Kogi Journal of Education and Pedagogy (KOJEP), Vol. 4, No. 1, JUNE, 2025

ISSN 2736-0091
E-ISSN 2737-0107

EFFECT OF TRAUMA-FOCUSED COGNITIVE BEHAVIOURAL THERAPY ON AGGRESSION AMONG SEXUALLY ABUSED ADOLESCENTS IN OGUN STATE

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Abstract

Sexual abuse has become a great impediment in our society today; its activity is evident in all facet of our society; secular and sacred; This study aimed at investigating the effect of Trauma Focused Cognitive Behavioural Therapy on Aggression among Sexual Abused male and female Adolescents and how it affects their day to day activities. Quasi-experimental pre-test post-test control group design was employed for this study. It was hypothesised that Trauma-Focused Cognitive Behavioural Therapy (TF-CBT) will not significantly ameliorate aggressive behaviour among sexually abused adolescents irrespective of their gender. The findings revealed that Trauma-Focused Cognitive Behavioural Therapy (TF-CBT) significantly reduced aggression, among sexually abused adolescents who were exposed to it. Further research is required to decipher the long effect of trauma-focused cognitive behavioural therapy on sexually abused as a counseling tool. In conclusion, Trauma Focused Cognitive Behavioural Therapy should be administered more to victims of sexual abuse to ascertain its effectiveness in managing aggression among sexually abused adolescents.

Keywords: Adolescents, Aggression, Sexual abuse, Trauma, Trauma-Focused Cognitive and Behaviour Therapy

Introduction

Sexual instinct is a natural and acceptable biological reaction in all healthy humans. It is made for procreation and emotional satisfaction for those who engage themselves in the expression of their sexual urge. When an individual finds it difficult to express this biological trait, they are considered unhealthy and require medical attention. United Nations International Children's Emergency Fund (UNICEF) according to (David, Oliver, Wapmuk, Gbajabiamila, Aigbe, Herbertson, & Odeyemi 2018) defined Child sexual abuse as the involvement of a child in a sexual activity that they do not comprehend, unable to give informed consent to, or for which the child is not developmentally prepared and cannot give consent, or that violate the laws or social taboos of society.

Aggression is likely to occur in retaliation or without provocation; subsequently, frustration due to shelved goals can cause aggression. It is an action carried out by an individual with the intention to damage, destroy or cause injury or harm or anxiety to others or even to one's self or the devastation of one's property or that of others, (Nnachi, 2013). According to Gabbey (2013), aggressive behaviour can be reactive or, in retaliation, it can also be proactive as an attempt to provoke a victim. It can also be self-directed. He further stated that a variety of factors can influence aggressive behaviour. These include family structure, relationship with others, work or school environment, psychiatric issues, and life experience. Imhonde (2014), on the other hand, opined that there are factors that perpetuate an aggressive personality. He stated that aggression is more pre-dominant under three conditions, namely: Under high level of frustration; when there is a payoff response to acting out and when it is learnt through observation.

In Summary TF-CBT can be an effective treatment for reducing aggression in sexually abused adolescents. However more research is needed to fully understand the effect of TF-CBT on aggression in this population. Human life completes its journey through various stages, and one of the most vital stages is adolescence. Adolescence is the period of transition from childhood to adulthood and plays a decisive role in the formation of pro-social or anti-social adults. Adolescence, according to Steinberg (2014), is a dynamically evolving theoretical construct informed through physiologic, psychological, temporal, and cultural lenses. It is a critical developmental period of years conventionally understood as the years between the onset of puberty and the establishment of social independence. According to Sacks (2013), adolescents are individuals between the ages of 10 and 19 years.

Sexual abuse is a form of violence that involves any unwanted sexual activity or behaviour, including rape, molestation, and sexual harassment. It is a widespread problem that affects individuals of all ages and genders and has serious physical and psychological consequences. One common definition of sexual abuse is based on the perpetrator's behaviour. According to the World Health Organization (WHO), sexual abuse involves any sexual activity or behaviour that is perpetrated against

ISSN 2736-0091
E-ISSN 2737-0107

someone's will or without their consent (WHO, 2016). Another conceptualization of sexual abuse focuses on the power dynamics between the abused or victim and the perpetrator. This view recognises that sexual abuse is often a form of interpersonal violence that is rooted in social inequalities and power imbalances (Gavey & Schmidt, 2001).

Aggression is a multifaceted phenomenon that involves a range of behaviours aimed at harming others physically or emotionally. In Nigeria, aggression is a prevalent issue with significant negative consequences. A study conducted by Okeke and Olotu (2017) found that aggression was prevalent among secondary school students in Nigeria, with 53.6% of participants reporting being involved in physical fights. The study also revealed that factors such as gender, age, and family background were significant predictors of aggression among the students. Another study by Ogunfowokan, Lawal, and Akinhanmi (2016) examined the relationship between aggression and substance abuse among adolescents in Nigeria. The study found that adolescents who engaged in substance abuse were more likely to exhibit aggressive behaviours, including physical fighting and verbal aggression.

Trauma-focused cognitive-behavioural therapy (TF-CBT) is a form of psychotherapy that has been shown to be effective in reducing the symptoms of post-traumatic stress disorder (PTSD) in individuals who have experienced sexual abuse. There is evidence that TF-CBT can also reduce aggression in individuals who have experienced sexual abuse. Cohen, Mannarino, Kliehermes, Murray, and Traudt (2018) examined the effectiveness of TF-CBT in reducing aggression among adolescents who had experienced sexual abuse. The study found that TF-CBT was effective in reducing both physical and verbal aggression in adolescents. Similarly, Chaffin, Silovsky, Funderburk, Valle, Brestan, Balachova, and Bonner (2012), Ajuwon and Olaleye (2019), all found that TF-CBT was effective in reducing aggression among individuals who had experienced sexual abuse. The study found that victims of sexual abuse who received TF-CBT showed significant reductions in both physical and relational aggression. Though there is limited research work on the impact of sexual abuse on men, Eze, Onu, and Umeakuana (2020) discovered that 14.4% male undergraduate students in Nigeria reported experiencing sexual abuse. Invariably the positive self-image of a sexually abused adolescent is questionable, it is required that to have adolescents grow into a productive adulthood, attention must be paid to avoid reproducing themselves on other innocent adolescents through adequate counseling process.

Hypothesis

This hypothesis guided the study:

There is no significant difference in the post-test mean scores on the level of aggression exhibited by sexually abused male and female adolescents exposed to TF-CBT and those in the control group.

Methodology

The research design for this study was quasi-experimental pre-test post-test control group design. This design is appropriate because it involves human experiment where rigorous controls and randomization were not feasible. There were two experimental groups; (comprising one treatment and one control group) used for the study. The treatment group was exposed to Trauma Focused Cognitive Behavioural Therapy, while the control group was a waiting list treatment expectancy group.

The design is represented as follows:

R 0_1 X 0_2

R 0_3 0_4

Where:

R represents Randomization

0_1 and 0_3 represents pre-test

0_2 and 0_4represents post-test

X represents treatment Focused-Trauma Cognitive Behavioural Therapy (TF-CBT)

Independent variable: Experimental condition which is at two levels:

a) TF-CBT
b) Control

Dependent variables: Aggression.

Moderating variable: Gender which is at two levels:

a) Male
b) Female

The target population of this study comprised all sexually abused adolescent in senior secondary school 2 (SS 2) students in Ogun State, South-West Nigeria. The study was carried out in Abeokuta Ogun State, South-West Nigeria. A sample of 61 participants consisting of 30 male and 31 female students were involved in the study. Multistage sampling process was employed to select the sample for the study. Hat and draw was used in selecting two local government areas out of the 20 local government areas in Ogun State for this study. Subsequently, one senior secondary school from each of the two local government areas was selected using simple random technique. Furthermore, sexually abused students from each of the senior

ISSN 2736-0091
E-ISSN 2737-0107

secondary schools two (SS2 students) were selected using Children/Adolescent Attribution perception scales (CAPS). A total of 88 out of 273 SS2 students were identified to have suffered one form of sexual abuse or the other. International Trauma Questionnaire Children and Adolescent Version (ITQ-CA) was administered to determine from the sample those who were traumatised by the abuse, and scored five (5) and above, this yielded 61 eligible participants for the study. Out of this, only 22 male and 26 female students completed the study; 13 of them dropped out before the last session was conducted.

The following research instruments were used to obtain relevant data for the study:

Children's Attributions and Perceptions Scale: Children's Attributions and Perceptions Scale (CAPS) was adopted for this study because it was designed to assess those perceptions and attributions perceived to be particularly relevant to sexually abused children and that are not measured by existing instruments. It was originally called the semi-structured interview for children. It was developed by Mannarino, Cohen and Berman in 1994. It contains 18 items and four subscales which include four items in feeling different from Peers, four items for perceived Attributions of negative events, five items of perceived Credibility and five items of interpersonal trust. It was printed without any reference to sexual abuse. It has a 5 scale response ranging from Never (1) to Always (5). It has internal consistency of 0.68

International Trauma Questionnaire Children and Adolescent Version: International Trauma Questionnaire Children and Adolescent Version (ITQ-CA) was adopted for this research study and was developed by Cloitre, Shevlin, Brewing, Bisson, Roberts, Maerck, Karatzias, & Hyland, in 2018. It measures and scores trauma related problems. It contains 22 item questionnaires with two major subscales [Post-Trauma Stress Disorder (PTSD) and disturbance in self organisation (DSO)]. Post-Trauma Stress Disorder (PTSD) consists of items 1-6 and 12-17 with 5 likert scales. While the Disturbance in self-organization is items 7-11 and 18 – 22 with yes or no responses. Participants who scored five and above were adjured to be traumatised as a result of finding it difficult to organise self. The International Trauma Questionnaire Children and Adolescent Version (ITQ-CA) PTSD scale has a coefficient reliability of 0.87, while the International Trauma Questionnaire Children and Adolescent Version (ITQ-CA) DSO scale has a coefficient reliability of 0.90.

Buss Perry Aggression Questionnaire (BPAQ): Buss Perry Aggression Questionnaire (BPAQ) was adopted for this research study and was developed by Arnord. H. Buss and Mark Perry in 1992. It consists of 29 items scale of four subscales: Physical aggression (PA) items 0-9; verbal aggression (VA) items 10-14; Anger (A) items 15-21 and hostility (H) items 22- 29. These items are rated on 5 point likert scale ranging from (1) "Extremely Uncharacteristic" to (5) "Extremely Characteristics". The score for each scale is the sum of rating for its items. Items 9 and 16 are scored in the opposite direction due to the setting of the items. Higher score indicate higher aggression behaviour. It has a test retest reliability of 0.78 for physical aggression; 0.68 for verbal aggression; 0.75 for anger and 0.76 for hostility.

The administration of the research instruments were carried out in three phases within the period of six weeks by the researcher and his research assistants.

The researcher administered the research instruments to the 31 participants with the help of the research assistants as a pre-test a week before the commencement of the treatment session. There were one treatment group and one control group. The selected schools were randomly assigned to treatment and control groups. The experimental group was exposed to Trauma-Focused Cognitive Behavioural Therapy (TF-CBT). They were exposed to an hour per week of TF-CBT. The control group was not given any treatment.

Treatment Session

1. **Introduction and administration of instruments:**

The researcher established rapport with the participants and assured them of confidentiality. He further explained the objectives, protocol and conduct of the study to the participants. The research instruments were administered to obtain pre-test scores of the study.

2. **Identification of Problems:**

The session began with the introduction of Trauma-Focused Cognitive Behavioural therapy (TF-CBT) and the common types of trauma which includes violence or sexual assault, child birth, death of a beloved one or close person, suicide attempt and witnessing violence. The participants were encouraged to share any traumatic experiences they had in the last six months. They were given homework to state how they managed the trauma that they experienced.

3. **Affect Expression:**

The researcher reviewed the previous session and the homework that was given. Participants were asked to mention some negative and unpleasant thought that came into their mind. Affect expression was introduced (outward expression of inward feelings such as anger, agitation, sad, happy, elated etc.). Afterwards the participants acted out some inward feelings while others pointed out what such posture meant. Assignment was given at the end of the session to write out skills that helped them manage distressing emotions. (e.g. talking to others, deep breathing, listening to music, imagery, etc.).

4. **Dysfunctional Helpful Thoughts/Coping Skills:**

The homework of previous sessions was recorded; the participants were exposed to cognitive coping skills e.g. breath restraining, progressive muscle relaxation, self-monitoring, behaviour activation, listing pros and cons, identification of non-

ISSN 2736-0091
E-ISSN 2737-0107

traumatic related problematic thoughts and their helpful replacement. This would enable them develop positive reaction to unpleasant situations. They were given assignment to note helpful thoughts used to replace dysfunctional thoughts.

5. Introduction to the concept of trauma narrative

The participants were told short story from our national daily citing different types of trauma that is not directly on the sexual abuse. This is to ensure that anxiety was not built up on the participant. Afterwards, they were given the opportunity to introduce and share something similar to the content read. The researcher continued on the coping skills that will be needful in situations similar to this. Assignment was given to the participants to outline three coping skills they can use at home and in school.

6. Fundamental Trauma Narrative

With the help of research assistants, the researcher engages the children individually on personal narrative of trauma, areas to identify to enable adequate help includes" overarching trauma that indicates symptoms e.g. self-blame, betrayal, etc. and areas that seems shameful or sad for them to disclose and finally areas they exhibited personal strength, support for others or kindness demonstrated. While this is ongoing, the research assistants will engage the rest participants in sharing what lessons they intend others to learn, trauma related avoidance behaviour will be discussed e.g. not walking in the dark alone, not sleeping alone, or visiting opposite sex alone. They will be asked to draw pictures reflecting common mode of children after a traumatic experience.

7. Creating Value for Living:

The assignment of previous lesson was considered and reviewed. The researcher explained the role value plays in overcoming traumatic situations; the quest for vengeance or desire for suicide is no option for a goal oriented person. They are encouraged not to allow any trauma take away their focus from their dreams. Homework was given.

8. Review/Administration of Post-test and closing

All previous sessions were reviewed, and the overall experiences were discussed. The researcher did a summary of all the important points highlighted during the period of the study on TF-CBT. Questions were asked by the participants and answers proffered by the researcher. The post-test research instruments were administered immediately and the participants were treated to a light refreshment to bring the study to a close.

Group Two – Control Group

The participants in this group were not given any treatment. The research instruments were administered on them as a pre-test on the first week of the study, five weeks after the post-test was administered on them. They were appreciated afterward and the study came to a close.

Results

The data collected from the various instruments were analysed using both descriptive and inferential statistics appropriate for each hypothesis. The means and standard deviations for pre and post-tests assessment measures were computed while Analysis of Covariance was used to test the hypothesis at 0.05 level of significance.

Hypothesis Testing

There is no significant difference in the post-test mean scores on level of aggression on sexually abused male and female adolescents exposed to TF-CBT and those in the control group. The hypothesis was tested using Two -Way Analysis of Covariance (ANCOVA). The results of the analysis are presented in the Tables 1 and 2.

Table 1: Means and Standard Deviation of Pre-test and Post-test Means scores on Aggression by Experimental Group and Gender

Experimental Condition	Gender	N	Pre-test		Post-test		Mean Difference
			Mean	S.D	Mean	S.D	
	Male	12	67.83	8.33	43.08	14.68	-24.75
TF-CBT	Female	14	63.29	9.08	44.00	12.36	-19.29
	Total	26	65.38	8.87	43.54	13.28	-21.84
	Male	10	60.80	17.61	40.20	12.96	-20.60
Control	Female	12	65.83	12.99	51.83	14.64	-14.00
	Total	22	63.55	15.09	46.55	14.81	-17.00
	Male	22	64.64	13.49	41.77	13.68	-22.87
Total	Female	26	64.46	10.90	47.92	13.84	-16.54
	Total	48	64.54	12.02	44.98	13.96	-19.56

Table 1 showed that the male participants exposed to TF-CBT and their female counterparts obtained pre-test mean scores of 67.83 (±8.33) and 63.29 (±9.08) as against post-test mean scores of 43.08 (±14.68) and 44 (±12.36) respectively. This yielded pretest-posttest mean gains of minus -24.75 and -19.29. The data indicated strong reduction in aggressive behaviour among male and female participants. It further showed that there was no significant difference in the scores of both male and female

ISSN 2736-0091
E-ISSN 2737-0107

group. However, the data indicated that TF-CBT had more positive impact on the male (-22.87) participant than the female (-16.54) mean gains.

Table 2: Two-Way ANCOVA On Aggression post-test by Experimental Group, Sex with Aggression pre-test

Source	Type III Sum of Squares	df	Mean Square	F	Sig.	Partial Eta Squared
Corrected Model	2300.186[a]	4	575.047	5.019	.002	.318
Intercept	700.209	1	700.209	6.111	.017	.124
Agg_pretest	652.414	1	652.414	5.694	.021	.117
Groups	906.579	1	906.579	7.913	.007	.155
Gender	594.791	1	594.791	5.191	.028	.108
Groups * Gender	98.512	1	98.512	.860	.359	.020
Error	4926.626	43	114.573			
Total	91647.000	48				
Corrected Total	7226.812	47				

a. R Squared = .318 (Adjusted R Squared = .255), n.s. = not significant, p value > 0.05 level

The analysis of covariance (ANCOVA) in Table 10 shows that p-value of 0.359 is greater than 0.05 level of significance. This indicates that there was no significant difference between the groups (experimental and control) post-test scores on aggression, F (1, 43) = .860, p = 0.359 based on gender. This implies that the post-test scores on aggression of males did not differ from that of the females significantly. Hence the null hypothesis was accepted. The data further showed that the treatment had more impact on the male than the female participants. On the overall, the male group indicated serious reduction in aggressive behaviours than the female, although the improvement within groups was not significant.

Discussion of Findings

The hypothesis stated that there was no significant gender difference in the post-test mean scores on aggression among sexually abused adolescents exposed to TF-CBT and those in the control group. Consequently, the null hypothesis was accepted while concluding that the male participants exposed to TF-CBT had more positive impact of the treatment as they exhibited better reduction in aggressive tendencies than the female participants. The analysis further revealed that the reduction index of aggression by the male and female groups was not significant so the null hypothesis was accepted. This finding was in tandem with the study conducted by Haskett, and Kistner (1994); Briere (1996); Kendal, Williams and Finkelhor (1993) which revealed that aggressive behaviour is a persistent pattern of behaviours among male and female adolescent which have negative outcome, more especially among sexually abused adolescents.

Conclusion

Further research study will be required to determine the effectiveness of TF-CBT as an intervention for reducing aggression among sexually abuse adolescents in Nigeria, and how to integrate it as a counselling tool in providing help and care for survivors of sexual abuse.

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