen in both the disorganized attachment style and Reactive Attachment Disorder, trauma plays a key role (Kay & Green, 2013; Benoit, 2004; Van Ijzendoorn & Bakermans-Kranenburg, 2003). Studies have shown that trauma inflicted by a primary caregiver can disrupt the normative development of secure attachment and can increase the risk of disorganized attachment (Becker-Weidman, as cited in Esch, 2013). In a study on the trauma experienced by Japanese children eight months after the 2011 Japan Earthquake, the children who experienced it were at higher risk of developing PTSD (Usami et al., 2012). Additionally, that study showed that the children who had experienced house damage and evacuation had more severe mental symptoms (Usami et al., 2012). Some research has shown that traumatic experiences within the first 5 years of life may continue to have effects down the road (Esch, 2013). Streeck-Fischer and Van der Kolk (as cited in Esch, 2013), have hypothesized that physical abuse and neglect are predictors of the highest rates of arrest later in life. Furthermore, it has shown that children who experience even brief separation trauma early in life are more prone to develop insecure attachment and carry that with them into adulthood (Bryant et al., 2017).

Non-Western Cultural Considerations of Attachment

While Attachment Theory has been occasionally touted as universal, many studies have brought up concerns regarding its implicit biases (Van Ijzendoorn & Kroonenberg, 1988; Rothbaum, Weisz, Pott, Miyake, & Morelli, 2000; Otto & Keller, 2014). There has been substantial criticism that the ‘Strange Situation,’ Ainsworth’s tool to diagnose a child's attachment, is rooted in Western middle-class norms (Rothbaum et al., 2000). Van
Ijzendoorn & Kroonenberg (1988) conducted a meta-analysis of attachment styles in individualist, such as the United States, and collectivist, such as Japan, cultures. They found that while most every country had similar secure numbers, the collectivist countries tended to have an overabundance of insecure ambivalent styles and that individualist countries had an overabundance of insecure avoidant styles (Van Ijzendoorn & Kroonenberg, 1988). However, it is worth noting that the cultural meanings of those categories may be different (Rothbaum et al., 2000). So, for example, an insecure ambivalent style of attachment may be seen as being worse in an individualist culture than a collectivist culture (Rothbaum et al., 2000). There are also research limitations to consider. A culture that is not used to the setting and concept of a laboratory, such as the one used in Ainsworth’s ‘Strange Situation,’ may be more susceptible to the ecological validity limitations of a study than a culture that is familiar with a laboratory. For example, in a study using the ‘Strange Situation’ in Java, it found that the mothers were less sensitive to their children in the lab than they were in their homes (Otto & Keller, 2014). The use of the ‘Strange Situation’ also has limitations when it comes to measuring children who have been taken care of collectively, such as in a tribal culture (Otto & Keller, 2014).

Sierra Leone

History of Sierra Leone

Sierra Leone is a West African country with a population of just over 6 million according to the Central Intelligence Agency (2019). It was a former British colony until it gained its independence in 1961 (Central Intelligence Agency, 2019). Since that time,
its most notable event has been the Civil War that raged for eleven years from 1991-2002 (Central Intelligence Agency, 2019). Additionally, Sierra Leone has been plagued by several disasters in recent years, such as the Ebola outbreak in 2014-2015 (Nordström, 2015) and the mudslides of 2017 (Harris et al., 2018).

The Sierra Leonean Civil War lasted from 1991-2002 (Voors, Van Der Windt, Papaioannou, & Bulte, 2016). The conflict took place between the main rebel group, the Revolutionary United Front (RUF), and government forces, who were eventually reinforced by United Nations peacekeepers (Voors et al., 2016; Central Intelligence Agency, 2018). The conflict began in 1991 when rebel forces entered from neighboring Liberia (Voors et al., 2016). Then violence slowly spread from eastern Sierra Leone to engulf major cities Kenema, Bo, and Freetown (Voors et al., 2016). The fighting would go on to reach its peak during 1998 (Voors et al., 2016). Finally, the war was declared over in January 2002, when an internationally mediated peace treaty was agreed to (Voors et al., 2016). Overall, the effects of the war were devastating, with over half of the Sierra Leonean population displaced (Voors et al., 2016). Additionally, 50,000 Sierra Leoneans were killed and thousands more suffered injuries, rapes, and assaults (Voors et al., 2016). However, a real consequence of this war involved children.

Previous research has shown that witnessing, experiencing, and perpetuating violence have severe negative consequences on the mental health and social reintegration of young people (Betancourt, Brennan, Rubin-Smith, Fitzmaurice, & Gilman, 2010). During the course of the Sierra Leone Civil War, an estimated 10,000 children were used as child soldiers by the various fighting groups, according to a United Nations statement in September 1999, when the war was winding down (Tremblay, 1999). Prior research
has shown that former child soldiers have high rates of PTSD and depression (Betancourt et al., 2010). A longitudinal study done of child soldiers in Sierra Leone showed that these children’s war experiences have long-term consequences, but that these consequences can be mitigated by proper intervention (Betancourt et al., 2010).

Besides the Civil War, natural disasters and diseases have also played a role in Sierra Leone’s recent history. In 2014, what began with the death of a faith healer would soon balloon into an epidemic (World Health Organization, 2015). On May 10, a faith healer who had been treating Ebola patients in neighboring Guinea contracted the disease and died (WHO, 2015). Hundreds of people attended her funeral and also contracted the disease (WHO, 2015). The World Health Organization tracked 365 deaths to that funeral alone (2015). These deaths in turn led to more infections and deaths as the disease flourished. Assisting in this spread was the poor living conditions many Sierra Leoneans lived in (Fitzgerald, Awonuga, Shah, & Youkee, 2016). Only about a quarter of the population has a private toilet (Fitzgerald et al., 2016), and 25% of the population has no toilet at all, according to a 2008 national survey (Statistics Sierra Leone and ICF Macro, 2009). Also, the lack of adequate healthcare is quite noticeable with only .2 doctors per 10,000 population (Fitzgerald et al., 2016). Additionally, a devastating mudslide in 2017 killed over 500 and affected nearly 6000 people (Harris et al., 2018). Of these 6000, nearly 1000 were children under 5 (Van Wagenen & Halberg, 2017). Furthermore, the water showed high levels of contamination, which put the victims at risk for infection with diseases such as Cholera (Van Wagenen & Halberg, 2017). The UN also estimates that 204 children lost their homes (Van Wagenen & Halberg, 2017).
Economy of Sierra Leone

Sierra Leone’s economy has been slowly growing despite a few bumps in recent years (Central Intelligence Agency, 2019). However, that growth has yet to positively affect the general population. With an unemployment rate hovering around 15% and about 70% of the country below the poverty line, the vast majority of the country remains extremely poor (Central Intelligence Agency, 2019). The reasons for this are many. First, the country still has not fully recovered from the Civil War, which had fully collapsed the economy (The Commonwealth, 2018). Additionally, the Ebola epidemic in 2014-2015 caused tourism to grind to a halt and caused GDP growth to be -20.5% (Central Intelligence Agency, 2019; The Commonwealth, 2018). However, the economy has started to grow again at 6.3% and 3.7% in 2016 and 2017, respectively (Central Intelligence Agency, 2019). However, a real problem plaguing the economy is the lack of infrastructure (Central Intelligence Agency, 2019). Only about 5% of the total population can consistently get electricity and only 1% outside of urban areas (Central Intelligence Agency, 2019; Statistics Sierra Leone and ICF Macro. 2009). Furthermore, Sierra Leone suffers from a lack of an adequate road system (Central Intelligence Agency, 2019).

Language Use and Education in Sierra Leone

The demographics of Sierra Leone are changing slightly as their population continues to rapidly increase (Central Intelligence Agency, 2019). Despite its official language being English, many do not speak it (Central Intelligence Agency, 2019). The top language spoken is Krio, an English-based Creole, with over 95% of the population being able to understand it (Central Intelligence Agency, 2019). However, English is
mainly limited to those in the population who are literate, and literacy remains low (Central Intelligence Agency, 2019). Only 48% of the total population can read and write in one of the four major languages of Sierra Leone; English, Mende, Temne, and Arabic, according to a 2015 estimate (Central Intelligence Agency, 2019). Overall, education is also seen as extremely lacking, with nearly half of men and two-thirds of women possessing no education (Statistics Sierra Leone and ICF Macro, 2009). In addition, only 32% of men and 19% of women had completed secondary school (Statistics Sierra Leone and ICF Macro 2009). Finally, only 5% of men and 3% of women have gone on to higher education (Statistics Sierra Leone and ICF Macro, 2009), which is a reason why so many high skilled jobs, such as doctors and nurses, have gone unfulfilled (Fitzgerald et al., 2016).

**Family Lifestyles in Sierra Leone**

43% of households in Sierra Leone have at least one child under 18 who is living there without a birth parent, according to a survey conducted by the government of Sierra Leone in conjunction with the United Nations (2008). An average household consists of about six people, with nearly half of these being people under 15 years of age (Statistics Sierra Leone and ICF Macro, 2009). Child labor is prevalent with nearly 31% of children, having at one time, participated in an activity that qualified as child labor (Statistics Sierra Leone and ICF Macro, 2009). This would be defined as a child from 5-11 years old participating in one hour of economic activity or at least 28 hours of domestic chores in the week preceding the survey (Statistics Sierra Leone and ICF Macro, 2009). Moreover, the definition for a child from 12-14 years would be at least 14 hours of economic
activity or 28 hours of domestic chores in the week preceding the survey (Statistics Sierra Leone and ICF Macro, 2009). Finally, child mortality is high in Sierra Leone (Statistics Sierra Leone and ICF Macro, 2009). According to the survey, 3.6% of children die before one month and 5.3% of children die between one month and one year, so in total, 8.9% of children die before their first birthday (2008). Overall nearly one in seven, or 14%, die before they reach the age of 5.

Servant Heart Research Collaborative

Overview of the Servant Heart Research Collaborative

The Servant Heart Research Collaborative was a joint effort between the University of Maine’s Honors College and the Child Rescue Center in Bo, Sierra Leone. This author was approached to work on the Collaborative’s Attachment Theory program in the Fall of 2016 by two donors representing the Child Rescue Center and work began in earnest in the Spring of 2017. The program’s original mandate, as put to this author and others, by the Child Rescue Center was to research Attachment Theory and then put together a year-long program based on Attachment Theory, roughly six trainings, to be taught to six caregivers who care for about 50 orphaned children.

The Child Rescue Center in Bo, Sierra Leone is a Christian organization that provides support to over 600 vulnerable children (Child Rescue Center, n.d.). Of these 600 children, about 500 are supported by having their school fees, uniforms, books, and medical care paid for by the Child Rescue Center (Child Rescue Center, n.d.). However, the remaining 100 children get more personalized and intensive care (Child Rescue Center, n.d.). They are a part of the ‘Family Care Program,’ which matches the children...
up with a caregiver because that child’s parents were either unavailable or abusive (Child Rescue Center, n.d.). Initially, there were only six caregivers and a seventh that was an alternative if one got sick, and they were referred to as ‘aunties.’ These six to seven female caregivers were responsible for taking care of these children, who ranged in ages from 3-16, in a similar set-up to an orphanage program. However, in the Fall of 2018, it was learned that the government of Sierra Leone, in conjunction with UNICEF, would be transitioning those children out of the orphanage care-style of the ‘aunties,’ and into the care of close relatives scattered mostly around Bo and a few outside of the city. So, it went from an audience of six to seven caregivers, who could speak a little English, to about sixty close relatives who could mostly not speak English. It was quickly realized that this was a potential problem and made sure that the trainers there who would teach the trainings to the relatives could both understand the trainings and the relatives, so that there would be as little a language barrier as possible. To further facilitate this point, the language in the trainings was changed to be as basic as possible.

When designing the trainings, it was attempted to put them together based around a main topic and a few, related, secondary topics. Additionally, learning objectives for each training were set.

**Topics of Trainings**

The topics covered in training one was an introduction to attachment and how to create and identify secure attachment with your child. The learning objectives for training one were: understand and explain in your own words what is attachment; be able to discuss what is secure attachment and what does it look like; be able to give examples of
how to build secure attachment with your child; understand your role as a caregiver; know multiple ways to make your child feel safe; explain what are the Three T’s (Talk, touch, and time); and give examples of why and how to use the Three T’s.

The topics covered in training two were an introduction to trauma and the effects it could have on a child along with how to talk to your child. The learning objectives for training two were: understand and explain in your own words what is trauma; be able to discuss what trauma disrupts; be able to give examples and identify what response to trauma may look like in your child; understand the limitations of a child who has experienced trauma; and know how to use specific compliments.

The topics covered in training three were an introduction to attunement and about understanding triggers. Additionally, the caregivers were told how to properly react to a child who is experiencing a triggering event. The learning objectives for training three were: understand and explain in your own words what is attunement; understand and explain in your own words what are triggers; be able to give examples and identify what a response to a trigger may look like in your child; explain how to respond to a child experiencing a trigger; and know how to reflect with your child after he or she has experienced a trigger.

The topics covered in training four were an introduction to temperament, resilience, and self-management strategies for children. The learning objectives for training four were: understand and explain in your own words what is temperament; understand and explain in your own words what is resiliency; be able to give examples and identify what resiliency may look like in your child; be able to discuss ways that you, as a caregiver, can help build resiliency in your child; give examples of what makes a
calm and stable home; understand and explain in your own words what are self-management strategies; and give examples of self-management strategies.

The topics covered in training five were emotional regulation and limit-setting. The learning objectives for training five were: understand and explain in your own words what is emotional regulation; be able to discuss what the goals of emotional regulation are and be able to explain what are SLOW and LOW; give examples of why and how to use SLOW and LOW; be able to discuss ways that you, as a caregiver, can teach your child emotional regulation using strategies; be able to discuss why consistent responses are important; understand and explain in your own words what is a limit; and know how to use the steps of how to enforce a limit.

The topic covered in training six was caregiver well-being, which involved both an introduction to it and strategies on how to enact it. The learning objectives for the final training was: understand and explain in your own words what is well-being; be able to give examples and identify what being tired as a caregiver may look like; explain why feeling tired as a caregiver is natural; be able to discuss ways that you can use self-care to prevent feeling tired as a caregiver; and to be able to explain why it is important to practice self-care.

**Program Evaluation**

**Introduction to Program Evaluations**

According to the Centers for Disease Control, a program can be many things, such as a research initiative, a training program or a direct intervention (2012). In fact, the definition is kept broad so that a program can be considered any number of candidates
that can benefit the public health in some way (Centers for Disease Control, 2012; Rossi et al., 2004). A vast swath of these programs should be considered social programs, loosely defined as “programs designed to benefit the human condition” (Rossi et al., 2004, p. 6). At some point, there becomes a need to distinguish a worthwhile program from an ineffective one (Rossi et al., 2004). This is where a program evaluation comes in. A program evaluation helps by determining whether the program works, if there are any improvements to be made, and provide evidence for continuing support of the program (Cairney et al., 2007). A more formal definition reads that a program evaluation is “the systematic collection of information about the activities, characteristics, and outcomes of programs to make judgments about the program, improve program effectiveness, and/or inform decisions about future program development” (Centers for Disease Control, 2012, p. 3). In order to successfully and thoroughly evaluate a program, one must use a framework of evaluation that has been rigorously tested by public use over a significant period of time.

Several frameworks for program evaluation have been put forth in the literature that meet the above criteria (Cairney et al., 2007; Centers for Disease Control, 2012; Rossi et al., 2004; McNamara, 2002). However, for the purposes of this project, the CDC's Framework for Program Evaluation in Public Health (2012) was selected to base this program evaluation on. The CDC’s Framework (2012) was selected because of the flexibility provided in the framework and its emphasis on accounting for practical and realistic limitations that may affect the program evaluation. Additionally, it was chosen for it accounting for considerations of context, such as culture, within the framework
(Centers for Disease Control, 2012). Finally, it was chosen for it having been introduced in 1999 and shown to be effective over a long period of time (Kidder & Chapel, 2018).

According to the framework provided by the CDC, there is a six-step guide to program evaluations (2012). Those steps are, in order from one to six: engage stakeholders; describe the program; focus the evaluation design; gather credible evidence; justify conclusions; and ensure use of evaluation findings and share lessons learned (Centers for Disease Control, 2012). All information below is referenced from the CDC’s Framework (2012) as described above, unless otherwise stated.

**CDC’s Guide to a Program Evaluation**

**Step One.** Step one is engaging with stakeholders, which are people or organizations invested or otherwise involved with the program. A stakeholder could be one of many people, such as program staff, managers, funding agencies, or even the participants themselves. They are important because they can play a vital role before, during, or after the program. One must also be able to prioritize the stakeholders based on how important they are to the program. Stakeholders can also play an important role in data collection.

**Step Two.** Step two is describing the program, which is helpful to narrow the questions to only those most relevant. It also involves the following components: needs; targets; outcomes; activities; outputs; and inputs. Additionally, a program description involves discussion of the context surrounding the program and of the stage of development that the program is in. A description of the program culminates with a depiction of the relationship of activities and outputs.
A: Need is defined as being the problem that is being addressed by the program.

B: Targets are the people that are necessary to make the program function, this includes participants as well as funding organizations and staff.

C: Outcomes are changes in someone that you hope will result from the program’s activities, these results can be short, intermediate, or long-term. Bennett and Rockwell (As cited in Centers for Disease Control, 2012), developed a potential hierarchy of effects.

At the base of the hierarchy is participation, which is how many people participated (Bennett & Rockwell, as cited in Centers for Disease Control, 2012). The next level in the hierarchy is the participants reactions, which are their feelings towards the program. The third level in the hierarchy is the participants learning, which are their knowledge and skills, as affected by the program. The fourth level in the hierarchy is the participants actions, which patterns of behavior adopted by the participants. The fifth level of the hierarchy are any social or environmental changes due to the program. The sixth and final level of the hierarchy are the long-term health outcomes of the participants as a result of the program.

D: Activities are the actions taken by both the program and its staff to achieve the desired change in the participants behavior.

E: Outputs are the direct return of activities, usually as a quantifiable number.

F: Inputs are the people, money and information needed, from outside the program, that the program is dependent on.
G: The context is a discussion on the larger environment of which the program operates. This could include any external factors, such as politics, history, and social and economic conditions.

H: The stage of development of a program can be separated into three distinct categories; planning, implementation, and maintenance. Planning is the first stage of development of a program and is when the program has not been put into practice yet. The second stage is implementation, which is when the program has been fully implemented, but not for a very long time. Finally, the third stage is maintenance, which is when the program has been completed or has many years of data collected.

I: The relationship between activities and intended outcomes is a visual representation of a logic model, which explains how the program will produce the intended outcomes through its use of activities.

**Step Three.** Step three is focusing the evaluation design, which is going to ask the question, ‘Is the program working?’ To answer this question, there are a couple of different types of program evaluations that can be used. These different types are covered under the broad umbrellas of two groups: Implementation/Process and Effectiveness/Outcome.

Implementation/Process program evaluations focus on whether the activities are taking place as intended, or if the participants are being reached through the activities. Implementation/Process evaluations focus on contrasting actual and planned performance in order to determine whether the program was faithful to the original intent of it. There are several measurements that can be compared and contrasted, such as: the location where the program is being provided; the number of people being exposed to the
program; the demographics of the people being exposed to the program; the staffing; the number of trainings for staff; and the number of activities and meetings. Some of the most important factors that could compromise implementation, which will be expounded on, are transfers of accountability; dosage; access; and staff competency. Transfers of accountability are when a program cannot produce the intended result unless some person or organization takes an action. Dosage is when the intended outcomes of a program are dependent on the number of times a participant can be exposed to the program. Access is when intended outcomes of a program require an increase in demand to be effective, along with an increase in supply of services to meet the demand. Finally, staff competency is the measure of how well the program is delivered by staff, not only by their technical competency, but also by how well they are matched to the target audience being exposed to the program. Implementation/Process evaluations help distinguish a bad program idea from a good program idea that was either simply implemented poorly or had a flawed process.

Effectiveness/Outcome program evaluations focus on the outcomes that a program tries to create. Typically, these outcomes are broken down into short, intermediate, and long-term outcomes. These outcomes, in order for the program to be successful, must include some sort of change. This change can be seen in many ways, such as in people’s beliefs, behaviors, or changes in the environment which include social norms. In order for an Effectiveness/Outcome program evaluation to be properly completed, one must ask three vital questions of the program. First is efficiency, which is asking if the program’s activities are being produced with minimal resource consumption. Second is cost-effectiveness, which is asking if the value produced by the program
outweighs its cost. Finally, the last question to be asked is about attribution, which is asking if any of the outcomes could be related to other confounding variables outside of the program.

Once the type is settled upon, one must take into account questions revolving around the utility, feasibility, proprietary, and accuracy of the program evaluation.

Questions regarding the utility of the program evaluation ask about the purpose of the evaluation and the use of the evaluation. The purpose of the evaluation refers to the general purpose of the evaluation, such as whether it is to determine the effects of the program or to fine-tune a certain aspect. The use of the evaluation refers to what the input of the users, such as stakeholders, would be for the design of the evaluation and questions the evaluation should seek to answer. Additionally, it makes reference to what the information collected by the program evaluation will be put towards, such as documenting success or identifying areas of the program that need improvement.

Questions regarding the feasibility of the program evaluation ask about how the stage of development that the program is in will affect the evaluation’s focus, what the intensity of the program is, and how logistical considerations could affect the results of the evaluation. Depending on the stage of development of the program, the questions that an evaluation seeks to answer may change. For instance, an evaluation about a program in the planning category would seek to answer who the targets are and how to reach them, whereas a program in the maintenance category would seek to answer what the results of the program were and what the impact was.

Questions regarding the proprietary and accuracy of the program evaluation revolve around the evaluation questions and the evaluation design. The evaluation
questions should reflect what is hoped to be understood from the evaluation and should be consistent with what type of evaluation has been chosen. The evaluation designs typically fall into one of three categories: experimental design, quasi-experimental design, and observational design. Experimental designs use random assignment to assign participants to equivalent control and experimental groups in order to test hypotheses about the program. Quasi-experimental designs take a similar approach to experimental designs but do so without the random assignment and equivalent control and experimental groups. Finally, observational design differs from the other two by not being set up as an experiment and not relying upon a control and experimental group. It can take the form of methods such as a case study or a cross-sectional survey, amongst others, and is seen as the most widely used design for program evaluations.

**Step Four.** Step four is about gathering credible evidence. The process of collecting data for a program evaluation revolves around five main concepts. Those are: indicators, sources of evidence and methods of data collection, quality, quantity, and logistics.

Indicators are “specific, observable, and measurable statements” (Centers for Disease Control, 2012, p. 56) that help to define exactly what is meant by a certain term and what is being measured. They can be developed for either activities or outcomes.

After selecting what specifically should be measured, one must select how they are going to collect the data. The first step is figuring out whether the data collected is going to be primary or secondary data. Primary data is data that is collected by yourself, whereas secondary data is data that is collected by a third party and that you are repurposing for your needs. Some factors that influence which type of data to pick are the
context, which involves things such as the financial resources available to gather data, and the content, which involves things such as whether the behavior is observable. Additionally, it should be determined whether it is in the best interest of the evaluation to collect qualitative data, quantitative data, or both.

A quality data collection method produces data that is reliable, valid, and informative. A reliable set of data repeatedly produces the same results. A valid set of data measures what it is intended to measure, and an informative set of data should give insights into what it is trying to measure.

The quantity of data is simply how much data is intended to be collected. One must take into account any issues with obtaining a representative sample and effect size when determining how much data to collect. Additionally, the quantity of data collected should reflect the context of the situation.

The logistics are the “methods, timing and physical infrastructure” (Centers for Disease Control, 2012, p. 67) for collecting data. The issues of determining whether there are any cultural preferences in gathering data are a part of logistics, as well as protecting the confidentiality of participants.

Step Five. Step five is about justifying your conclusions. Not simply reporting on the data, this also involves analyzing and interpreting the data. Program standards should also be set so that the program can be judged appropriately.

Data analysis is effectively done by tabulating all of the available data and then looking for patterns in the evidence. This can be done by comparing and contrasting different types of data and seeing what results from it.
Program standards are benchmarks specific to that program that are used to judge its effectiveness. Ideally, these standards should be developed with input from stakeholders and can center around many things, a few of which are; the needs of participants, the program mission and objective, and community values and perceptions.

In fully judging the data that was collected and analyzed, one makes a statement about a program’s, or part of, worth and merit using the standards defined. As a part of this judgement, one must also consider, and elaborate on, the limitations of the program evaluation and any other possible explanations for the results.

**Step Six.** Step six is ensuring the use of evaluation finding and sharing the lessons learned. This is the final step in the CDC’s guide to program evaluations and uses the evaluation to improve the program in some way. The conclusions from step five can be used to show where the program was effective, what parts can be improved, and whether it was justified. There are five elements that go into making sure that the evaluations findings will be put to good use and those are: recommendations, preparation, feedback, follow-up, and finally dissemination.

Recommendations are actions to consider executing as a result of the evaluation. Recommendations should be soundly supported with evidence and be of relevance and in accordance to the program’s goals.

Preparation refers to the steps taken to eventually use the recommendations. Through preparation, both positive and negative implications of the recommendations can be discussed, along with multiple options to improve the program.

Feedback is what is gained by holding discussions with stakeholders and commenting on potential changes.
Follow-up refers to the support that users need after receiving results and justifying conclusions. Follow-up helps to prevent recommendations from being ignored in the process of making decisions.

Finally, dissemination involves communicating evaluation conclusions to the appropriate audiences in a timely manner.

**WEIRD**

**Introduction to WEIRD**

There can be no question that there exists a gap in the literature as it relates to the use of a population that is not Western, Educated, Industrialized, Rich, and Democratic (Henrich et al., 2010). These populations, otherwise known as WEIRD, comprise nearly 96% of the samples in psychological research, despite only making up 12% of the world's population, according to a study in 2008 (Arnett). Additionally, these populations are not easily generalizable to the rest of world, due to the extremely different conditions in which they exist (Arnett, 2008).

Additionally, of the non-WEIRD research samples, Africa is practically at the bottom, with less than 1% representation, despite accounting for about 16% of the world’s population in 2015 (Arnett, 2008; United Nations, 2017). This can in part be explained by the fact that there are very few first or second authors in major publications from African countries (Arnett, 2008). Despite a pledge from the African Union in 2010 for every country to spend 1% GDP on research, very few have followed through (de Haan et al., 2015).
In order to understand the differences between populations in WEIRD vs. non-WEIRD countries, the term ‘Western Country’ needs to be defined. While many varying definitions of ‘The West’ exist, this author chose to define it as any country in what is considered Europe by the United Nations (2017), or any primarily English-speaking country, so the United States, Canada, Australia, and New Zealand (Arnett, 2008). According to an estimate by the United Nations in 2015, these ‘Western’ countries would make up just about 15% of the World’s population (2017). There has been evidence that shows non-Western populations have differences with Western populations on key psychological domains; such as social decision making, independent and interdependent self-concepts, types of reasoning (analytical vs. holistic) and moral reasoning (Henrich et al., 2010). Additionally, similar differences were shown when comparing industrialized vs. non-industrialized countries (Henrich et al., 2010). There also remains a stark contrast between educational rates in Western countries and the rest of the World, specifically Africa. The rates for tertiary education in Europe and North America were both over 50%, but in sub-Saharan Africa, it was below 10%, according to the World Bank in 2014 (as cited in Roser & Ortiz-Ospina, 2019). All of the Western countries listed above are also firmly a democracy, whereas the global rate, including those Western countries, is only about 60% (Desilver, 2017). Finally, according to the International Monetary Fund (2019), the Western countries listed above also make up over 50% of the World’s GDP, despite only accounting for 15% of the World's population (United Nations, 2017).

All of this evidence points to the fact that WEIRD populations enjoy many privileges that are not shared around the world. The Western countries have higher rates of democracy, wealth, education, and industrialization than the global average. This leads
to a concern when discussing the generalizability between these WEIRD populations and the rest of the world. Much more research needs to be done regarding populations in non-WEIRD countries.
CHAPTER 3

PROGRAM EVALUATION

Attachment Theory Program Evaluation

Introduction to Attachment Theory Program Evaluation

Sierra Leone has had a long history of traumatic events, such as war, disease, natural disaster, and poverty (Central Intelligence Agency, 2019; Nordström, 2015; Harris et al., 2018). It is expected that these events have a strong likelihood to cause trauma in children and adolescents (“National Child Traumatic Stress Network,” n.d.). Furthermore, it is also expected that these traumatic events can and will cause significant and long-term negative effects (Lubit et al., 2003). It is also expected that these traumatic events will have a negative effect on the attachment of the child or adolescent (Kay & Green, 2013; Benoit, 2004; Van Ijzendoorn & Bakermans-Kranenburg, 2003; Usami et al., 2012; Bryant et al., 2017). Finally, it has been presented in the literature that there are both personal and societal health benefits to improving a child or adolescents’ attachment (Moulin et al., 2014; Kay & Green, 2013). With that in mind, the Servant Heart Research Collaborative put together a program, consisting of six trainings, to be taught to caregivers in Bo, Sierra Leone with the purpose of improving the attachment relationship between the caregivers and their children. In order to evaluate this program, this author will be using the six-step process developed by the Centers for Disease Control (2012).
Evaluation Goal

The goal of this evaluation is to determine the implementation and the effectiveness of the Servant Heart Research Collaborative’s Attachment Theory Program in teaching attachment theory and related behaviors to the caregivers. In addition, this evaluation will also attempt to determine the effectiveness of the program in changing the behaviors of the caregivers to those outlined in the program, which are considered more welcoming of a secure attachment. Finally, this evaluation will also attempt to determine if there are any improvements that could be made to the program.

Evaluation Team

The team for this evaluation consists of myself, Alexander Reppond, as supported by my advisors Dr. Julie DellaMattera and Dr. Rebecca Schwartz-Mette. Additionally, the team includes the donors, who wished to remain anonymous, who served as a conduit between myself and the Child Rescue Center in Bo, Sierra Leone in addition to be the main stakeholders for both the evaluation and program itself. Finally, there are the two Sierra-Leonean trainers, Amie and Deborah, who served as the facilitators for the program and were responsible for distributing and collecting the surveys for the participants.

Step 1: Engaging Stakeholders

Stakeholder Assessment

There were three main groups of stakeholders that needed to be identified. They were the two donors, the trainers, and the caregivers who are the participants.
Donors Involved in Program Operations

The donors served as the most influential stakeholders during the process of program operations. They were responsible for the communication, delivery, and funding of the program in the Child Rescue Center. Additionally, they were responsible for suggesting edits and changes to the trainings in the program itself before delivery and implementation at the Child Rescue Center. Finally, they were responsible for organizing the transportation of the surveys, which they also had creative control over, from the Child Rescue Center in Bo, Sierra Leone to this author at the University of Maine in Orono, Maine.

Trainers Involved in Program Operations

Additionally, the two locally born trainers, Amie and Deborah were instrumental in implementing the program. They are staff at the Child Rescue Center and were tasked with learning the program, so understanding all six trainings, and then helping facilitate each training to the participants at every monthly meeting. They were multilingual and so could speak and understand both English, which the trainings were in, and Krio, which most of the participants could presumably speak. They were also responsible for distributing, taking dictation of the participants words, and then collecting the surveys that will be used for the evaluation.

Persons Served or Affected by the Program

Participants attending the monthly training at the Child Rescue Center in Bo, Sierra Leone were the main people served by the program. Their goal is to have a better attachment relationship with their child or children. They attend a monthly meeting to
discuss one of the six trainings in the program at the Child Rescue Center. At the end of each training they would also fill out a survey by either dictating or writing their responses themselves.

**Intended Users of Evaluation Findings**

The main intended users of the findings of this evaluation are the donors. They will work with the Child Rescue Center to attempt to implement some of the recommendations made by this evaluation. They will also use this evaluation to determine if additional funding is required to make changes or to continue and expand the program to a wider target population.

**Step 2: Background and Description of the Servant Heart Research Collaborative’s Attachment Theory Program**

**Program Description Components**

**Need (A)**\(^1\). Given that these children have been separated from their parents due to either the death/disappearance of their parents or that their parents were abusive towards them, it would be expected high levels of trauma and insecure attachment. So, the need for this program comes from these levels of trauma experienced by the children supported through the Child Rescue Center. Furthermore, the participants have not undergone any formal training in regard to the care of heavily traumatized and poorly attached children. Therefore, a program based in attachment theory is needed in order to

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\(^1\) Letter used for easier reference to terms defined in Chapter 2: Literature Review, under ‘Program Evaluation’
improve the lives of these children and attempt to mitigate developmental and behavioral problems that can occur due to insecure attachment and trauma.

**Targets (B).** The targets for this program are the donors, trainers, and participants. The participants need to transfer the information and skills they learned from the program to their own lives and roles as caregivers. The trainers need to effectively communicate the program's message to the participants. The donors need to ensure funding for the program and that the objectives of the program are communicated clearly to the trainers.

**Hierarchy of Outcomes (C).** Here are the outcomes that were hoped to see from the program, listed from most superficial and short-term, to the most deep and long-term. It was hoped that numerous people attend the training meetings, and that they continue to attend the trainings consistently. It was also hoped that they will agree with the program, understand it, and enjoy attending the trainings. It was hoped that the participants will gain knowledge about attachment theory and skills from the program that they can use. It was hoped that the participants will use the knowledge and skills they acquired from the program at their home and with their children. It was hoped that, due to the use of the knowledge and skills gained from the program, the participants will develop a better attachment relationship with their child. Finally, it was hoped that the participants' children will have an improved life and have a better attachment relationship with their future children.
Activities (D). The activities for this program are twofold. The donors must provide the funding to the Child Rescue Center so that the program can be implemented correctly. Additionally, the trainers must be able to effectively deliver the program.

Outputs (E). The outputs for the donors funding are to provide transportation for the participants to the training meeting site, the trainers pay, and the infrastructure needed to implement the program, such as chairs, projectors, and handouts of program materials. The outputs for the trainers delivering the program are that the participants understand the material and have any questions answered, that they complete all the parts of that specific training, and that the participants are informed of when the next meeting is, and where.

Inputs (F). The program is dependent upon the funding of the donors, the competency of the trainers, and the validity of the information that the program is based on.

Context (G). Historically, Sierra Leone has faced numerous hardships. The majority of its population lives in poverty and the country has still not recovered from the devastating civil war. Additionally, natural disasters such as mudslides, and diseases such as Ebola have complicated their recovery. So, while the need for this program is incredibly high, due to the aforementioned events, the capacity for implementing it is quite low. Funding for it is relatively low and can be inconsistent. The Child Rescue Center has a lack of internet and occasional power outages, along with a staff that has not
been expertly trained. A language barrier exists with a majority of the country being illiterate in English, despite it being an official language. Additionally, elections were recently held and that could lead to a shift in philosophy regarding the Child Rescue Center, since they exist under the jurisdiction of the national government. Finally, it should be noted that a cultural barrier exists, since this program was developed using information that was mostly gathered off of WEIRD populations.

**Stage of Development (H).** The stage of development of this program can be classified as being in the implementation stage. At the writing of this evaluation, the program has only completed four out of six of the trainings and it has been restricted to a limited audience.
Relationships of Activities and Intended Outcomes (I). Below, in figure 3.1, is a depiction of the program’s logic model.

Figure 3.1 – Logic Model of Attachment Theory Program

Step 3: Focus of the Evaluation

Focusing the Evaluation

The stakeholders will use the findings from this evaluation to better understand the effects of this program and see if it should or could be continued. Additionally, they
will see if any part of the program can or should be improved, and if the program should be expanded to other populations outside of Bo, Sierra Leone.

**Evaluation Questions**

There were several questions that the evaluation seeks to answer. Based on the logic model they fell into two categories: Implementation and Effectiveness. These questions were created with significant input from the primary stakeholders, the donors.

**Implementation Questions**

1. Is the participants demographic data representative of a sample population?
2. How does the number of participants who attended the program compare to the number invited?
3. Are the trainers competent enough to carry out the trainings?
4. Did the participants understand the information in the program?
5. Was the training enjoyable for the participants?
6. Have participants gone to all of the trainings that have currently been completed?

**Effectiveness Questions**

7. Do the participants express the intention to change their beliefs or behaviors?
8. Was any change in beliefs or behaviors possibly caused due to other trainings?

**Evaluation Design**

This evaluation will use a complementary mixed-method design for a observational survey with the intent to gather data relating to the participants enjoyment
and understanding of the program, as well as demographic data, in order to determine the effectiveness of the program. This type of design has been shown to have validity in the literature (Greene, Caracelli, & Graham, 1989). No control group was used due to resource limitations and feasibility concerns as provided by some of the stakeholders. Additionally, no pre-test was used due to resource limitations. As previous data on the attachment relationships and behaviors in Sierra Leone caregivers is nonexistent, the decision was made to assess the data gathered against benchmarks that were set by the donors.

Resource and Logistical Considerations

As has been noted above, resources available are extremely scarce. The evaluation is being carried out by one person, this author. Additionally, data collection is dependent on the reliability and consistency of the two trainers for the program. There is also no way to directly contact these trainers, as this author has to relay instructions through a third-party (donors). Furthermore, accurate data collection is dependent upon the timeliness of transportation of survey methods from Bo, Sierra Leone to Orono, Maine. These considerations present themselves as potential compromises to the design of the evaluation as a whole.

Evaluation Standards

With those considerations noted, it is my belief that the data collected will be useful and should be feasible to collect. All data will be kept confidential and will be run through a third party (This author’s thesis advisor; Dr. Julie DellaMattera) to eliminate
names collected to preserve anonymity for participants over multiple questionnaires. Additionally, Institutional Review Board (IRB) approval was sought and obtained for the methods used.

Step 4: Gathering Credible Evidence

Indicators and Benchmarks

In order to answer the evaluation questions, they first need to be operationalized. For each question, a measurable indicator was developed so that the questions could be measured based on the survey results. Additionally, for each question a standard for achievement, or benchmark, was developed so that the answer could be properly and fairly evaluated based on the expectations of the program. All the benchmarks were developed with considerable input from the primary stakeholders, the donors. The evaluation questions are listed below.

1. Is the participants demographic data representative of a sample population?

   This question will be answered using the participant’s demographic data that is gathered from the demographic questionnaire and will be compared and contrasted with already existing data from the 2008 Sierra Leone Demographic and Health Survey. The benchmark for achievement for this question will be if the demographic questionnaire (refer to appendix B, question 6) household size is within one standard deviation of national survey household size.²

² Under reference entry: (Statistics Sierra Leone and ICF Macro, 2009)
2. How does the number of people who attended the program compare to the number invited?

This question will be answered by measuring the number of unique participants who completed the evaluative questionnaire (refer to appendix C). 65 families were invited to attend the program by the Child Rescue Center organization (Donors, personal communication, September 21, 2018). These families are all related (aunt, uncle, etc.) to the children who are being dispersed, and they have also worked with the Child Rescue Center before. So therefore, the attendance of 65 unique participants is the benchmark.

3. Are the trainers competent enough to carry out the trainings?

This question will be answered by participant data on whether the participants reflected back content through the evaluative questionnaire (refer to appendix C, question 1). It is assumed that if the trainers were competent, then the vast majority of participants would be able to reflect some content from the training back through the questionnaire. Therefore, the benchmark that will be used to determine competency is that 85% or greater of participants qualitative answers, from the program as a whole, will reflect content back from the specific training that they attended.

4. Did the participants understand the information in the program?

This question will be answered by participant data from the evaluative questionnaire (refer to appendix C, questions 2, 3, and 4). The benchmark for this
question is that the average score on the quantitative evaluation questions listed is greater than 4.0 out of 5. All of these questions will be using a Likert-style scale [Strongly Disagree(1) - Strongly Agree(5)].

5. Was the training enjoyable for the participants?

   This question will be answered by using participant data from the evaluative questionnaire (refer to appendix C, questions 6 and 7). The benchmark for this question will be that the average score on the quantitative question #6 will be greater than 4.0 out of 5 and that less than 5% of participants have responses critical of trainers from qualitative question #7. This question will be using a Likert-style scale [Strongly Disagree(1) - Strongly Agree(5)].

6. Have participants gone to all of the trainings that have currently been completed?

   This question will be answered by tracking participants as they attend the trainings using the evaluative questionnaire as identification. Participants will be tracked to see if they drop out of the trainings or if they join later trainings. The benchmark for this question will be that at least 75% of participants have gone to each subsequent training after their first attended training.

7. Do the participants express the intention to change their beliefs or behaviors?

   This question will be answered by using participant data from the evaluative questionnaire (refer to appendix C, question 1). The benchmark for this
question will be that 65% or greater of participants state at least one thing that they have or will change at home. It should be noted than in order to qualify for this indicator, a participant will have to not only reflect information from the training, but also stipulate that they intend to use it at their home as a course of action.

8. Was any change in beliefs or behaviors possibly caused due to other trainings?

This question will be answered by using participant data from the demographic questionnaire (refer to appendix B, question 8). The data gathered will be analyzed to see if any external trainings could have had an effect on the results of the program. The benchmark for this question will be that it is determined that the other trainings did not confound the results.

Data Collection

This survey consisted of two questionnaires. The first questionnaire (appendix B) asked qualitative and quantitative questions that asked about demographic data and was given to participants only once when they attended the trainings for the first time. The second questionnaire (appendix C) used self-report questions that were designed to gather both quantitative and qualitative data about the program’s six training and was given to participants after each training was completed. This data was then collected by the two trainers and sent, by a combination of mail and human transport, to this author’s advisor in Orono, Maine. The advisor then deidentified the data, as per IRB instructions.
The first questionnaire asks participants if they work outside the home, what job they have if they do so, what program at the Child Rescue Center are their children enrolled at, how many children are they caring for, the ages of those aforementioned children, and any other trainings they may have had.

The second questionnaire asks participants which training they have completed, and to list three useful or interesting ideas from the training that they will immediately use at home, and two suggestions for improving the training. The word ‘lesson’ was used in place of training on the questionnaires because it was felt that ‘lesson’ was easier to understand for a limited-English speaking population. They were also asked to rate a few questions from 1 (strongly disagree) to 5 (strongly agree). Those questions were: Q2: *I have learned a lot of new knowledge about the ideas presented in this lesson*, Q3: *I feel confident about using the knowledge I learned in this lesson*, Q4: *I think that the activities were relevant and helped me gain a clear understanding of the ideas in this lesson*, Q5: *I enjoyed the group activity*, Q6: *I feel this lesson was worthwhile and useful overall*.

The survey mainly relies on self-reported, primary data. Although secondary data will be used for generalizability purposes.

It should be noted that the questionnaires that were used were not completely of this author’s own design. They were a product of the donors who wanted some very basic follow-up information about the program, not necessarily a thorough evaluation. It has been attempted to adapt the questionnaires and use them for the purpose of this program evaluation. Unfortunately, the weaknesses that are presented by these questionnaires, which this author does readily admit exist, were unable to be corrected due to financial, time, and logistical constraints.
Step 5: Justifying and Drawing Conclusions

Data Results

Data was collected from two batches of survey data. The first batch (B1) included the first two trainings and the second batch (B2) included the third and fourth trainings. At the time of this evaluation the fifth and sixth trainings had yet to be completed. Contrary to the instructions given to the trainers, whom distributed and collected the survey, evaluative questionnaires were handed out only after the second and fourth trainings, instead of all the trainings individually. Additionally, not all participants who filled out an evaluative questionnaire also filled out a demographic questionnaire, which limited demographic questionnaire collection. These issues should be noted when reading the results and will be expounded on in the discussion and limitation section of this report.

1. Is the participants demographic data representative of a sample population?

   The average size of a household for Sierra Leone nationally, according to the 2008 Sierra Leone Demographic and Health Survey, is 5.9 people. There were 43 total responses to the demographic questionnaire, which had a mean of 5.95 people with a standard deviation of 1.7 and a variance of 2.88.³

2. How does the number of people who attended the program compare to the number invited?

³Note: For calculating the household size for the sample population, it was assumed that there was only one adult in each household, as it was impossible to determine if it was a single-parent or two-parent home.
The total number of evaluative questionnaires that were filled out was 110. Of these 67 were unique, so therefore there were 67 unique participants who attended the trainings, and 65 were invited.

3. Are the trainers competent enough to carry out the trainings?

Overall, 96 out of the 110 total responses (87.3%) reflected back content from the trainings. In the first batch, trainings 1 and 2, 45 out of the 46 total responses (97.8%) reflected content back. In the second batch, trainings 3 and 4, 51 out of the 64 total responses (79.6%) reflected content back.

4. Did the participants understand the information in the program?

Overall, question 2 (I have learned a lot of new knowledge about the ideas presented in this lesson) had 107 total responses (97.3% response rate), with the mean score being 4.59 with a standard deviation of .8 and a variance of .63 on a 1-5 scale (Strongly Disagree-Strongly Agree). Question 3 (I feel confident about using the knowledge I learned in this lesson) had 109 total responses (99.1% response rate), with the mean score being 4.48 with a standard deviation of .71 and a variance of .51 on a 1-5 scale (Strongly Disagree-Strongly Agree). Question 4 (I think that the activities were relevant and helped me gain a clear understanding of the ideas in this lesson) had 107 total responses (97.3% response rate), with the mean score being 4.36 with a standard deviation of .69 and a variance of .47 on a 1-5 scale (Strongly disagree-Strongly agree).
For the first batch of data, trainings 1 and 2, question 2 had 44 total responses (95.7% response rate), with the mean score being 4.59 with a standard deviation of .61 and a variance of .38. Question 3 had 46 total responses (100% response rate), with the mean score being 4.37 with a standard deviation of .53 and a variance of .28. Question 4 had 45 total responses (97.8% response rate), with the mean score being 4.27 with a standard deviation of .49 and a variance of .24.

For the second batch of data, trainings 3 and 4, question 2 had 63 total responses (98.4% response rate), with the mean score being 4.59 with a standard deviation of .9 and a variance of .81. Question 3 had 63 total responses (98.4% response rate), with the mean score being 4.56 with a standard deviation of .81 and a variance of .66. Question 4 had 62 total responses (96.9% response rate), with the mean score being 4.44 with a standard deviation of .80 and a variance of .63.

5. Was the training enjoyable for the participants?

Overall, quantitative question 6 (*I feel this lesson was worthwhile and useful overall*) had 107 total responses (97.3% response rate) with the mean score being 4.45 with a standard deviation of .79 and a variance of .62 on a 1-5 scale (Strongly Disagree-Strongly Agree).

For the first batch of data, trainings 1 and 2, question 6 had 45 total responses (97.8% response rate) with the mean score being 4.42 with a standard deviation of .54 and a variance of .29.
For the second batch of data, trainings 3 and 4, question 6 had 62 total responses (96.9% response rate) with the mean score being 4.47 with a standard deviation of .93 and a variance of .86.

There were no mentions of criticism of the trainers in any of the questionnaires.

6. Have participants gone to all of the trainings that have currently been completed?

For the first batch, there were 45 unique responses (To explain the discrepancy between having 46 total responses, but only 45 unique responses, allow me to briefly elaborate. Two evaluative questionnaires had the same participant name, but different answers to the questions. Therefore, they were both counted as separate responses in the first batch of data but were considered to be one unique participant for the purposes of this evaluation).

For the second batch, there were 64 total responses, of which 22 were unique. 42 (93.3%) of the participants who attended the first two trainings also attended the third and fourth. Furthermore, 22 (32.8%) of the participants for the third and fourth training batch were new, with only a 5.51%(n=3) attrition rate from the first batch to the second batch.

7. Do the participants express the intention to change their beliefs or behaviors?

Overall, 50 out of the 110 total responses (45.5%) reflected content back from the trainings and stipulated that they intended to use it at their home. In the first batch, trainings 1 and 2, 21 out of the 46 total responses (45.7%) reflected
content back from the trainings and stipulated that they intended to use it at their home. In the second batch, trainings 3 and 4, 29 out of the 64 total responses (45.3%) reflected content back from the trainings and stipulated that they intended to use it at their home.

8. Was any change in beliefs or behaviors possibly caused due to other trainings?

A two-tailed T-test was performed on the quantitative questions 2,3,4, and 6 using the participants who stated that they had received additional training prior to this program and those participants who stated that they had not received additional training prior to this program. There were 28 unique participants who filled out a demographic questionnaire, 10 of which indicated they had previous training and 18 of which indicated they hadn’t. The participants were grouped according.

Data was taken from both batches of evaluative questionnaires. In batch one, there were a total of 29 responses, due to the aforementioned evaluative questionnaire that was doubled. In batch 2, there were a total of 26 responses, due to two participants dropping out (one from each training/no training group) and not having any surveys that were doubled. Therefore, there were 55 total responses using both batches, with 35 of those responses indicating that they have had no additional training and 20 indicating that they have had additional training. No significant differences were found between the groups on any of the quantitative questions previously stated.

The data can be found below in table 3.1.
Table 3.1 - Mean Level Group Differences by Prior Training Status

<table>
<thead>
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<th>Quantitative Question #</th>
<th>t</th>
<th>p</th>
<th>Training M(SD) $n=20$</th>
<th>No Training M(SD) $n=35$</th>
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<td></td>
<td></td>
</tr>
<tr>
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<td>0.13</td>
<td>.89</td>
<td>4.45(.92)</td>
<td>4.48(.89)</td>
</tr>
<tr>
<td>3</td>
<td>1.04</td>
<td>.31</td>
<td>4.30(.95)</td>
<td>4.51(.55)</td>
</tr>
<tr>
<td>4</td>
<td>1.19</td>
<td>.24</td>
<td>4.50(.50)</td>
<td>4.26(.78)</td>
</tr>
<tr>
<td>6</td>
<td>0.82</td>
<td>.42</td>
<td>4.53(.94)</td>
<td>4.32(.79)</td>
</tr>
</tbody>
</table>

Discussion and Limitations

1. Is the participants demographic data representative of a sample population?

   Given that the mean household size for the sample was 4.95 and the mean household size according to the national survey was 4.9. The benchmark for achievement for this question was that the sample would fall within one standard deviation of 4.9, and since it did, it is therefore, when taken at face value, it is believed that this was a representative sample.

   Although an unfortunate limitation was that the demographic questionnaire did not ask the participant how many people were in their household, but instead asked how many children that they cared for. This made it difficult to ascertain whether there were two parents in the household or just one,
so in an attempt to keep the data consistent, it was assumed that just there was just one parent. Future evaluations of this program or similar programs should include specific questions asked to participants regarding household size.

Additionally, only one measure was used to determine demographic data. This, along with the fact that the one measure had its own faults, leads this author to conclude that this benchmark’s results were inconclusive.

2. How does the number of people who attended the program compare to the number invited?

According to information from the primary stakeholders, there were about 65 families eligible in the area to attend this program and its trainings. Results from the evaluative questionnaire indicated that 67 unique participants attended at least one of the trainings. Therefore, this benchmark of 65 unique participants was considered to be achieved, when taken at face value due to several limitations.

However, there were a couple of assumptions that needed to be made to reach this conclusion, which could be seen as limitations. First, it was assumed, but it is possible that not all of the 67 unique participants were of different families. While an attempt was made to match last names, the legibility of the names on the questionnaires was not ideal and it is possible that cultural norms played a role in a participant either not listing their full name or instead listing their maiden name. Secondly, it was assumed that all of the unique participants were adults. Neither the demographic nor the evaluative questionnaire asked the participants age, so it is possible that an older child took one of the questionnaires.
Future evaluations should make sure that the questionnaires used to collect data ask the age and specify first and family name, so that any possible confusion could be avoided.

Since it is possible that these limitations compromised the accurate collection of data, this author concludes that this benchmark’s results are inconclusive.

3. Are the trainers competent enough to carry out the trainings?

The trainer’s competency was to be judged by how well the participants reflected content back from the trainings. In the first batch of data, from the first and second trainings, 97.8% (n=45) of participants reflected content back. Whereas in the second batch of data, the third and fourth trainings, 79.6% (n=51) of participants reflected content back. Overall, 87.5% (n=96) of participants reflected content back, which was above this question’s benchmark of 85%.

Therefore, it can be said that this benchmark was achieved, at face value.

However, an interesting note was the seeming drop off between the first batch of data and the second batch in terms of content being reflected back. This is believed to be due to a couple of reasons. First, it is possible that this is just a result of the number of people attending the training going up, from 46 in the first batch to 64 in the second batch. Secondly, it is possible that the training just got harder for the participants to understand. It was planned for the first two trainings to be of the easier, introductory type, and then for the subsequent training to get more challenging and deal with more complex concepts, such as triggers and
resilience. Future evaluations should seek to control for the number of participants in order to eliminate variation due to sample size between data batches.

In the view of this author, this limitation did not significantly impact the result of the data for this benchmark. Because the benchmark stated that this 85% mark was for the program overall and not individual trainings, the benchmark is still considered achieved.

4. Did the participants understand the information in the program?

The benchmark for this evaluation question was that for quantitative questions 2, 3, and 4 (Q2: I have learned a lot of new knowledge about the ideas presented in this lesson, Q3: I feel confident about using the knowledge I learned in this lesson, and Q4: I think that the activities were relevant and helped me gain a clear understanding of the ideas in this lesson), the mean score would be a 4.0 or greater. Participants were asked to respond to the statements above using a Likert-style scale (strongly disagree-disagree-neutral-agree-strongly agree) which were then coded into their corresponding numerical values (1-2-3-4-5, respectively). The mean average for question 2 through both data batches was 4.59, which was consistent throughout each batch individually (B1: 4.59, B2: 4.59). For question 3, the mean average overall was 4.48, with slight differences between the first batch (4.37) and the second batch (4.56) of data. For question 4, the mean average overall was 4.36, with slight differences between the first batch (4.27) and the second batch (4.44) of data. Since all of these means are over the stated benchmark of 4.0, it can be said the participants did understand the
information in the program, when considering at face value. As for why the means on question 3 and 4 were higher in the second batch then the first batch, it is believed it has to do with the expanded participant population, which helped minimize outliers on those two questions.

One major limitation with this benchmark is the language barrier. As previously stated in the literature review section on Sierra Leone, under 50% of the population can read and write English, despite it being the official language. No test of English proficiency was carried out on the participants, so their English comprehension level is unknown, which may impact the results. Therefore, given this limitation and uncertainty, this author concludes that this benchmark’s results are inconclusive.

5. Was the training enjoyable for the participants?

The benchmark for this evaluation question was that for quantitative question 6 (I feel this lesson was worthwhile and useful overall), the mean score would be 4.0 or greater. Participants were asked to respond to the statement above using a Likert-style scale (strongly disagree-disagree-neutral-agree-strongly agree) which was then coded into their corresponding numerical values (1-2-3-4-5, respectively). The mean score overall was 4.45, with batch 1 (4.42) being slightly lower than batch 2 (4.47). This small difference is believed to be due to the increase in the number of participants that were seen from the first batch of data to the second. Additionally, there was no reported criticism of the trainers.
Therefore, it can be concluded at face value, that the training was enjoyable for the participants.

One limitation to keep in mind is that the question on the evaluative questionnaire was not worded well to ascertain the participants enjoyment of the trainings. A better worded, more informative, question could have been used to more directly discover their enjoyment levels. Future evaluations should include a more strictly worded question to truly get at their enjoyment.

Additionally, the lack of criticism should be understood through a lens of context and culture. In many cultures, criticism is discouraged from being made publicly because it could be a seen as a sign of disrespect. Furthermore, these participants are receiving these trainings for free, and they may be concerned that if they criticize the trainers, then they will not be invited to future trainings, even though this would not be the case. Future evaluations should look to specifically and enthusiastically convey to the participants that if they were to criticize the trainers, it would be kept confidential and would not, in any way, jeopardize their eligibility for these trainings. Moreover, future research should be carried out to better understand the cultural nuances of Sierra Leoneans of which the literature was practically nonexistent in regard to their behaviors using criticism.

Due to these two limitations, this benchmark’s data is not fully reliable, and the results should be considered inconclusive.

6. Have participants gone to all of the trainings that have currently been completed?
All in all, 45 participants showed up to the first two trainings (B1) and then 64 participants showed up to the third and fourth training (B2). Of these 64 participants, 42 of them had also gone to the first two trainings. With 22 new participants showing up and only 3 participants dropping out, the attrition rate was 5.51%. The benchmark for achievement of this evaluation question was that at least 75% of participants would continue going to the trainings. With only 3 participants dropping out from the first batch, that meant that 93.3% of participants ($n=42$) continued on with the trainings. Therefore, this benchmark was achieved, when considered at face value.

However, there are some limitations to note. First, keeping track of the participants was extremely difficult. It was difficult to determine that someone from B1 was someone in B2 as names were often illegible. Additionally, participants would occasionally change up their name, and by that it is meant that they would use their middle name as their last name when before they used just their last name. The lack of consistency made following the participants almost impossible. Therefore, some assumptions and educated guesses had to be made when assigning participants identities and this should be kept in mind. Future evaluations should make sure that there is a much more consistent identifying system in place. Additionally, the program staff should be trained to be more stringent in requiring the participants to list their full, legal names.

Given the uncertainties surrounding this benchmark’s data, it should be considered inconclusive.
7. Do the participants express the intention to change their beliefs or behaviors?

The benchmark for this evaluation question was that at least 65% of responses stated at least one thing that they would or have changed at home. The results showed that only 45.5% ($n=50$) of the responses overall stipulated this. Therefore, this benchmark was not achieved.

It should be noted that there were several limitations to consider with this question. First, the qualitative question was not worded in a specific enough way to gather their intent. The way it was worded, “Please list three useful or interesting ideas that you will use immediately at home” led participants to just list one-word answers from the training, such as ‘attunement’ or ‘talking.’ While this could have been interpreted as they would do more talking with their child at home, there was not an explicitly stated plan or course of action that they would undertake, so it was not considered to have been achieved. Future evaluations should create a question that specifically asks how the participant would use the information they learned in their home.

Additionally, another limitation to consider is the language barrier. Perhaps the reason for the short answers to this question was simply due to the participants not being very literate regarding the English language. While it is possible that a more strictly worded question would have proved better results, it is also possible that the participants who wrote or dictated these answers, that were not specific enough to succeed for the qualifier that there be a plan, simply did not have a firm enough grasp on the language to provide detail. This should be kept in mind and explored for future research.
8. Was any change in beliefs or behaviors possibly caused due to other trainings?

The benchmark for this evaluation question was that in order for it to succeed, it must be determined that additional trainings did not have an effect on the results of the program. The data was collected from 55 total responses to the demographic questionnaire that could be matched with a corresponding evaluative questionnaire (B1: n=29; B2: n=26). There were 20 participants who stated they had received other training, and 35 participants who stated that they had not received other training. A two-tailed T-test was performed and found that there were no significant differences between the groups. Therefore, it was determined that previous trainings did not have a confounding impact on the results, so this benchmark was achieved, at face value. There should, however, be a few limitations to note.

The sample size was considerably lower for this evaluation question due to a couple of reasons. First, there were fewer demographic questionnaires filled out than evaluative questionnaires. While the reasons for this are not clear, it appears that any participants who were new and joined during the second batch of data collection were not given the demographic questionnaire. This limits all of the data for the demographic questionnaire to those participants in the first batch. Additionally, 20 of the demographic questionnaires could not be matched to a corresponding evaluative questionnaire and had to be withheld from analysis for this evaluation question. As has been mentioned previously, it is believed that this is due to names not being consistently recorded correctly. This could be error by the trainers or due to the influence of cultural norms and many last names. Future
evaluations should replicate this with larger and more consistent groups, to truly test the implications.

Additionally, it should be noted that the trainings reported by participants varied wildly. Some participants had attended talks by experts at local universities about parenting while others received some training from church groups. Due to the small sample size, all of these were grouped under the umbrella term of ‘other trainings.’ Future evaluations should look at whether there were any differences between these groups based on previous training types.

Despite these limitations, it is in this author’s judgement that the data collected for this benchmark was reliable, and so therefore it is considered achieved.

**Additional Limitations**

A large limitation that should be kept in mind as this evaluation is being read is the validity of the program as a whole. As most of the participants did not speak English fluently, the validity of using multiple trainings that are written in English should be questioned. While the results of this evaluation seem to indicate that, on a whole, the participants enjoyed and learned from the trainings, future evaluations should consider having a translation in Krio, the local predominant language of Sierra Leone.

Additionally, it should be noted and considered, at least from a philosophical standpoint, about whether this program was presumptuous. It was mainly developed by three Caucasian, middle class, American college students (Of which this author is one), only then to be approved and distributed to Sierra Leone by two Caucasian, upper middle
class, Christian donors. These people together are the quintessential WEIRD (Western, Educated, Industrialized, Rich, and Democratic) demographic. So therefore, is it indeed presumptuous to deliver a program that was created by these WEIRD people, developed using attachment theory research that was mainly comprised of information about WEIRD populations, to a decidedly non-WEIRD population? It was certainly not the intent of this program to act as a sort of post-imperialistic incursion on the culture and domestic practices of Sierra Leoneans. However, future research should be carried out to determine whether a program such as this, so steeped in Western norms and biases, could have any unintended consequences on the cultural development of Sierra Leone and similar countries.

Finally, it should be noted that the evaluative questionnaires were not given out after each individual training, per instructions, but were instead only given out after the second and fourth training. This resulted in only having two batches of data instead of four.

Step 6: Use of Evaluation Findings

Program Recommendations

Overall, it was considered that this program tentatively achieved seven out of eight benchmarks at face value, so therefore it can be said that this program has shown some promise. However, due to the major limitations that affected several of the benchmarks used for this evaluation, it can only be considered that two benchmarks (#3 & #8) were achieved, one (#7) was not achieved, and five (#1, #2, #4, #5, #6) were deemed inconclusive due to validity and reliability concerns. Of note were that previous
trainings were not believed to have significantly interfered with the results of this program and the trainers were believed to be competent, due to the consistency with which participants reflected data back. Despite the program being believed to show promise, further evaluation is needed to determine this program’s true impact. As expected, there are several recommendations to make that could improve this program substantially.

First, it is recommended that the record-keeping and ability to consistently track participants be improved on the demographic and evaluative questionnaires. If this program wishes to truly measure its impact, the only way to do that is to keep better track of who is attending the trainings. On the demographic questionnaires, basic contact information should be taken down, so as to better match the participants from training to training. Additionally, they should be told to use their full legal name, so nicknames would not muddy the identifying information.

Secondly, it is recommended that improvements be made to ensure that the questionnaires are handed out consistently to the participants after each training. This would ensure that each individual training can be measured for its impact. Additionally, it is recommended to combine the demographic and evaluative questionnaires into one. This will ensure that there are no discrepancies between the number of demographic questionnaires and the number of evaluative questionnaires. Finally, it is recommended to conduct a pre-test and post-test questionnaire, after the program, to better measure the impact.

Thirdly, it is recommended that the wording on the questionnaires needs to be revisited. Demographic questionnaires should be widened in scope to include more
measures such as age, sex, household size, and level of education. Additionally, the evaluative questionnaires should include more specifically worded questions to truly ascertain the impact of this program.

Fourthly, it is recommended that the participants be given handout materials to bring back home with them so they can reference as needed. Many participants reported that they wished to have copies of the trainings with them at their own home. This would allow the material covered to be better put into action at their home, as they would be able to constantly reference the trainings, instead of trying to memorize them at each monthly meeting.

Finally, it is recommended that it should be considered to translate the program into the language of Krio in order to have the participants understand the trainings better. Even though English is the official language of Sierra Leone, many Sierra Leoneans do not speak it well and Krio would be a good alternative because it is spoken by such a wide proportion of the population.

**Conflict of Interest Disclosure Statement**

This author would like to acknowledge that they helped create the Attachment Theory Program that this thesis has evaluated. However, this author does not seek and will not be able to profit from any future success this program may have. Therefore, this author discloses this potential conflict of interest.
Reference List


Esch, Anya K.. (2013). Disorganized Attachment and Trauma in Children. Retrieved from Sophia, the St. Catherine University repository website: https://sophia.stkate.edu/msw_papers/175


APPENDICES
APPENDIX A: LETTER OF IRB APPROVAL

—— Forwarded message ——
From: Gayle Jones <gayle.jones@marwa.edu>
Date: Wed, Sep 19, 2018 at 15:44 AM
Subject: Re: IRB
To: Julia Delaflora <julia.delaflora@marwa.edu>

As long as he is working with a completely de-identified dataset, the study does not fit the definition of "human subject," so no IRB review required! Just be sure it's de-identified (sometimes info other than names can be identified?)

Gayle
APPENDIX B: “DEMOGRAPHIC QUESTIONNAIRE”

Participant Information (only at module 1)

1. Date: ________________________________________________

2. Name: ______________________________________________

3. Do you work outside the home? __________________________

4. If yes, what do you do? __________________________________

5. In what program are your children enrolled? ________________

6. How many children are you caring for in your home? ___________

7. List the ages of the children you are caring for: ________________

8. List any other training, workshops, or schooling (with dates) you have had, which helps you in your role as a parent / caregiver:

   _______________________________________________________

   _______________________________________________________

   _______________________________________________________

   _______________________________________________________

   _______________________________________________________

   _______________________________________________________

   _______________________________________________________
APPENDIX C: “EVALUATIVE QUESTIONNAIRE”

Attachment Theory Workshop Module Evaluation

- Date: ____________  - Name: ________________________________

Please circle the Attachment Theory Workshop module you just completed.

Module 1  Module 2  Module 3  Module 4  Module 5  Module 6

1. Please list three useful or interesting ideas that you will use immediately at home.
   1) ______________________________________________________________________
   2) ______________________________________________________________________
   3) ______________________________________________________________________

2. I have learned a lot of new knowledge about the ideas presented in this module. Circle one.
   1-strongly disagree  2-disagree  3-neutral  4-agree  5-strongly agree

3. I feel confident about using the knowledge I learned in this module. Circle one.
   1-strongly disagree  2-disagree  3-neutral  4-agree  5-strongly agree

4. I think the activities were relevant and helped me gain a clear understanding of the ideas in this module. Circle one.
   1-strongly disagree  2-disagree  3-neutral  4-agree  5-strongly agree

5. I enjoyed the group activity. Circle one OR skip if you did not do any group activity.
   1-strongly disagree  2-disagree  3-neutral  4-agree  5-strongly agree

6. Overall, I feel this module was worthwhile and useful. Circle one.
   1-strongly disagree  2-disagree  3-neutral  4-agree  5-strongly agree

7. Please list two suggestions for improving this module:
   1) ______________________________________________________________________
   2) ______________________________________________________________________

Please feel free to write any other comments or suggestions on the back.
APPENDIX D: “TRAININGS USED IN ATTACHMENT THEORY PROGRAM”

Attachment Theory Workshop and Self-Paced Refresher Training

Forming Healthy Relationships Between Caregivers and Children.

Created with and for parents, guardians, and caregivers of children and youth in Sierra Leone.

Module 1: Introduction to Attachment Theory and Secure Attachment

What is Attachment?

- Attachment is a strong emotional bond between child and caregiver.
- Caregivers should try to have secure attachment with each child for whom they care.
What is secure attachment?

- Secure attachment is when a child feels safe, secure, and cared for by their caregiver.
- When a child is securely attached, they feel comfortable around their caregiver.
- The child knows their needs will be met by their caregiver.
- The child and caregiver can correctly understand each other’s body language.

What does secure attachment look like?

- Your child wants to be physically close to you.
- Your child feels happy and comforted when you return to them.

Activity 1: Identifying Secure Attachment

Look at the following photos of parents with their children.
Of these photos, which children seem like they have secure attachment? How can you tell?
Activity 1: Identifying Secure Attachment

Module 1 - Photo A - Slide 25

Here are the photos again with explanations for which children appear to have secure attachment with their parents.

Activity 1: Identifying Secure Attachment

Module 1 - Photo B - Slide 26

Children with secure attachment tend to pull away or resist when their parents are located outside of the room.

Activity 1: Identifying Secure Attachment

Module 1 - Photo C - Slide 27

Parents who spend time together will find that their child tends to have stronger secure attachment.

Activity 1: Identifying Secure Attachment

Module 1 - Photo D - Slide 28

Parents who spend time together will find that their child tends to have stronger secure attachment.

Activity 1: Identifying Secure Attachment

Module 1 - Photo E - Slide 29

Children who appear to be and always resist the idea of being left alone with the following signs of secure attachment.

Activity 1: Identifying Secure Attachment

Module 1 - Photo F - Slide 30

Parents who spend time together will find that their child tends to have stronger secure attachment.
How can I create secure attachment with my children?

What is your role with each child?
- As a parent or guardian you are the protector, provider, and guide for the child(ren) for whom you care.
- You are there to make the child(ren) feel safe and loved. When children know they have a consistent caregiver, they are able to explore and learn about the world while feeling secure.

How do we create safety for our children?
- A child's understanding of safety may be different from yours.
  - Ask them what makes them feel safe?
  - Ask them what makes them feel unsafe?
- Provide them with two or three choices.
  - Example: I need your help. Would you like to sweep, go get water, or take care of your little brother?
- Giving choices shows children that you trust them.

What else can we do to create safety?
- Set limits.
  - Structure creates stability.
  - “There is only so much with which I can help you. However, I will try my best to always be there for you.”
- Create routines.
  - Be predictable.
  - Be consistent.

When in doubt, use the Three T’s:

**TALK** - Each day, encourage your child to talk about their life. “Tell me something new you learned today. Tell me about the favorite part of your day. Please tell me how you were kind today.”

**TOUCH** - Children love physical contact. Hugs, soft touches, like rubbing their backs, putting them on the shoulder, or holding hands, can help children feel emotionally close to you.

**TIME** - Make sure to put aside some time each day to spend with each of your individual children. While family time is very important, make sure you have a one on one connection with each child - they love individual attention.

Activity 2: Remember the Three T’s

Talk with a person next to you:
- What are some important memories you have with your own parents or caregivers?
- Do you remember them practicing talk, touch, and time?
- If yes, did you feel closer to your parents because of this?

Thank you for participating in today’s lesson!
You have learned how to help your children form secure attachments with you.

Produced by:

[Logos and text for Servant Heart Research Collaborative and Honors College at the University of Maine]
Thank you to our consultants in Sierra Leone:

- Rosa Satta
- James Hall
- Deborah Ransell
- Joseph Juma
- Innocent Baidone
- Henry Ripple
- Sarit Fondron Chat
- Martha Abu
- Emmanuela Lyman
- David Muna
- Haneef Hadey

Module 2: Impacts of Trauma

What is Trauma?

- Is an experience or event that causes extreme stress and loss of control.
- Can deeply impact development.
- Can be a one-time event or it can occur repeatedly over time.
- Affects everyone differently, and it can come from a variety of sources.
Trauma Disrupts
- Attachment
- Learning
- Social skills
- Attention
- Sense of Safety

Activity 1: Sources of Trauma
Trauma can come from a variety of sources.

Take a look at each of the following photos and discuss with a partner next to you how your seeing or experiencing the event would make you feel.

Activity 1: Sources of Trauma
- Political Refugees
- Natural Disasters such as Mudslides
- Disease
- Famine and Drought
- Violence in the Family
- Loss of a Loved One
Activity 5. Sources of Trauma

Sexual Assault or Abuse

Activity 5. Sources of Trauma

Bullying

Activity 5. Sources of Trauma

Next, take a second look at the photos. Imagine you are a child and think about how seeing or experiencing the event would make you feel if you were that child. How could these events be a cause of trauma for a child?

Activity 5. Sources of Trauma

Natural Disasters Such as Mudslides

Activity 5. Sources of Trauma

Political Refugees

Activity 5. Sources of Trauma

Disease

Activity 5. Sources of Trauma

Famine and Drought

Activity 5. Sources of Trauma

Violence in the Family
Trauma can come from many sources.
You do not need to understand the cause of trauma to identify and care for a child who has experienced trauma.

What might trauma look like in your child?
A child who has experienced trauma might:
- Have difficulty concentrating or paying attention.
- Be withdrawn and quiet.
- Be aggressive, especially towards other children.
- Be manipulative and deceitful, frequently lying.
- Act out or have a lot of energy.
- Appear or feel sad frequently.

Understanding the Limitations of Children Who Have Experienced Trauma
- Children can appear to be extra sensitive and have difficulty relaxing.
- Children can have trouble effectively communicating what they want and need.
- Children can feel like outsiders with their age groups.

Children who have experienced trauma may be more sensitive than other children. Therefore they need to hear more encouragement and receive more contact than their peers.

Children who have experienced trauma need 10 times more compliments than negative remarks.

This means that for every correction a child hears from you, they should hear 10 positive comments or compliments:
The encouragement children hear should be:
- Real
- Specific
- Constant

Children are more likely to repeat a behavior if they receive specific, not general, positive feedback afterwards.

Instead of saying “Good job!” Try saying, “Thank you for coming over when I called your name.”

Here are a few helpful examples:

Activity 2: Specific Compliments

For this next activity, turn to your friends or neighbors that are here. Thank them for something that they do. Practice making sure that your compliments are specific.

Watch them smile!

Thank you for participating in today’s lesson!

You make your children’s day better with each encouragement or compliment you give.

You are their hero!

Produced by:

Servant Heart Research Collaborative

The University of Maine

Honors College

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Special thanks to:
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- Nancy Slevin
- Andrea Slevin
- Kathy Morel
- Phoebe
- Unsplash
- OpenClipart

Thank you to our consultants in Sierra Leone:
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Module 3: Understanding Attunement

What is attunement?

Attunement is the ability to recognize and react to another person’s emotional state or needs.

One part of recognizing and reacting appropriately to a child’s emotional state or needs is understanding their personal triggers.

What is a trigger?

- A trigger can be an experience that causes certain feelings based on memories.
- A trigger could be a sight, sound, smell, taste, or even a feeling or emotion.
- Triggers are personal, and different for each person.
- Triggers do not always have to cause a severe/bad reaction. For example, when you hear a song on the radio from a long ago memory, it could trigger happy, nostalgic feelings.

Responses to Triggers

- A child’s response to a trigger that causes a severe reaction is similar to them being in a dangerous situation.

This response could include:

- Crying
- Being extremely quiet or moody
- Feeling worried
- Acting detached or distant
- Or something entirely different - trigger responses are different for each child.
Activity 1: Understanding How Your Body Reacts

Close your eyes and think about a time that you felt very upset. How did it feel?
- Did you feel like your heart was in your chest?
- Did your tummy feel tight?
- Did you feel heat all over?
- Did you feel like your heart was pounding in your chest?
- Did your breaths feel faster than normal?
- Did you know what caused you to become upset?

Talk with someone next to you about how your body reacted one time when you were very upset. Then let them tell you about theirs.

How to React to Triggers

- If you feel as though a child is experiencing a trigger that causes negative feelings, remind yourself to stay calm.
  - Take a deep breath.
  - Remember that all emotions are temporary - your child will feel better eventually.
- No matter what, the most important thing that you can do when your child is upset is to let him/her know that you are there for him/her and that you care about them.
  - If they are okay with it, hugs and back rubs are great comfort.

Activity 2: Helpful Alternatives

Turn and talk with a partner about a few activities that you could do with a child when he or she becomes upset.

What is one thing that calms you or makes you feel better when you become upset?
- Do you like to cry, sing, or pray?
- Does going for a walk help?
- Do you like to sit down and talk with someone?

How to React to Triggers

- If a child seems quiet and withdrawn, say to them: "You seem really upset, right now. Then do an activity to raise their energy level.
  - Playing a game, cooking together, or singing a song.
- If your child seems loud and weedy, say to them: "You seem really upset right now." Then do an activity to lower their energy.
  - Try listening to them, going for a slow walk together, or getting them a drink of water.

After a Trigger:

- As the child either calms down or brings their energy level up, make sure to encourage them and compliment them.
  - Remember that sometimes, a 'success' is just the child realizing that they are upset and that you are there with them.

Reflection

- Once the child is feeling better, take a few minutes to talk with them. Find out how they were feeling when they were triggered.
- As their caregiver, reflect with the child and help them learn what upset them. Then you will be better able to help them the next time they become upset.
Thank you for participating in today’s lesson on Attunement!

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- Noelia Mondal, University of Maine Honors, Senior Level Cultural Advisor

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  - Philia Jusuf
  - Nancy Sasin
  - Abdul Sairany
  - Polly Wood
  - Pasab
  - Unsplash
  - Openclipart

Thank you to our consultants in Sierra Leone:
- Boa Safa
- James Hoero
- Sabrina Kramnik
- Joseph Juras
- Imranu Bahram
- Henry Mabbe
- Sarah Kandhokon
- Mahlia Xu
- Duenwadi Lami
- David Hez
- Mahib Musaphie
- Mohamed Tabso
What is temperament?

Temperament is how a child generally feels and acts.

- Some children are naturally friendlier than others.
- Some children have an easier time with change.
- Some children spend more of their time relaxed than their peers do.

Temperament is a dominant quality with which we are born.

What is resiliency?

Resiliency, a noun, comes from the word resilient. Resilient is an adjective that means, recovering easily from shock, illness, or hardship.

Resiliency is a mental strength. It is the ability to recover from a difficult situation or trauma and become strong, healthy, and successful.

Do you know someone who manages to be happy and positive most days? It is likely that person is very resilient in the face of obstacles.
What does resiliency look like in children?

Children who are resilient may be relaxed.

Children who are resilient may be very smart.

Children who are resilient may have a positive attitude.

Children who are resilient may have an easy-going temperament.

Children who are resilient may use self-management strategies.

Activity 1: Identifying Resiliency

Take a look at each of the following images again. Now think about your own children. Do you see some of these same characteristics in your children's personalities and behaviors?
How can you, as a caregiver, help children build resilience?

- Be a role model.
- Be supportive.
- Care for their health - physical and mental.
- Create a calm and stable home.
- Teach your child self-management strategies.

Creating a Calm and Stable Home

The security of a calm and stable family, with a consistent routine, lessens stress in children. It allows them to develop independence and confidence. To help create a calm and stable home for your children, you can help your kids:

- Go to sleep and wake up at the same time every day.
- Eat meals with the family at the same time every day.
- Set aside particular times for play and for baths.

What is a self-management strategy?

- Self-management is your ability to take responsibility for your behavior and well-being.
- Self-management strategies are helpful, healthy ways to stay in control of your emotions.

Teaching Your Child Self-Management Strategies

- The goal of teaching self-management strategies to a child is to give them the ability to calm themselves in a difficult or stressful situation.
- Self-management strategies give a child the opportunity to think about their feelings, and why they are feeling them.
- The ability to use self-management strategies builds resiliency.
Activity 2: Self-Management Strategies

Take some time and think about how you have calmed down in difficult or stressful situations in the past. What self-management strategies did you use?

Now, find a partner and share your own top 3 self-management strategies.

Helpful self-management strategies to teach your children:

- **Take a break** - This is one of the simplest, but most useful, self-management strategies. It is always a good idea when a child is upset to suggest taking a break from whatever they are doing. Suggest an activity, or simply sit down together and rest for a moment.

- **Take deep breaths** - When your child feels upset, frustrated or anxious, a great way for them to calm down is for them to take a deep breath. Inhaling for about 4 seconds, holding it for 4 seconds, and then exhaling for 4 seconds. They should wait another few seconds and then repeat the exercise for a total of 5 to 7 times. Parents should do this breathing exercise with their children.

Activity 3: Breathing Exercise

As a group, practice the breathing exercise mentioned in the previous slide. Focus on calming your mind and body.

**Take a deep breath**

- Inhale through your nose for 4 seconds.
- Hold the breath for 4 seconds.
- Exhale slowly through your mouth for 4 seconds.
- Repeat this process 10 times in a row.

Thank you for participating in today’s lesson on Temperament and Childhood Resiliency!

---

Credits

- Dan Linnell, University of Maine Undergraduate Sociology; Sociology
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- Photos: Anna Lee, Rebecca King, Joseph Kim, Veronica Blackman, Merry Zeller, Shawn Kradisman, Marie Carlen, Emmaus Loria, David Mus, Michael Kauyans, Mohammed Nabi

Thank you to our consultants in Sierra Leone:
What is emotional regulation?

- Emotional comes from the word emotion.
- Emotions are feelings.
- Regulation comes from the word regulate.
- Regulate means to control.
- Emotional regulation is the ability to regulate or control your emotions.

Emotional regulation is when you are in control of:
- Your feelings and emotions.
- How you show your feelings and emotions to others.

What are the goals of emotional regulation?

- To help children identify and put into words the feelings that are behind their actions.
- To correct negative behaviors by replacing them with positive, healthy behaviors.
- To respond consistently to the child.

What should we know about working on emotional regulation with children?

- Learning emotional regulation is a process that takes time and lots of patience before children can successfully copy the skill.
- When speaking to a child who is upset or who may become upset easily, it is important to stay calm and use the principles of SLOW and LOW.

Activity 1: SLOW and LOW

Find a partner for the following activity:

One partner will role play a child and their reaction to losing their slippers. The other partner will role play a caregiver who is trying to talk with the child about what is wrong. The person role playing the caregiver should practice using the 9 principles of SLOW and LOW.
How do I teach my child how to regulate his or her emotions?

Regulating emotions is a skill that children need. Children learn how to regulate their emotions by being taught. One way children are taught to regulate their emotions is by watching how you regulate your own emotions. As a parent, be a good role model.

Emotional regulation strategies that you can teach to your children:

- **Emotional awareness**
  - What am I feeling?
  - Why do I feel this way?
- **Self-calming**
  - How can I calm myself down right now?
  - What can I do to make myself feel better?
- **Distraction**
  - How can I take my mind off this problem?
  - Can this issue wait for now?

Activity 2: Using Your Senses to Regulate Emotions

Students who have experienced trauma may feel anxious or become upset more easily than some of their peers. They might need extra help learning to calm down. There are different ways to do this.

Take a look at some ways for children to focus on their senses to distract themselves and calm down.

Self-calming - Use Your Five Senses

- **Touch**
  - Hold your hands over a leaf to see how it feels.
  - Rub a friend’s hair.
  - Hold hands with a friend.
- **Sight**
  - Go for a walk and look all around:
  - Look at clouds in the sky.
  - Look at the trees.
  - Look at buildings and vehicles.
  - Look at animals and people.

Self-calming - Use Your Five Senses

- **Smell**
  - Sit outside and breathe in the fresh air.
  - Smell some flowers.
  - Smell what people are cooking.
- **Taste**
  - Put a little salt on a clean finger and put it on your tongue.
  - Drink a cup of tea.
  - Eat a sweet.
- **Sound**
  - Listen to music.
  - Talk with a friend.
  - Go outside and listen carefully for the sounds of birds, the wind, vehicles, and more.

Activity 2: Using Your Senses to Regulate Emotions

What other activities could you practice to engage your senses?

Share your answers as a whole group.

Thank you for your hard work so far!
Take a few minutes to stand up and stretch before we continue.

What strategies can I use as a caregiver to encourage my child’s emotional regulation?

- Give consistent responses.
- Set limits.
- Encourage with compliments and positive comments.
Consistent Responses:

- Being a consistent caregiver means that you provide regular, safe, and expected responses to a child’s behavior.
- You are calm, measured, and controlled with your responses.

Setting Limits:

- Limits are clearly defined rules and boundaries that caregivers create to give their children structure and to keep them safe.
- Whether a child is at school or at home, they should always know what they are allowed to do and what they are not allowed to do.
- If your child is not allowed to do something, tell them beforehand. This is how you set a limit.

Steps of Enforcing a Limit:

1. Acknowledge the feeling:
   - “I know you are upset and frustrated.”
2. Name the limit or negative behavior:
   - “You cannot hit anyone.”
3. Name the consequence or discipline:
   - “You are going to apologize to your friend by saying four things: 1) I am sorry I hit you, 2) It is wrong because I hurt you, 3) I will keep my hands to myself, 4) Will you forgive me?”
4. Name a more appropriate behavior:
   - “Next time, please use your words, instead of hitting.”

Steps of Enforcing a Limit:

What do you do if your child repeats the negative behavior? Follow the same four steps, and add an extra consequence. The four steps would look like this:

1. Acknowledge the feeling:
   - “I know you are upset and frustrated.”
2. Name the limit or negative behavior:
   - “You cannot hit anyone. This is the second time you have hit your friend.”

Steps of Enforcing a Limit:

3. Name the consequence or discipline:
   - “First, you are going to apologize to your friend by saying four things: 1) I am sorry I hit you, 2) It is wrong because I hurt you, 3) I will keep my hands to myself, 4) Will you forgive me?”
   - “Second, you will write really on a piece of paper 50 times: I will not hit people. I will use my words.”

Steps of Enforcing a Limit:

4. Name a more appropriate behavior such as one of the following:
   - “Next time, use your words, instead of hitting.”
   - “Choose to walk away from what or who is upsetting you.”
   - “Take 5 deep breaths.”

Steps of Enforcing a Limit:

If your child continues to repeat this negative behavior, in addition to the four steps of enforcing a limit, this time you need to take away a privilege something they enjoy doing.

For example:
“Your will not be allowed to play football for the next week” or “Your will not watch a film show for the next week.”

When you take away a privilege, remember to tell your child they will get another chance to have that privilege back after the period of time stated.

Keep it positive!

Children need to be told what they can do, not just what they cannot do. Focus on this good behavior more than you do on the negative behavior.
Activity 3: Limits Workshop

Make a small group of three to four people.

1. Think of a negative behavior that one of your children does that you talk with them about often.
2. Share your group.
3. As a group, come up with one or two different good behaviors that you could tell your child to do instead.
4. Once you have one or two good behaviors, practice what you could say to your child to set a limit with them. Follow the four steps on Slide 29: Steps of Instituting a Limit.

What does encouragement look like?

While encouragement was discussed in Module 2, here are some important reminders:

- **Encouragement** is a positive comment, but can go with a loving action - like a hug.
- **Specific** - For every correction, there should be 10 positive comments or compliments.
- **Real** - Encouragement should be real, specific, and constant.
- For example: if your child was well-behaved today, do not just say “Good job” but instead say “I really like how well behaved you were at school today.”

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**The University of Maine**

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Thank you for completing Module 5! You can be a positive role model for your children!

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Image and Photo Credits

Special thanks to:

- Phoebe Araujo
- Nancy Swaray
- Abdulai Swaray
- Polly Moral
- Pedro Gomes
- Umut Baskan
- Omo Olopade

Thank you to our consultants in Sierra Leone:

- Rina Sitti
- Amna Hima
- Salmah Kamara
- Joseph Suma
- Issa Mande
- Harry Salawu
- Sam Kamara
- Martha Kojo
- Daoudou Lona
- David Musa
- Mohamed Husseine
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Module 6: Caregiver Well-Being

What is well-being?

Well-being is the state of being comfortable, healthy, and happy with your mental, physical, and emotional health. It is important to take care of your own well-being so that you can live a positive life and teach your children to live positive lives too.

Activity 1: Group Reflection

Take a few minutes on your own to think about the times you have felt:

- Guilty
- Stressed
- Afraid
- Other

Get into a small group of 3 to 4 people. Share with each other what the above 4 emotions felt like when you experienced them.
Activity 1: Group Reflection

In your small group, talk about your personal answers to the following questions:

- Does sharing these feelings with other parents make you feel less alone as a caregiver?
- Were there any different feelings shared by others in your group?

Module 6 - Slide 10

What about our own situations makes us feel these different emotions?

Module 6 - Slide 11

Feeling tired as a caregiver is natural.

“The expectation that we can be immersed in suffering and loss daily, and not be touched by it, is as unrealistic as expecting to walk through water without getting wet.”

- Dr. Rachel Naomi Remen, Kitchen Table Wisdom

Activity 2: Group Discussion

Can you think of any local sayings we use to express feeling tired or have to do with raising children?

(The sayings can be in any language.)

Module 6 - Slide 12

What can we do to prevent feeling very tired?

Module 6 - Slide 13

Self-care is any activity that you do in order to take care of your mental, physical, and emotional health.

Self-care looks different to every person. It is something that fills you up and makes you feel happy.

As a reminder, strategies like taking a break or going for a walk when stressed work well.

Self-care can also be talking with a friend, reading your Bible, or cooking a meal.

Activity 3: Self-Care

With a piece of paper and pencil, create a list of memories that make you feel better when you are having a hard day:

- A rewarding experience you have had as a caregiver
- Three compliments you have received
- The names of 3 people whose lives you have helped change

Module 6 - Slide 14

Here are some more examples of self-care you can practice the next time you do not feel bright.

- Take a bath
- Read a book
- Talk to a friend
- Write a letter
- Take a walk
- Sleep
- Play music
- Laugh
- Do something special for yourself
**Activity 3: Self-Care**

Share your list with the people around you.
Think about people in your community to whom you can turn for support during hard times.
Add the names of these support people to your list.
Keep this list in your home to look at when you are not feeling well emotionally, spiritually, and/or physically.

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**Why do we need to practice self-care?**

We are all responsible for the children of our community.
It is natural for everyone to feel stressed, tired, or sad some days.
We owe it to all children not to let our own struggles prevent us from helping and caring for them.
We must take care of ourselves too.

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**Here are a few gentle reminders for hard days:**

- You may not always understand why your child behaves the way he or she does. This is natural and okay.
- Change happens very slowly.
- Simple, compassionate actions make a difference.
- If all you can do on a hard day is give your child a hug, then it is a good day.

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**Congratulations! You have completed all 6 modules of the Attachment Theory Workshop and Self-Paced Refresher Training.**

- Module 1 - Introduction to Attachment Theory and Secure Attachment
- Module 2 - Impacts of Trauma
- Module 3 - Understanding Attachment
- Module 4 - Temperament and Childhood Resilience
- Module 5 - Emotional Regulation
- Module 6 - Caregiver Well Being

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Special thanks to:

- Professor Ivoa
- Nanny Swaney
- Andullie Swaney
- Polly Moore
- Prebay
- Unipolish
- Openrobot

Thank you to our consultants in Sierra Leone:

- Rosal Swat
- Jembe Hub
- Sawadibale Kanan
- Joseph Jinmore
- Issa Moore
- Henry Kibbee
- Ismail Mendenon
- Marni Neto
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