



## RESEARCH ARTICLE

## Childhood Trauma Intervention: A Consideration for Kenyan Curriculum

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For over 10 years, Kenya has experienced a chain of disasters that have ranged from natural calamities to ethnic and political unrests (Mtungi & Maingi, 2011). The government, security forces, and international agencies have intervened by offering humanitarian support, rehabilitation programs, or countering the potential root causes. Kenyan children have witnessed all these disasters and they live with the memories for years. Even though the national educational policy and human rights organizations have continuously advocated for education "for all children," the dominant curriculum focus has been on boosting students' performance in national exams (Sifuna, 1990). In this paper, I argue that, as the environment in Kenya has largely evolved, so have the related challenges. These changes can pose threats to the brain development, thoughts, behavior, and learning processes of the children, which will be mirrored in the future community if they are not well-managed. I further propose that the integration of Cognitive Behavior Therapy (CBT) into the Kenyan school curriculum could foster the development of the children's resiliencies and cultivate sustainable positive thinking that will promote learning and performance.

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**Introduction**

The days when adults in the African community could successfully control a child's environment using a mythological, informal curriculum have been overtaken by the rapid evolution of systemic channels through which a child is exposed to the environment (Last, 2000). The African traditional/cultural strategies in which elders used myths, riddles, and storytelling to pass moral lessons, warnings, and cultural norms on to their kids have vanished (Magesa, 2004). Children are now exposed to an insecure environment where they sometimes know the truth before or better than the adults around them (Kaplan, 2005; Arowolo, 2010). The environment is no longer under the management of the adults' structures of "dos" and "don'ts" (Last, 2000). Furthermore, the current evolution in the technological world that interacts with the child through tools like radio, music, television, and the Internet has gone viral or polluted the African culture. It is indisputable that the African community today is living a world out of Africa while remaining in Africa.

**Background**

Thinking processes among children have been influenced through either negative or positive environmental exposure and on this fact, young children in Kenya are not excluded: they have been the subjects of neglect, abuse and violence. In addition, Kenyan children have been exposed to environmental stimuli that pose as stressors and potentially impede their brain development. In early 2008, Kenya experienced post-election violence that led to the displacement of over 100,000 families and the destruction of properties worth millions of shillings (Human Rights Watch, 2008). In this violence for example, children witnessed their parents being killed by well-known neighbours, the loss of their properties (Hansen, 2009), and other traumatic events. From the 2007/2008 violence until today, the country has experienced a series of natural disasters, sporadic violence, protests, and other traumatising events (BBC Kenya Profile, 2012) in which children have been involved either directly or indirectly (Venton, Fitzgibbon, Shiterek, Coulter, & Dooley, 2012). However, there have not been any efforts to assess the impact of this violence on children, no adoption of trauma healing strategies in the school curriculum, and no similar

strategies within religious organisations. Furthermore, the Kenyan school curriculum and teacher preparation structures have neglected to focus on factors that support positive child brain development.

### **Purpose of the Study**

I will explore the pertinent literature regarding the impact of trauma on a child's thought processes, brain development, academic achievement, and coping strategies. Also, I will analyze recent evidence from research on the use of cognitive behavioural therapy (CBT) as an alternative approach for the management of trauma among children from as early as when they are in their pre-operational operational stage (2 to 7 years). In addition, I will establish the relationship between CBT and specific theories of child development. Finally, I will discuss the application of CBT on trauma management in a school setting as a possible approach that could be integrated in a child's curriculum to facilitate positive trauma coping strategies among children in Kenya.

### **Trauma and Children**

Trauma, stress, and neglect experienced early in a child's life can significantly impact their cognitive and emotional development, and their social /academic performance (Putnam, 2006). In fact, from as early as when a child is 3 years old, trauma can cause alterations in the way children view themselves and the world, in the way they process information, and in the way they respond to environmental conditions (Steele, 2008). Therefore, although the related outcomes of childhood trauma are profound and long-lasting, it is unfortunate that the impact of trauma on children has often not been appreciated and remains untreated (Lubit et al., 2003). Without any intervention, trauma impedes a child's cognitive and behavioural processes, and thus negatively affects the child's learning, performance, and behaviour (Steel, 2007). Anderson-Ketchmark & Michelle (2009) revealed that the cause of behaviour and emotional deviance can be trauma accrued in early childhood from as early as conception. When placed in a helpless and fearful situation, children imagine (have thoughts about) what they could have done to offer a solution (Steel, 2007). For example, after watching a documentary on child soldiers in Uganda, I heard my own children say: "If I could be a spider man and have a gun, I could go lay a trap get those kidnappers and rescue those kids who have been kidnapped by the rebel group in Uganda." When children are continually exposed to negative environmental pressure without relevant interventions, they can develop negative coping strategies like rebelliousness, drug abuse, and even suicide (Putnam, 2006).

Learning theories emphasise that acquiring a new complex schema of behaviour such as changing from a sedentary lifestyle to an active lifestyle normally requires modifying many of the small parts of behaviour composing the overall complex pattern (Prochaska & Diclement, 1986). As we manipulate the environmental variable in an attempt to shape the child's cognitive development through education strategies, the need to anchor early intrinsic emotional control is of paramount importance (Putnam, 2006; Roberts 2002). Miller (2011), in the analysis of anxiety disorder among school children, revealed that the time interval between a traumatic situation and respective interventions may lead to deleterious and subtle effects such as a lowered self-confidence or increased feelings of frustration. With this in mind, the earlier the child is trained to monitor his or her own thoughts and distinguish bad from good, the better they are in developing resiliencies (Roberts 2002).

### **Impact of Trauma on a Child's Cognitive Development**

In the current century, children are increasingly exposed to diversified triggers of trauma (Putnam, 2006). The trauma accrued from protracted political instabilities like the current situation in most African countries, ethnic unrest like the situation that happened in Kenya, child abuse, and natural disasters like the earthquakes in Haiti and Japan has posed an increasing need for rigorous intervention approaches. Research confirms that most trauma intervention programs exclusively target adults while children are given less consideration (Roberts, 2002). Steele (2008) precisely explained that the effects of trauma on learning and behavior have become more typical among children of all ages in schools. In addition, trauma has been increasingly proved to cause cognitive and behavioural alterations among growing children. From early childhood through maturity, trauma has been found to alter the way we view ourselves and the world around us, the way we process information, and the way we behave and respond to our environment (Anderson-Ketchmark et al., 2009).

The absence of early trauma intervention programs has led to the alteration of cognitive processes and behavioural responses among children. In turn, this has resulted in learning deficiencies, performance problems, and problematic behavior (Lubit, Rovine, DeFrancisci, & Eth, 2003). A study by Alean and Slater (2007) examined the impact of trauma among Arab children as a result of a government policy to destroy houses in the unrecognized Arab villages in the Negev of Israel. Nineteen participants (boys and girls) were asked to draw pictures of where they live, write a story about their drawings, and talk about them. The researchers used descriptive analysis to examine the drawings and stories. The findings revealed that the participants had experienced negative emotional and psychological effects because of the destruction of their homes and ongoing destruction in their under-resourced,

unrecognized villages. This situation is not unique to Arab children. Kenya has experienced similar situations from the 2007-2008 post-election violence and the most recent 2013 political parties' nominations, not to mention a series of strikes organised by civil societies including the most current Kenya teachers union strike over teachers salary increment.

With such evidence from research, teachers are challenged to provide precise intervention programs within the school setting that focus on facilitating sustainable trauma healing among children alongside curriculum delivery (Steele, 2008). To facilitate positive child growth, the curriculum needs to focus on intervention programs that further the healing process and manage the possible resultant deviant outcomes among children (Adams, Bandura, & Beyer, 1977). In addition, these programs need to be owned by the children (Adams et al., 1977). Children need help to develop independent skills regarding listening to their own thoughts, making decisions, filtering out thoughts, and owning the related consequences (Lansdowne, 2011). Cognitive behaviour therapy (CBT) is one of the interventions that have been used to motivate intrinsic emotional and behaviour management and positive thinking among people of all ages (Dobson, 2005). It has been recommended that the collaborative adoption of cognitive behaviour therapy in schools would facilitate positive child development (Foa, 2009).

### Cognitive Behaviour Therapy

**Definition.** Cognitive behaviour therapy is a short-term, goal-oriented psychotherapy treatment that takes a hands-on, practical approach to problem-solving. Its goal is to change an individual's patterns of thinking, deviant behaviour, and negative feelings (Broderick, Fullerton, Jiwani, Somer, & Querée, 2007). Cognitive behaviour therapy has been used in the management of a wide range of issues in a person's life, including sleeping difficulties, relationship problems, drug and alcohol abuse, trauma, and depression (Sample & Kadden, 2001).

Cognitive behaviour therapy works by changing people's attitudes and their behaviour by focusing on the thoughts, images, beliefs, and attitudes that they hold and how this relates to the way they behave as a way of dealing with emotional problems (Broderick et al., 2007). Cognitive behavioural therapy can be considered to contain a combination of behavioural therapy and psychotherapy because it considers the impact of an individual's self-esteem and development of thinking patterns (Broderick et al., 2002). This view is informed by Adams et al. (1977) who revealed that, human behaviour and performance are affected by self-efficacy and hence, can be altered through intrinsic positive thoughts. Also this thought concurs with the analysis of Vygotsky's social constructivist theory as explained by Miller (2011). Miller concluded that the child's cognitive development is influenced by environmental relationships. Therefore, CBT pays close attention to the relationship between individual's problems, behaviour, and thoughts (Broderick et al., 2007).

**History.** In a review of the history and future of CBT, Dobson, Beck and Beck (2005) dates the therapy to as early as the 1960s. Cognitive behavioural therapy was the brainchild of Aaron T. Beck, a psychiatrist who observed that, during his analytical sessions, patients tended to have an **internal dialogue** going on in their minds almost as if they were talking to themselves. Nevertheless, they would only report a fraction of this kind of thinking to him. For example, in a therapy session, he noted that the client could be thinking to himself or herself:

"He (the therapist) hasn't said much today. I wonder if he's annoyed with me?" pg. 263.

These thoughts might make the client feel slightly anxious or perhaps annoyed. He or she could then respond to this thought with a further thought:

"He's probably tired, or perhaps I haven't been talking about the most important things." pg 263.

The second thought could change both the client's feeling and his or her resulting behaviour. Beck realized that the link between thoughts and feelings was very important, and, hence, invented the term "**automatic thoughts**" to describe emotion-filled thoughts that might pop up in the mind. This link between thoughts, feelings, and resultant behaviour is an important aspect that children and adults need to be aware of because research explains that people are not always fully aware of negative thoughts, but could learn to identify and report them through guidance from an experienced person with skills in CBT (Miklowitz, 2006). If a person was feeling upset in some way, the thoughts were usually negative and neither realistic nor helpful. Beck found that identifying these thoughts was the key that enabled the client to understand and overcome his or her difficulties. He named it "cognitive therapy" because of the importance it places on thinking.

This approach is now known as cognitive behavioural therapy (CBT) because the therapy employs behavioural techniques as well (Broderick et al., 2007). The balance between the cognitive and the behavioural elements varies among the different therapies of this type, but all come under this umbrella term (Herbelin, Riquier, Thalman, & Vexo, 2002). As explained by the Mayo Foundation for Medical Education and Research (MFMER) report (2009), CBT has since undergone successful scientific trials in many places by different teams, and it has been applied to a wide variety of problems.

**Main steps in cognitive behaviour therapy.** According to Somers and Querée (2007), CBT tends to be short and takes four to seven months for most emotional problems. The client and the therapist, work together to understand what the problems are and to develop a new strategy for tackling them. Cognitive behaviour therapy introduces the client to a set of principles that are applicable throughout their lives (Froggatt, 2006). Although there are different ways to conduct cognitive behavioural therapy, outlines from different studies clearly highlight the following five steps (Benazon, Ager, & Rosenberg, 2002; MFMER, 2009; Steven, Michael, & Jonathan 1999; Gale & Lam, 2000; Miller, Short, Garland, & Clark, 2010):

1. Identify a troubling situation. For instance, a child may be experiencing trauma because of the deaths of both parents, rape, a divorce, or anxiety about an event. Babies up to 5-year-old children will cry a lot or act out the trauma in play (Leverington, 2008).
2. Develop an awareness of thoughts, beliefs, or feelings about the situation. This includes internal dialogue (what you tell yourself about the experience) and beliefs about yourself and other people in the situation. Thoughts and feelings can be either positive or negative, rational, or distorted. It is important to become aware of how the situation is interpreted.
3. Pinpoint negative or inaccurate thinking. What an individual thinks about a situation has a direct impact on how he or she responds to it. By consistently feeding the brain with negative self-talk, the responses to the situation will be inaccurate and distorted. This can lead to undesirable or negative reactions that include:
  - Physical responses. For example, tension. Preschool children will cry a lot, have clinging behaviour, chew cloths, sit in one place for a prolonged period, and sometimes become over-reactive (Grant, 1987).
  - Emotional responses. For example, difficulty concentrating or feeling depressed, angry, sad, nervous, guilty, or worried.
  - Behavioural responses. For example, eating when not hungry, avoiding tasks, working more than usual, spending an increased amount of time alone, obsessing about a situation, blaming others for problems, or abusing drugs.
4. Challenge negative or inaccurate thinking. This involves testing the validity of an individual's perceptions of an event. For example,
  - All-or-nothing thinking. One may see things as either "all good or all bad." For example, "I failed my mathematics exam so I am a failure."
  - Mental filtering. Seeing only the negatives and dwelling on them, distorting one's view of a person or situation. For example, "I am just a poor child from refugee camp, now everyone is looking down upon me."
  - Converting positives into negatives. One rejects his or her achievements and other positive experiences by insisting that they do not count. For example, "I only did well on that test because the teacher sympathised with my family situation."
  - Jumping to negative conclusions. One reaches a negative conclusion when little or no evidence supports it. For example, "They are all looking at me; it's all because they know that I was raped."
  - Mistaking feelings for facts. Confusing feelings or beliefs with facts. For example, "I feel like I am a minority so there is no need to participate in class activities." No matter how strong a feeling is, it is not a fact. Usually adolescents become self-critical and experience survivor guilt (Leverington, 2008).
  - Self put-downs. Self-undervaluing, putting oneself down, or using self-deprecating humor. This can result from overreacting to a situation such as making a mistake. For example, "I don't deserve anything better."
5. Change inaccurate thoughts and beliefs. This occurs through the process of "erasing and replacing." When one recognizes a negative, self-defeating thought, one should press the internal stop button in the mind by saying "stop" to oneself. This should be immediately followed by replacing the negative thoughts with positive affirmations that support and encourage. Following this strategy enables an individual to find constructive ways to manage a situation.

Referring to the five steps Ellis (1999) blends the CBT process into the ABC model, which includes "Activating event (A) leads to emotional and behavioural Consequences at (C), with the emotional consequences being mediated by beliefs at (B)."

## Cognitive Behaviour Therapy and Development Theories

**Neuroscientist perspective.** As analysed by the National Research Council (2000) in how people learn, a neuroscientist perspective explains that the environmental stimulus exposed to a child early in his or her development determines the formation and pruning of the brain synapses, which decode the respective stimulus just like a "lock and key." Therefore, exposure to traumatising situations earlier in life may lead to the development of coping strategies as the child struggles to survive through them (Miller et al., 2010). The challenge in this process is that the long-term impact of continuous exposure to trauma and the counter process of coping strategies may result in deviant behaviour (Ellis, 1991). The deviant behaviour, in turn, may affect the child's integration into the community, school, family, and peer groups, and, hence, protract the trauma circle (Miller et al., 2010). For example, a female child who is subjected to rape earlier in life may develop a low self-esteem as she interacts with her peers and, eventually, may permanently hate male humans (Cohen, Mannarín, & Knudsen, 2005).

As Kandel explained in the CBC commentary "The Brain that Changes Itself," what one thinks may change his or her brain wiring (Doerge et al., 2008). Hence, an example of Arab children narrating stories and drawing pictures of their homes being burned by the government will forever affect the child's relationship with the government (Alean & Slater, 2007). The assumption posed by CBT is that the more a child learns to have positive thoughts, the higher the possibility he or she will select positive coping strategies (Miller et al., 2010). The child also learns to distinguish between a negative thought or belief from the positive alternative (Dobson, 2005). As the child practises CBT, he or she will develop ownership in the management of his or her own thoughts (Benazon et al., 2002), which is a clear link to the pruning and formation of synapses to cope with the environment.

**Piaget's cognitive stage theory.** Various cognitive interventions have been integrated in CBT intervention among children (Kinney, 1991). Piaget, for example, analysed the stages of child cognitive development (Miller, 2011). This formed a basic platform for determining the appropriate age for CBT intervention. For example, the "pre-operational stage" of child development has been arguably considered as being not appropriate for CBT because children in this stage lack the logical thought structure necessary for disputing irrational and dysfunctional cognitions (DiGiuseppe, Linscott, & Jilton, 1996). However, children in the "operation stage" "concrete operational" and "formal operational" stages could be included in the CBT intervention with some adoption because their hypothetical-propositional thought structures required by CBT is still developing (Ellis, 1991; De Benedict, Wiriga, 2000). During the CBT intervention process, children in this stage are asked to deal with familiar yet relatively abstract concepts like "fairness," "friendship," or "trust" (Kinney, 1991). In considering CBT among children, the therapist is expected to adjust his/her communication style and expectations to the cognitive developmental level of the child (Benazon et al., 2002).

Piaget's theory provides a reasonably sound theoretical structure for the use of CBT with children. This theory however, focuses primarily on the development of logical/mathematical thought structures in the child, not on the development of social-cognitive structural change (Miller, 2011). Nevertheless, the CBT therapist should prioritize Piaget's logical thought structures map of reasoning about the self and one's social world in their practice (De Benedict & Wiriga, 2000). As the CBT therapist attempts to direct and guide the child's awareness regarding logical thinking ability, social perspective-thinking should also be given consideration. This type of thinking includes a child's fluidity in anticipating and appreciating his perspectives, viewpoints, and motives of other children and adults (Kinney, 1991).

**Information processing theory.** Another view of cognitive development in relation to CBT is the fact pursued by information processing theory. A child plays an active role in receiving information from the environmental stimulus and progressively modifying them to suit his or her needs (Miller, 2011). Human beings have a unique way of processing information. Beck, in explaining his experience with patients, draws a journey through which information travels (as cited by Dobson, et al., 2005). In this process, environmental experiences trigger some thoughts, which eventually stimulate internal imagery (inform). The internal imagery leads to self-dialogues that consequently influence behaviour (Herbelin et al., 2002). In a human's mind, a word and the actual item or event enter into a bi-directional stimulus relation wherein each can equally stand for the other (Khemlani-Patel, Neziroglu & Veale, 2008). For example, the word "Banana" and the actual banana are equal in a person's mind because of the person's unique ability to decode the information as displayed by language (Miller, 2011). An interpretation that one gets from informational signals automatically influences beliefs or thoughts and so does his or her subsequent behaviour (Armitage, Conner, & Norman, 1999).

The other issue influencing the CBT model is the complex relational ability of the human mind (Khemlani-Patel et al., 2008). A child's ability to think relationally, for example, in establishing similarities and differences allows him or her to engender diverse relations. This skill eventually provokes the child to have an explicit comparative, evaluative, and causal relations ability that may be reflected in a self-dialogue and, hence, influence his or her behavior (Alean & Slater, 2007; Bandura, 1999). For example,

“Why did the teacher call my name last(A)? Students whose names are called last, meanstheyperformed poorly(B).I will never attend this class again (C)” or

“Why is it that when they talk about refugees or Internally Displaced Persons (IDPs), every one turns his or her eyes on me (A)? This may be the reason why no one wants to play with me (B). I hate the teacher, I hate the school and I will never talk to anyone in this class (C).”

Research has shown that,if not well-managed,the route of self-modification in information processes may lead to distortedthoughts about oneself and the environment. Hence, behavioural and psychological problemsmay result (Miller, 2011).For example, biases toward attending to threatening information or toward interpreting ambiguoussituations as threatening contribute to excessive or unnecessary anxiety. The focus of CBT is to facilitate a child or client to establish alternative responses that necessitate positive shifting appraisals, core beliefs, and associated biases in attentionand memory forms (Khemlani-Patel et al., 2008).

Finally, the expected CBT outputis changeeffected throughlearning new experiences that overshadow previous forms of maladaptive learning and information processing. For example, facing the challenge of being displaced because of violence may help one develop conflict mitigation or post conflicts counseling skills as role models (Ellis,1999). Therefore, change can occur in the shortterm because of learning these new thoughts and behaviours, and this change can be maintained over thelong term as these newly acquired responses generalize across situations and time (Brodrick et al., 2007). Cognitive behavioural therapyalsoinvolves the teaching of new coping skills such as assertiveness, relaxation, or self-talkto produce amore effective response to environmental situations (Miller et al., 2010). This is expected to leadto an improved outcome over time as the new skills are practiced and implementedrepeatedly.

**Cognitive behaviour therapyand trauma among children in school.**With the unique ability of changing one’s behaviour through positive thoughts and beliefs, CBT has been used successfully to manage trauma. In a research by **Smith et al. (2007)** aimed at evaluating the efficacy of individual trauma-focused CBT for managing posttraumatic stress disorder in children and young people,a 4-week symptom-monitoring baseline was conducted on 24 children and young people. The participants involved those who experienced either (a) a motor vehicle accident or (b) interpersonal violence, or (c) who had witnessed violence. A groupof 12 participants was then placed on the waiting list and served as a control while the other 12 participants weresubjected to a 10-week CBT program. The results from this studyindicated that the participants who received CBT showed significantly greater improvement in symptoms related to depression and anxiety, andsignificantly better functioning in terms of behaviour.With theseresults, it was clear thatCBT has a positive impact on managing trauma in children. In this research, however, it was not clear on how the baseline was established prior to intervention or whether the same strategies were used for all ages or if there weremodifications involved(Eliss 1999).

In a study by Cohen, Deblinger, Mannarino, and Steer (2004), 299 children with a mean of 10.76 years were subjected toCBT and Child–Centred Therapy (CCT) with an aim of establishing the most effective intervention. All of the children met at least five of the six DSM-IV criteria of post-traumaticstress disorder. Out of this sample, 60% of the participants were white, 28% African-American, 4% Hispanic, 7% bi-racial, and 1% were of another ethnicity.The participants wereregiven an initial screening by evaluators and then randomly assigned either to a CBT group or to a comparison group, which used a CCT program. During the therapy sessions, the children chose what topics to discuss and largely led the direction of the sessions.

The CBT treatment program focused on expressing feelings, training in coping skills, understanding relationships between thoughts and behaviors, and gradual exposure to the traumatic event.Both treatments were given once a week and involved two consecutive 45-minute sessions: one for the child and one for the child’s parent for a total of 90 minutes of treatment sessions each week.The findings from this research revealed thatthe participants in both conditions had improved scores on all measures for post-traumatic stress disorder symptoms over the course of the study. However, the CBT participants had significantly lower scores on survey measures of post-traumatic stress disorder, Children’s Depressive Inventory (CDI), and Children’s Attributions and Perceptions Scale thanthe CCTparticipants had.Cognitive behavioural therapywas recommended as the most effective intervention for children in this stage of growth. This study, however, did not explicitly explain thespecific courses of trauma to the children in the sample, which is a factor that should be considered inthe generalization of the intervention (Benazonet al., 2002).

In a separate study,Cohen et al. (2005) considered using CBT in treating sexually abused children. The study involved a sample of 82 children and adolescents who were referred to a traumatic stress program. In this study, 60% of the participants were Caucasian, 37% African-American, 2% bi-racial, and 1% Hispanic.The participants included in the studyhad had contact with sexual abuse within a period of sixmonths before the onset of the study. The CBT treatments focused on the topics of feeling identification, stress inoculation techniques, direct

discussion, and the gradual exposure of traumatic events. In addition, education about healthy sexuality and safety skills was administered. The findings from this study indicated that the participants exhibited fewer and/or less pervasive symptoms of post-traumatic stress.

## Conclusion

With the current environmental and psychological stressors in Kenya, the child's cognitive development is exposed constantly to trauma (Alean & Slater, 2007). Cognitive behavior therapy emphasizes the power of individual thoughts/beliefs and their influence on behavior (Ellis, 1999). A growing child needs to be guided to develop and intrinsic positive thoughts strategies, and independence in problem solving (Prochaska & Diclement, 1986). With research evidence available on the effectiveness of CBT on trauma management among children (Cohen et al., 2005; Cohen et al., 2004; Smith et al., 2007), it is paramount to consider a collaborative approach in its implementation within the school setting (Millers et al., 2010). The Kenya Ministry of Education needs to equip teachers with skills that will help them effectively respond to children's needs. At the same time, the Ministry needs to update the curriculum to merge the needs of Kenyan children as observed in the environment. Poor performance may just be a result of a child's brain hosting a chain of traumatizing experiences. This will not be solved by any teaching strategy but by an approach that will join their mental dialogues and help them come out successfully.

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